THE RIGHT TO CONFIDENTIALITY IN THE CONTEXT OF HIV/AIDS

by

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PROMOTER: PROF MN SLABBERT

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I, Paul Tobias Mtunuse, declare that *The Right to Confidentiality in the Context of HIV/AIDS* is my own work and that all the sources that I have used or cited have been indicated and acknowledged by means of complete references.

…………………………… 28 February 2013

Paul Tobias Mtunuse  DATE
DEDICATION

This thesis is dedicated to my lovely wife, Tumela Mtunuse and my two kids, Palesa and Kamohelo Mtunuse, for all their love and the sacrifices they made throughout the entire period of my study and the days and nights that I was away.
I would like to thank the Lord, Almighty God, for the life and strength He has given me to persevere until I achieved the completion of this research. It is only through His power that I managed at the end to accomplish this valuable achievement. To Him be glory and honour. I would like to thank the Lord Jesus Christ for all the second chances He gave me throughout my life. For as the apostle Paul states in Philippians 1:21, “For to me, to live is Christ and to die is gain.” It is only through the grace of the Lord that I am still alive today.

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PT Mtunuse
SUMMARY

The purpose of this study is to investigate the right to confidentiality in the context of HIV/AIDS through an interdisciplinary lens. This study indicates that whilst confidentiality is important and should be preserved in order to protect persons living with HIV/AIDS against stigmatisation, discrimination and victimisation, this should be balanced by other equally important interests, such as the protection of public health and individual third parties who may be affected by the intentional or negligent infection of others with HIV. As the consideration of the legal issues relating to confidentiality and privacy cannot be divorced from the social context in which HIV/AIDS plays out in South African communities, the study will examine, amongst others, the victimisation, discrimination and stigmatisation experienced by persons living with HIV/AIDS, followed by a critical exploration of the present legal and ethical framework governing privacy and confidentiality, including medical confidentiality, as well as the duty to disclose a positive HIV-status, in the context of HIV/AIDS. Possible limitations on the right to privacy in this context are also examined, which include, amongst others, a consideration of making HIV/AIDS notifiable diseases in South Africa. The study suggests that it is imperative that legal interventions aimed at curbing the spread of HIV will need to be mindful of the unique social, cultural and economic forces that impact on the duty to disclose a positive HIV-status to partners and other affected third parties. Insights gained from philosophical theories relating to Africanism, individualism, communitarianism and utilitarianism are valuable tools in facilitating a clearer understanding of relevant social and cultural factors that keep South African society locked in the present stalemate with regard to the disclosure of HIV status.

Key terms:

HIV/AIDS, the right to confidentiality, the right to privacy, the right to dignity, medical confidentiality, limitation clause, stigma, discrimination, victimisation, criminalisation, Constitution of the Republic of South Africa, persons living with HIV/AIDS, individualism, communitarianism, utilitarianism, Africanism, notifiability, partner notification.
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CHAPTER 1

INTRODUCTION

“It all started as a rumour...Then we found we were dealing with a disease. Then we realised it was an epidemic. And now we have accepted it as a tragedy.”

1.1 HISTORICAL BACKGROUND

1.1.1 Introduction

The origins of human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) are traced back by scientists and researchers to as early as 1884. Many scholars agree that AIDS was recognised as a syndrome of illnesses by scientists in 1981. There is also agreement that HIV, the virus which causes AIDS, was identified or isolated in 1983. This means that AIDS as a disease was discovered by scientists in the 1980s, although it had originated much earlier around 1884. It is accepted


4 Berer and Ray 6, Barret-Grant 11, Squire 25, Harris and Haigh 1, and Osborn 22.

that AIDS originated from Africa before it spread to other parts of the world.\textsuperscript{6} This chapter will look at the historical background and origins of HIV and AIDS. It will also include an overview of the HIV/AIDS epidemic in South Africa. A thorough overview of the origins of HIV and AIDS, as well as the spread of the pandemic in South Africa is necessary, as this will contextualise and inform the discussion of legal and social issues relating to confidentiality and the disclosure of a positive HIV-status.

1.1.2 The Origins of HIV and AIDS

Reeves and Doms point out that AIDS resulting from HIV-1 infection was recognised in 1981 when a common pattern of symptoms was observed among a small number of homosexual men in the USA.\textsuperscript{7} Berer and Ray also point out that the earliest cases of people who died of HIV-related illnesses were identified in the 1980s from stored samples of tissue and fluids.\textsuperscript{8} Squire\textsuperscript{9}, however, explains that it is probable that HIV has a much longer and more dispersed existence in humans, involving long-term low levels of infection. HIV has been isolated from a 1959 plasma sample, but may have been around in humans since the 1930’s within Africa, moving to the US and then Haiti in the late 1970s.\textsuperscript{10} In fact, as Keele points out, there is now conclusive evidence that HIV originated in Africa.\textsuperscript{11} A 10-year study completed in 2005 found a strain of Simian Immunodeficiency Virus (SIV) in a number of chimpanzee colonies in south-east Cameroon, the first-mentioned the viral ancestor of HIV-1 that causes AIDS in humans.\textsuperscript{12}

During the last few years it has become possible not only to determine whether HIV is present in a blood or plasma sample, but also to determine the particular subtype of the virus.\textsuperscript{13} Studying the subtype of virus of some of the earliest known instances of HIV infection can help to provide clues about the time it first

\textsuperscript{6} Jasper at 3, for instance, points out that: “Because there was such a large concentration of victims in Central Africa, the consensus among researchers was that the virus somehow originated in this area.” See, also, Worobey 661-664, who points out that “[t]he authors suggest a long history of the virus in Africa and call Kinshasa the ‘epicentre of the HIV/AIDS pandemic’ in West Africa.” See, also, Squire 25, Levay and Valente 571, Waters 20 and Keele BF et al Chipmazee Resevoirs of Pandemic and Nonpandemic HIV-1 (2006) Science 313 (28 July) 523-526 at http://www.avert.org/history-aids-africa.htm (visited 28 July 2010).

\textsuperscript{7} Reeves and Doms 1253-1265.

\textsuperscript{8} Berer and Ray 6. They further point out that these cases include a seafarer from England, who died in 1959; a teenage boy from the USA, who died in 1969; a sailor, his wife and their youngest daughter from Norway, who began to develop HIV disease in the mid-1960s and had all died by 1976; and a blood donor from Zaire, in 1959.

\textsuperscript{9} Squire 25.

\textsuperscript{10} Squire 25.

\textsuperscript{11} Keele 523-526

\textsuperscript{12} Keele 523-526.

\textsuperscript{13} Varghese S History of HIV-AIDS at http://www.upublish.info/..J141444 (visited 21 July 2010).
appeared in humans and its subsequent evolution.\textsuperscript{14} A 1998 analysis of the plasma sample from 1959 suggested that HIV-1 was introduced into humans around the 1940s or the early 1950s.\textsuperscript{15} In January 2000, the results of a new study\textsuperscript{16} suggested that the first HIV-1 infection occurred around 1931 in West Africa. This estimate (which had a 15 year margin of error) was based on a complex computer model of HIV’s evolution. However, a study in 2008\textsuperscript{17} dated the origin of HIV to between 1884 and 1924, much earlier than previous estimates at that time. The researchers compared the viral sequence from 1959 (the oldest known HIV-1 specimen) to the newly discovered sequence of 1960. They found a significant genetic difference between these, demonstrating that the diversification of HIV-1 occurred long before the AIDS pandemic was recognised.\textsuperscript{18} In May 2003, a group of Belgian researchers led by Dr. Anne-Mieke Vandamme, published a report\textsuperscript{19} in the proceedings of National Academy of Science. By analysing samples of the two different subtypes of HIV-2 (A and B) taken from infected individuals and SIV samples taken from sooty mangabeys, Dr Vandamme concluded that subtype A had passed into humans around 1940 and subtype B in 1945. Her team of researchers also discovered that the virus had originated in Guinea-Bissau and that its spread was most likely precipitated by the independence war that took place in the country between 1963 and 1974 (Guinea-Bissau is a former Portuguese colony).\textsuperscript{20} Her theory was backed by the fact that the first European cases of HIV-2 were discovered among Portuguese veterans of the war, many of whom had received blood transfusions or unsterile injections following injury, or had possibly had relationships with local women.\textsuperscript{21}

In view of the evidence considered above, Africa can indeed be regarded as the continent where the transfer of HIV to humans first occurred (monkeys from Asia and South America have never been found with SIV’s that could cause HIV in humans).\textsuperscript{22} This has been confirmed by subsequent studies.\textsuperscript{23} In May 2006, the same group of researchers who first identified the Pan troglodytes troglodytes strain of SIVcpz,

\begin{thebibliography}{9}
\bibitem{14} Varghese at http://www.upublish.info/./141444 (visited 21 July 2010).
\bibitem{17} Worobey 2008 Nature 661-664.
\bibitem{18} Worobey 2008 Nature 661-664.
\bibitem{20} Vandamme PNAS, Vol. 100, No. 11, 27 May 2003.
\bibitem{22} BBC.co.uk (25 May 2006) HIV origin ‘found in’ chimps, cited at http://www.avert.org/origin-aids-hiv.htm (visited 30 June 2010).
\bibitem{23} Keele 523-526.
\end{thebibliography}
announced that they narrowed down the location of this particular strain to wild chimpanzees found in the forests of Southern Cameroon.24 By analysing 599 samples of chimpanzee droppings, the researchers were able to obtain 34 specimens that reacted to a standard HIV DNA test, 12 of which gave results that were virtually indistinguishable from the reactions created by human HIV. The researchers therefore concluded that the chimpanzees found in this area were highly likely the origin of both the pandemic Group M of HIV-1 and of far rarer Group N. The exact origins of Group O, however, remain unknown.25 HIV Group N principally affects people living in South-central Cameroon, so it is not difficult to see how this outbreak started.26 Group M, is the HIV sequence that the researchers recovered from the Kinshasa sample, which is the strain that is responsible for most HIV infection worldwide. The data point to 1908 as the year that group M (which now infects more than 31 million people worldwide) began its assault. The virus may have made the leap to infect people many times, but only at the turn of the century did this viral invasion gain a foothold in the population. Around that time, a hunter seems to have picked up the virus from a chimpanzee in the southeast corner of Cameroon and carried the pathogen along the main route out of the forest at the time, down the Sangha river, to Leopoldville (modern-day Kinshasa), where the Group M epidemic began.

With the increase of global travel, HIV was carried out of Africa and around the world.27 A 2007 study by Michael Worobey and Dr. Arthur Pitchenik, published in the proceedings of the National Academy of Sciences, claimed that, based on the results of genetic analysis, HIV probably moved from Africa to Haiti and then entered the United States around 1969.28

This research tied in with other facts that pointed to Haiti as the as the missing link in the chain of transmission. Firstly, many Haitian professionals worked for a time in the Democratic Republic of Congo (DRC) after it achieved independence from Belgium in 1960. The DRC is one of the countries where the disease has been established since the 1930s. In the early days of the US outbreak, the rate of AIDS infection among Haitians living in the US was 27 times higher than the broader US population. Worobey and his colleagues also concluded that the virus “jumped” from Haiti to Trinidad and Tobago, causing the

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predominantly heterosexual outbreak on these Caribbean islands. Following the discovery of a number of Haitians with Kaposi's Sarcoma and other AIDS-related conditions, medical journals and books began to claim that AIDS had come from Haiti, and that Haitians were responsible for the AIDS epidemic in the United States. These claims, often founded on dubious evidence, fuelled pre-existing racism in the United States (US) and many Haitians suffered severe discrimination and stigma as a result. A large number of Haitian immigrants living in US lost their jobs and were evicted from their homes as Haitians were added to the list of homosexuals, haemophiliacs and heroin users to make the ‘Four-H Club’ of categories at high risks of AIDS. It is now clear, therefore, that HIV is not one virus but exists as two major viral species, HIV-1 and HIV-2. HIV-1 is further divided into three groups, M, N, and O, with M the ‘main’ group, O the ‘outlier,’ and N filling the alphabetical gap between them. HIV-2 consists of seven subtypes, A through G, with a possible eighth group, H. HIV types 1 and 2 do not have a single simian species of origin, but two, the chimpanzee and the sooty mangabey. The three HIV-1 groups and eight HIV-2 groups are different enough from one another that they probably arose from 11 separate crossover events, suggesting eight sooty mangabeys and three chimpanzees were responsible for all known HIV infections among humans. HIV-2, along with HIV-1 and SIV consist of the subgenus ‘primate lentivirises’. The genomic organisation of these viruses is similar, although HIV-1 and SIV of chimpanzees (SIVcpz) encode a vpu gene, while the HIV-2 and SIV of sooty mangabeys (SIVsm) have a vpx gene.

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32 Marx 15. But see, also, Reeves and Doms 1253, who seem to agree only with the view that there have been seven independent transmissions from sooty mangabeys to humans, resulting in HIV-2 subtypes A-G and not eight as Marx seem to suggest.
33 Marx 15.
34 Reeves and Doms 1253-1265. See, also, http://www.aidssupport.aarogya.com/hiv/what-is (visited 23 July 2010), where ‘lentiviruses’ are defined as literally meaning ‘slow viruses’ because they take such a long time to produce any adverse effects in the body. They have been found in a number of different animals, including cats, sheep, horses and cattle. However, the most interesting lentivirus in terms of the investigation into the origins of HIV is the Simian Immunodeficiency Virus (SIV) that affects monkeys. It is now generally accepted that HIV is a descendant of a Simian Immunodeficiency Virus because certain strains of SIV’s bear a very close resemblance to HIV-1 and HIV-2, the two types of HIV. HIV-2 for example corresponds to SIVsm, a strain of the Simian Immunodeficiency Virus found in the sooty mangabey (also known as the green monkey), which is indigenous to western Africa. The more virulent, pandemic strain of HIV, namely HIV-1, was until recently more difficult to place. Until 1999, the closest counterpart that had been identified was SIVcpz, the SIV found in chimpanzees. However, this virus still had certain significant differences from HIV.
35 Reeves and Doms 1253-1265.
The function of Vpx is not clear, although it may play a role in nuclear import and the functions normally associated with HIV-1 Vpr may be provided separately in HIV-2 by Vpr (cell cycle arrest G2) and Vpx or Vpr SIVs can cause AIDS, while double mutant Vpx/Vpr SIVs are severely attenuated.36 HIV is thought to derive from west and west central African monkey retroviruses that crossed and hybridised in chimpanzees, forming Simian Immunodeficiency Virus, or SIV.37 As Squire38 points out, HIV belongs to a group of viruses called retroviruses.39 The genetic material of retroviruses is RNA; once they enter a host (human) cell, their genes are reproduced in the form of DNA, which is then incorporated into the chromosomes of the human cell. Therefore, it is extremely difficult for the body defences of the infected person to eradicate the virus.40 In describing the process in which this group of viruses came to be known as retroviruses, Dalton and Burris41 explain as follows:

Conversely, AIDS research has contributed to our understanding of such phenomena as retroviruses. Until 1980 no human retrovirus had been identified, though not for lack of trying. This was rather puzzling, since retroviruses had been found in most other species where their presence, though often innocuous, sometimes was associated with tumours or with slow, progressive illnesses affecting the blood, lungs, or nervous system. The existence of retroviruses in animals kept alive the hope that analogous human agents might yet be found to help explain the many diseases of unknown cause. Retroviruses have an unusual molecular structure. At first they seemed no different from other viruses that have ribonucleic acid (RNA) as their genetic material. Whereas all other organisms have deoxyribonucleic acid (DNA) as their fundamental genetic material (which is then transcribed into RNA and subsequently into protein molecules), some viruses carry only RNA. These viruses carry enzymes that allow them to bypass DNA entirely and create new RNA directly from their original molecular message. This is a relatively minor deviation from the usual sequence of genetic reproduction, from DNA to RNA to protein. In 1969, however, scientists demonstrated that a unique enzyme carried by some RNA viruses could transfer genetic information from the viral RNA into DNA, the opposite direction of all known prior reactions. The DNA thus created could then be inserted among the native genes in chromosomes of infected cells, with the result that the viral information was positioned to function as a ‘new gene’ for the infected host. The unique enzyme was called reverse transcriptase, and ultimately the group of RNA viruses bearing such enzymes was given the name ‘retroviruses.’42

HIV belongs to this family of viruses called retroviruses, which as Dalton and Burris43 above describe, seem to be highly complicated group of viruses.44 This might explain the reason why it is so difficult for scientists

36 Reeves and Doms 1253-1265.
37 Squire 25.
38 Squire 25.
39 Byer and Shainberg 162.
40 Byer and Shainberg 162. Levay and Valente at 572 agree and explain that: “Like the hepatitis A virus, HIV is an RNA virus, but once inside the host cell, the viral RNA is transcribed into DNA and inserted into the host’s genome. This makes HIV a retrovirus-‘retro’ because the direction of transcription is opposite from the usual DNA-to-RNA direction.”
42 Dalton and Burris 21.
43 Dalton and Burris 21.
44 See Waters 18, who agrees by adding: “In terms of its biological makeup, HIV is a highly unusual virus. It is
to find a vaccine to cure AIDS, which is the disease that is caused by HIV. Again, as pointed out by Byer and Shainberg above, it is extremely difficult for the body defences of the infected person to remove this virus.\(^{45}\) The reason is that this virus, once inserted in a human cell, camouflages itself among the chromosomes of the infected cells as one of these cells.\(^{46}\) Once inside the human body, HIV starts its job of destroying the human immune and nervous systems.\(^{47}\) Waters\(^{48}\) describes this destruction in the following manner:

Once introduced into the human body and activated, the virus does not randomly infect any available cell. Instead, it selectively attacks several kinds of cells crucial to the operation of the human immune and nervous systems. One particular kind of cell, the so-called CD4+ T-lymphocyte helper cell is especially vulnerable to HIV. The virus is literally attracted to special kind of protein that exists on the surface of these T-lymphocytes. Once the virus couples with this protein, it then injects its own genetic material into the human cell. When the viral particles thereby embedded in the human cells later are activated, the human cell literally is transformed into a ‘factory’ that creates more HIV. Most often the cell literally is destroyed as its own material is used up in the creation of more virus[es]. Once these viral particles are released into the bloodstream, they can selectively invade and rapidly kill still more T-lymphocytes, resulting in a dramatic depletion in their number. In this trait, HIV also shows itself to be radically different from the only other known group of human retroviruses, the human T-lymphotropic virus family. The ‘HTLV’ family, some of which are responsible for types of human leukaemia, do not kill cells but cause them to multiply rapidly and erratically. The result of an activated HIV infection is a virtual crippling of the human immune system, which cannot function properly without T-lymphocytes. As the T-lymphocytes count drops, a critical part of the human immune system effectively is shut down, rendering the body unable to detect many commonplace infections. Thus, the HIV host falls prey to a number of common bacteria and parasites that otherwise would be completely harmless. It also has been discovered that HIV is capable of infecting and disrupting certain other cells vital to the immune system, although apparently without killing them. It is not yet clearly understood what effect this secondary infection has on the immune system. Human nervous tissue, including brain cells, also are vulnerable to HIV infection and may be so severely disrupted that dementia results. In fact, the virus may be transported directly into the brain by infected immune cells, which effectively operate as ‘Trojan horses’.\(^{49}\)

Waters\(^{50}\) concludes by observing that researchers are of the view that HIV may be either a recently mutated virus or one that remained isolated, probably in Central Africa, for centuries without ever being communicated to outsiders, who thus have no natural resistance to it. This is indicated by the fact that the virus kills its primary host cells and thus causes a progression of diseases that may invariably be fatal. In

\(^{45}\) Byer and Shainberg 162.
\(^{46}\) Dalton and Burris 21.
\(^{47}\) Waters 18.
\(^{48}\) Waters 18-19.
\(^{49}\) Waters 20.
\(^{50}\) Waters 20.
terms of survival, a virus is better suited to its environment if it does not actually kill its host.\textsuperscript{51} Thus, some scientists believe that the present form of HIV is new, at least as far as most of the world’s population is concerned, and that the virus has not had time to evolve into a less virulent form, which would logically be expected. In any event, it is clear that HIV is an unusually destructive infection that once inside the human body, cannot be eliminated by any method currently known to science. Given the present state of medical technology, HIV literally is an infection that lasts for life.\textsuperscript{52}

1.1.2.1 AIDS - a zoonotic disease?

HIV, as, already discussed above, is thought to derive from west central African monkey retroviruses that crossed and hybridised in chimpanzees, forming Simian Immunodeficiency Virus.\textsuperscript{53} This virus was then transmitted to other chimpanzees and other species, notably humans. Such interspecies transmission could have happened through blood-to-blood transmission during hunting, much as earlier versions of the virus may have from the monkeys to chimpanzees.\textsuperscript{54} Many viruses, bacteria and other disease-causing entities cross species, most notably at present the avian flu. Some, such as BSE and salmonella, do so through meat consumption. Other monkey viruses are also found in humans where monkeys are eaten. When the human body encounters non-human viruses, it is usually unaffected or it fights these viruses off. Occasionally, however, SIV would have mutated into a more resistant form, HIV. Supporting this account, contemporary HIV and the related simian virus have many strains and high mutation rates again, like many other disease-causing entities such as flu viruses.\textsuperscript{55}

Ellison, Melissa and Campbell, in agreement with Squire\textsuperscript{56} above, observe that “[m]utation\textsuperscript{57} can allow micro-parasites to cross species and cause new human infections”.\textsuperscript{58} Animal diseases may be transmitted

\begin{thebibliography}{9}
\bibitem{Waters20} See, also Waters at 20, who points out that: “Researchers believe HIV may be either a recently mutated virus or one that remained isolated in some part of the world, probably Central Africa, for centuries without ever being communicated to outsiders.”
\bibitem{Squire25} Ellison G, Melissa P and Campbell C \textit{Learning from HIV and AIDS} (2003, Cambridge: Cambridge University Press) 47. In fact, according to Avert at http://www.avert.org/origin-aids-hiv.htm (visited 21 June 2010), “[i]t has been known for a long time that certain viruses can pass between species. Indeed the very fact that chimpanzees obtained SIV from two other species of primate shows just how easily this crossover can occur. As animals ourselves, humans are just susceptible. When a viral transfer between animals and humans takes place, it is known as zoonosis.”
\end{thebibliography}
to man under natural conditions (e.g. brucellosis, rabies, etc.) and such transmission is called zoonosis.\textsuperscript{59} Examples of zoonotic transmission include a strain of influenza, a virus HSN1, found in Hong Kong that emerged from chicken reservoir and swine influenza viruses. Zoonotic infections such as hantaviruses, the rabies virus and HIV are associated with exposure to infected body fluids, animal tissue, excreta or vectors (such as mosquitoes and ticks) that have fed on infected species.\textsuperscript{60} In order for scientists to establish how the zoonosis of HIV took place between animals and humans, and because AIDS was similar to a virus found in African monkeys, they developed a theory that tribal hunters contracted the disease after being exposed to the blood of infected monkeys.\textsuperscript{61} A zoonotic origin for HIV is supported by similarities in viral genome, phylogenetic relatedness, prevalence in the natural host, geographic coincidence and plausible routes of transmission. The molecular genotypes of pathogens suggest a zoonotic origin of HIV-1 from chimpanzees and HIV-2 from sooty mangabeys.\textsuperscript{62}

Reeves and Doms, also, support the idea that HIV is a zoonotic infection.\textsuperscript{63} They point out, for instance, that HIV is thought to have originated from zoonotic transmissions from SIV-infected non-human primates. SIVs from chimpanzees cluster phylogenetically with HIV-1; hence, the HIV-1 epidemic is likely to have originated from SIV\textsubscript{cpz}. In contrast, all criteria identifying HIV-2 as a zoonosis from the sooty mangabey are met: i.e. similarity in genomic organisation; phylogenetic relatedness; prevalence in the natural host; geographical overlap; and plausible route of transmission.\textsuperscript{64} Naturally, accordingly, infected sooty mangabeys, African green monkeys and chimpanzees do not develop SIV-related disease, even though

\begin{itemize}
\item \textsuperscript{59} See Crosby JT and Stregowski J at http://www.exoticpets.about.com/zoonosis.htm (visited 28 June 2010). Stregowski, for instance, defines zoonosis as: “[A]n infectious disease that affects animals and can be transmitted to humans.”
\item \textsuperscript{60} Ellison, Melissa and Campbell 47.
\item \textsuperscript{61} Jasper 3. See, also, Dalton and Burris 23, who seem to support this theory by stating that: “Although HIV is indeed a new human retrovirus, it is very closely related to certain primate retroviruses that may well have ‘jumped species’ from monkeys to man in Central Africa, possibly as recently as 1960.”
\item \textsuperscript{62} Ellison, Melissa and Campbell 47, citing Gao et al “Origin of HIV-1 in the chimpanzee Pan troglodytes troglodytes” 1999 (397) Nature 436-444, who found that two chimpanzee subspecies in Africa, the eastern Pan troglodyte schweinfurthii and Pan troglodyte troglodyte both harbour SIVcpz which exists in two highly divergent but subspecies-specific phylogenetic lineages. Such findings are consistent with the ancestor of SIVcpz strains infecting the common ancestor of P. troglodytes followed by host-dependent viral diversification. HIV-1 strains known to infect humans including the HIV-1 groups M, N and O are closely related to only the SIVcpz lineage found in P.t. troglodytes. The natural range of P.t. troglodytes coincides with areas of HIV-1 groups M, N and O endemcity which suggests that P.t. troglodytes is the primary ‘natural’ reservoir for HIV-1 and that it was the source of at least three independent introductions of SIVcpz into the human population. A possible route of transmission is hunting since chimpanzees are commonly hunted for food in Africa, especially within the West Equitorial region.
\item \textsuperscript{63} Reeves and Doms 1253.
\item \textsuperscript{64} Reeves and Doms 1253, they further point out that: “From phylogenetic analysis of divergent HIV-2 strains, it appears that there have been seven independent transmissions from sooty mangabeys to humans, resulting in HIV-2 subtypes A-G. Only one member each of subtypes C, E, F and G, and two of members of subtype D, have been identified and it is thought that these rare subtypes may be primary zoonotic infections.”
\end{itemize}
high virus loads can sometimes be detected in their plasma. Disease is only associated with cross-species transmission of the virus; that is, from sooty mangabeys into humans (HIV-2) and from chimpanzees into humans (HIV-1), hence zoonosis of HIV. However, there are writers who dispute the fact that AIDS is a zoonotic disease. Writers such as Marx, Apetrei and Drucker argue that the idea that AIDS is a zoonosis has never been proved and must be seriously questioned. They concede and acknowledge the simian source of HIV but argue that the emergence of the AIDS epidemic is not understood. Marx, Apetrei and Drucker contest the idea of AIDS as a zoonosis on the following grounds: (i) if AIDS was a zoonosis, there must be evidence of AIDS being directly acquired from animals; (ii) Despite long-term and frequent human exposure to SIV-infected monkeys in Africa, only 11 cross-species transmission events are known, and only four of these have resulted in significant human-to-human transmission, generating HIV-1 groups M and O and HIV-2 A and B. SIV, while capable of cross-species transmission, is thus poorly adapted for disease and epidemic spread. If AIDS was a zoonosis that is capable of significant human-to-human spread, there should be a plethora of founder subtypes and groups. (iii) Human exposure to SIV is thousands of years old, but AIDS emerged only in the 20th century. If AIDS was a zoonosis that spread into the human population, it would have spread to the West during slave trade. (iv) Experimental transmission of SIVs to different species of monkeys is often well controlled by the new host, showing that the virus and not the disease is transmitted. They conclude by pointing out that cross-species transmission of SIV does not in itself constitute the basis for a zoonosis. Transmission per se is not the major requirement for the generation of the AIDS epidemic. All HIVs do derive from simian species, but AIDS does not qualify as a zoonosis and this explanation cannot in itself account for the origin of AIDS epidemic. Therefore, AIDS is not a zoonosis but a human infectious disease of zoonotic origin. What is meant by zoonosis is a disease like rabies, not AIDS. There is no evidence that a person can contract AIDS from a monkey or chimpanzee. There is still a missing link.

Marx points out that some experts consider this debate, eg of whether AIDS is a zoonosis or not, as semantic and thus of little importance. Thus, because every case of human AIDS is acquired from

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65 Reeves and Doms 1253.
67 Marx, Apetrei and Drucker 2004 J Med Primatol 221.
68 Marx, Apetrei and Drucker 2004 J Med Primatol 220.
69 Marx, Apetrei and Drucker 2004 J Med Primatol 220.
70 Marx 15.
71 Marx, Apetrei and Drucker 2004 J Med Primatol 224.
72 Marx 15.
another human being, it cannot be a zoonosis and the discussion could end here. Yet the underlying question of what launches new diseases among humans, including not only AIDS but also avian flu, Ebola virus, and severe acquired respiratory syndrome (SARS), is critical to address because it remains unanswered. While the origin of HIV and the avian influenza virus and some leads on the Ebola and SARS viruses are known, the shocking fact is that the factors that launch animal viruses into epidemics, pandemics, or result in dead-end infections, are not known. Further, the ecological events that led SIV to become HIV with epidemic potential remain completely unknown. It is submitted, in agreement with Marx, Apetrei and Drucker above, that AIDS as a disease is not a zoonosis but a human infectious disease of zoonotic origin. This means that it is SIV, the virus that crosses species from monkeys to humans and mutates into HIV once in a human body and not AIDS the disease. As the writers above correctly point out, the simian origin of HIV is not disputed, meaning that there is agreement and evidence that HIV originated from animals, eg from chimpanzees and monkeys, and that it crossed to humans as SIV. However, there seems to be no conclusive evidence that AIDS as a disease crossed species from animals to humans and therefore, AIDS is not a zoonotic disease.

1.1.3 Historical Background from 1981

The accepted chronology of the pandemic begins in 1981, when the United States Centers for Disease Control (CDC) published the first reports of unusually high incidences of rare kinds of pneumonia, skin cancer and cytomegalovirus infection, all pointing to problems in immune system functioning among gay men in California and New York. This ‘Gay Related Immune Deficiency Syndrome’ or ‘Grids’ was renamed ‘AIDS’ the next year, and the HIV virus underlying the symptoms isolated in 1983. In 1981, doctors first started to see signs of a new illness amongst gay men in the United States of America. These men had developed unusual conditions, such as a rare chest infection and skin disorders, and special tests

Marx 15.
Marx 15.
Marx 15, who points out that: “Although the simian origin of HIV and other human retroviruses such as human T cell leukemia virus and human foamy viruses is not in dispute, the hypothesis that simian retroviral infections are zoonoses is.” Simply put, a zoonosis is a disease that is acquired from animals 
Marx 15, who further points out that: “Simply put, a zoonosis is a disease that is acquired from a vertebrate animal. Some microbiologists also consider vector-borne diseases as zoonoses. But the central meaning of zoonosis is that the disease, and not just the infection, is acquired from an animal not from another human being. When we think of zoonosis, we should think of rabies, not AIDS.”
Squire 25 and Browne-Marshall 2012 Duke Journal of Gender Law & Policy 407. See, also Reeves and Doms 1253, who point out that: “AIDS resulting from HIV-1 infection, was recognised in 1981 when a common pattern of symptoms was observed among a small number of homosexual men in the USA.”
showed that their immune systems were damaged. By 1982, the Centers for Disease Control established the term ‘Acquired Immune Deficiency Syndrome’ (AIDS).

In 1983, French researchers identified a new virus, now known as HIV, as the cause of AIDS. This type of HIV also became known as ‘HIV-1’. The researchers who isolated the new retrovirus (which was later known as Human Immunodeficiency Virus (HIV) and the cause of AIDS) were Dr. Luc Montagnier in France and Dr. Robert Gallo in the United States. In 1985, a second type of HIV was identified in sex workers from Senegal. This virus, called ‘HIV-2’, is found mostly in West Africa, and seems to be less easily transmitted (passed on) and less harmful than HIV-1. Scientists have since found out that there are also many different strains or subtypes of HIV. In South Africa, subtype C is most common. The early cases of AIDS were observed in gay men. After that, major epidemics were seen in another marginalised group, injecting drug users, in Western Europe, South East Asia, China and India.

1.1.4 Overview of the Pandemic in South Africa

The first recorded AIDS deaths in South Africa were in 1982, among white gay men. There were certainly cases in the heterosexual population during the 1980s, somewhat later than in East and Central Africa. But at this time, HIV was seen largely as a disease of westerners, white gay men and drug users, non-African, sexually transgressive ‘others’, though sometimes ‘other’ Africans were also thought responsible. AIDS deaths also tended to, as in the early stages of other countries’ epidemics, to be attributed to something ‘other’, such as TB, malaria or hunger.

In 1992, former president, Nelson Mandela, formed the National AIDS Convention of South Africa, with both the two post-apartheid health ministers, Dr Nkosazana Zuma and the late Dr Manto Tshabalala-Msimang, as members. By now, heterosexual cases had overtaken those among homosexual men. In 1994, the year of the first democratic elections, South Africa’s first community-based HIV organisation, the National Association of People Living with AIDS (NAPWA), was formed to fight discrimination and
A major shift towards public acceptance of HIV in South Africa happened with the death of Gugu Dlamini. In late 1998, this Durban NAPWA activist was beaten to death by a group of local people, including some of her neighbours, shortly after disclosing, on World AIDS Day, that she was HIV positive. This murder was nationally and internationally decried. The former president, Thabo Mbeki stated in response the following: ‘It is a terrible story. We have to treat people who have HIV with care and support, and not as if they have an illness that is evil’. Just before Dlamini’s murder, Simon Nkoli, a prominent HIV activist who had a long history of anti-apartheid and gay and lesbian activism, and was one of the openly gay members of the ANC (African National Congress), had died of AIDS. These two events were followed by the establishment at the end of 1998 of the Treatment Action Campaign (TAC). The TAC, probably the most effective HIV organisation in South Africa, was formed by a group including Zackie Achmat, another long-term anti-apartheid and lesbian and gay rights activist and long-time ANC member, and other activists.

By 2003 it was estimated that HIV had infected 5.1 million South Africans. Approximately 21.5% of all South African adults were said to be infected. Sub-Saharan Africa remains the region most severely affected by HIV/AIDS with approximately 3.1 million new infections having occurred in 2004 alone. This brought to 25.4 million the total number of people living with HIV/AIDS in this region. Of this number, 57% are women. It is estimated that 2.2 million Sub-Saharan Africans died of AIDS in 2003. In this year, it was estimated that there were 12.1 million AIDS orphans in Sub-Saharan Africa. By 2006 the number of people estimated to be living with HIV in South Africa had risen to 5.4 million, of which a total of 294 000 were children under the age of fourteen. These estimates were consistent with those of the Department of Health and UNAIDS, which pointed to 5.5 million people living with HIV or AIDS in 2005, of which 235 000 were children. Based on a wide range of data, including household and antenatal studies, UNAIDS/WHO in July 2008 published a report indicating an estimate of a 18.1% prevalence amongst those

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86 Squire 33.
87 Squire 33.
88 Squire 34.
90 McQuoid-Mason 5.
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92 McQuoid-Mason 5.
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94 McQuoid-Mason 5.
96 SANAC 23.
between the ages of 15 and 49 for the end of 2007. This implies that by the end of 2007, around 5.7 million South Africans were living with HIV, which included 280,000 children under the age of fifteen.

According to Higher Education HIV and AIDS Programme (HEAIDS), HIV and AIDS is a severe national problem in South Africa with 5.2 million adults and children estimated to be living with HIV in 2008, representing 10.6% of the total population of 47.8 million in 2008. Of the total population aged 15 years and older in 2007 (approximately 32.6 million), 5.4 million people were estimated to be living with HIV, a prevalence of 16.5%. This falls within the UNAIDS definition of a hyperendemic HIV epidemic. It is, however, interesting to observe that according to the recent study conducted by HEAIDS in the higher education institutions (HEIs), there seems to be a big difference between HIV prevalence at HEIs and the general population in South Africa. HEAIDS pointed out that:

The most striking finding arising from the HIV prevalence results in this study is that the measured prevalence in the combined HEI sector population is substantially lower than found among the general population in South Africa. While the distribution of HIV follows national patterns in terms of sex, race, age group and education, the HIV prevalence is lower in higher education population within all these demographic categories. In summary, the HIV prevalence results in the higher education sector are lower than in the general community but the patterns of infection are consistent with what has previously been reported. All major, community-based HIV prevalence studies conducted in South Africa (HSRC and RHPU) have found that overall, more females are HIV positive than males.

The HIV prevalence of this study were as follows: Academic staff had the lowest overall HIV prevalence at 1.5% [CI: 0.9%-2.3%], followed by students at 3.4% [CI: 2.7%-3.4%], administrative staff at 4.4% [CI: 3.2%-6.0%] and service staff at 12.20% [CI: 9.9%-14.9%]. It is encouraging to observe that according to, the above mentioned, recent study findings of HEAIDS conducted at HEI sector, HIV prevalence is much lower than that found in the general population in South Africa. It is submitted, however, that the reason for

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97 See http://www.avert.org/safricastats.htm (Visited 01 July 2010).
100 See UNAIDS Report on the Global AIDS epidemic (2008, Geneva: UNAIDS) 100 cited by HEAIDS at 1, which defines a hyperendemic epidemic as a situation where 15% or more ‘adults’ aged 15 years and older are living with HIV.
101 HEAIDS xviii and 105.
102 HEAIDS xviii.
103 HEAIDS 103.
104 HEAIDS 105.
105 HEAIDS xviii and 105.
this big difference might be attributed to the resources people in the HEIs have as compared to those of the general population, especially those in the rural areas. People in the HEIs have more access to HIV/AIDS information and therefore are much better informed about HIV/AIDS than those in the general population. As a result they are more knowledgeable about issues of HIV/AIDS prevention, testing, transmission, informed consent, etc., and they are more likely to use preventative measures such as, safe sex with the use of condoms, than the general population. In the HEIs, for instance, there are computers (internet access), newspapers, workshops, conferences, and regular seminars on HIV/AIDS. This view is further strengthened by the fact that academic staff has the lowest overall prevalence, followed by students and the administrative staff.\(^{107}\) Of the four categories, service staff has the highest HIV prevalence.\(^ {108}\)

It may be argued that the prevalence for service staff in this study may be a better reflection of the situation amongst the general population (especially in the rural communities), that is, of persons with little or no access to resources and information regarding HIV/AIDS. This study points to the meaningful impact of service-learning and outreach programmes addressing HIV/AIDS, eg Street Law programmes.\(^ {109}\) These programmes need to be rolled out in a consistent manner across all HEIs in order to benefit the general population and assist in curbing the spread of HIV/AIDS in South Africa.

It is estimated that in 2010, there were around 1.8 million orphans under the age of 15 in South Africa and this number is predicted to rise to over 2.5 million by 2015.\(^ {110}\) As HIV/AIDS mainly infects sexually active young adults, the people who are dying are primarily the parents of young children. Approximately 1000 people die each day of HIV/AIDS-related illnesses, thus creating approximately 450 new orphans daily.\(^ {111}\) South Africa currently holds the position of the country with the highest number of AIDS cases. If more children are orphaned by AIDS, it will create a humanitarian challenge on a scale that no nation has ever faced.\(^ {112}\) These statistics of AIDS prevalence and the high number of orphans in South Africa are truly devastating. It is for this reason, it will be proposed in this thesis that interventions aimed at reducing the spread of HIV be reconsidered.

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\(^{107}\) HEAIDS 105.

\(^{108}\) HEAIDS 105.

\(^{109}\) Institutions such as for instance the following: University of KwaZulu-Natal (UKZN), Walter Sisulu University (WSU), University of South Africa (UNISA), Fort Hare University (UFH), University of Cape Town (UCT) and others, use Street Law and other service-learning and outreach programmes (such as Population Medicine (WSU)), to educate people about HIV/AIDS.

\(^{110}\) Van Vuuren X Making Dreams come True-Noah Currently provides support and care for more than 30 000 AIDS orphans in Gauteng and KwaZulu-Natal 1, at http://www.noahorphans.org.za/wp-content/u (visited 05 August 2010).

\(^{111}\) Van Vuuren 1.

\(^{112}\) Van Vuuren 1.
The review of the origins and history of HIV and AIDS indicate that HIV and AIDS originated from African monkeys (chimpanzees and sooty mangabeys) and that these spread from Africa to the rest of the world.\textsuperscript{113} HIV has originated a long time ago, as early as 1884,\textsuperscript{114} much earlier than it was identified in 1980s.\textsuperscript{115} This period of silence between 1884 and 1980 might have led to the silent spread of this virus all over the world. However, in South Africa and other countries there are many factors that facilitate the continued spread of HIV and AIDS, such as ignorance, stereotypes,\textsuperscript{116} discrimination, victimisation, stigmatisation, amongst others. In some societies, HIV positive people are treated as outcasts and many die in silence. In the meantime ‘the silent war that kills 1000 a day’ continues.\textsuperscript{117} For this reason, measures such as making HIV and AIDS notifiable diseases, as is the case in Canada,\textsuperscript{118} for instance, should be considered.

At present HIV and AIDS are not notifiable\textsuperscript{119} diseases in South Africa, although in September 1997, the then Minister of Health had indicated her intention to make AIDS a notifiable disease. This attempt failed, however.\textsuperscript{120} Indeed, some writers, notably, Karim,\textsuperscript{121} feel that making AIDS notifiable is inappropriate for South Africa. This topic about whether HIV/AIDS should be made a notifiable disease or not in South Africa will be discussed in full detail in chapter 5, below. South Africa can also learn from other sister countries in Africa, such as Uganda. In 2002 it was reported that Uganda has achieved success in bringing the AIDS infection rate down from 30\% in 1986 to 6.1\% in 2002.\textsuperscript{122} President, Yoweri Museveni, was praised for being the driving force behind the success and in March 2002 he received an award from

\textsuperscript{114} Worobey 2008 Nature 661-664.
\textsuperscript{115} Berer and Ray 6, Barret-Grant 11, Squire 25, Harris and Haigh 1, and Osborn 22.
\textsuperscript{116} For instance, people who sleep with virgin babies thinking that they will be cured of the disease if they do so.
\textsuperscript{117} City Press, 24 August 2008 page 1. (The paper depicted this as “The Silent war that kills 1000 a day”). See, also, Van Vuuren 1.
\textsuperscript{118} See, Public Health Agency of Canada at http://wwwpublichealth.gc.ca or http://www.phac-aspc.gc.ca/..r-eng.php (visited 05 August 2010), which states that: “In Canada, AIDS is a notifiable disease. AIDS is legally notifiable in all Canadian provinces and territories. AIDS is legally notifiable at the provincial or territorial levels. HIV infection is legally notifiable at the provincial and territorial levels in all Canadian provinces and territories, except British Columbia. AIDS and HIV data are shared with the Centre for Infectious Disease Prevention Control (CIDPC) at the federal level by provinces and territories.”
\textsuperscript{119} See, National Health Act 61 of 2003, Regulations Regarding Communicable Diseases (No R 27 GG 25 January 2008) that do not list HIV or AIDS as Annexure 1 communicable diseases. See, also Van Rensburg HCJ, Fourie A and Pretorius E Health Care in South Africa: Structure and Dynamics (1992, Pretoria: Academica) 177, who also do not list HIV or AIDS as compulsory notifiable medical conditions.
\textsuperscript{120} Karim SSA “Making AIDS a Notifiable Disease-Is it an Appropriate Policy for South Africa?” 1999 (89;6) SAMJ 609.
\textsuperscript{121} Karim 1999 SAMJ 611.
\textsuperscript{122} See, Crisp T “Uganda’s AIDS Success” 2002 Nursing Update 31.
Commonwealth for his leadership role in this achievement. A multi-tiered approach has been adopted by the president. South Africa can certainly learn from Uganda’s success in this regard.

1.1.5 Definition of HIV and AIDS

1.1.5.1 HIV

HIV has been defined in many ways but what seems to be clear is that it is the virus that causes AIDS. Barret-Grant defines HIV as:

HIV is a virus that is only found in human beings, and attacks and slowly damages the body’s immune system (its defence against infections and diseases). HIV causes AIDS. HIV severely damages a person’s immune system, so that the body can no longer fight off infections and other diseases. When this happens, you get a group of particular medical conditions called ‘AIDS-defining conditions or illnesses’ and we say that you have developed Acquired Immune Deficiency Syndrome (AIDS).

There was once confusion in South Africa whether HIV causes AIDS and that confusion was made worse by the fact that the former president, Thabo Mbeki, also publicly questioned the link between HIV and AIDS. Today, however, it seems to be clear to every South African that HIV causes AIDS.

1.1.5.2 AIDS

AIDS refers to the acquired immune deficiency syndrome. An immune deficiency syndrome means that the immune system is being prevented from functioning. A syndrome is a group of symptoms or illnesses originating from one cause, in this case HIV. If HIV reduces immune function to a certain level, and or

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123 Crisp 2002 Nursing Update 31. Crisp states that: “The first is to acknowledge the enemy. The second is to sound the alarm and to give all leaders, from all walks of life in Uganda a direction and understanding of the causes and effects so that all speak with one voice. No contradictions. The next step is to identify and address pre-conceived notions about the scourge. It is not divine punishment? It is not anger from ancestral gods? It is not witchcraft? They then embarked on action to dispel these myths. Prominent persons who suffer were encouraged to talk about how they became infected. The president identified the problem in 1986. The awareness process was started, and the decline in infection was noticed in 1997. At the end of July 2002 the Americans announced their intention to follow the Uganda example”. If Americans would like to follow this example, South Africa should follow suit.

124 Barret-Grant 10. See, also McQuoid-Mason 1, who states that: “The word ‘HIV’ means the ‘Human Immunodeficiency Virus’ that attacks the immune system of human beings. The immune system is the part of the body that protects humans against infections and diseases. Once the immune system is attacked the body is gradually weakened and becomes easily infected with other viruses, bacteria and diseases”.

125 Barret-Grant 37. Today there is a debate which has been started by the Young Communist League that ‘Thabo Mbeki and his health minister should be charged with genocide’. See, Daily Dispatch, Wednesday, November 25, 2009 page 9, that has an article by Frans Cronje, “Mbeki and the charges of genocide”. Cronje argues that: “The former President is morally but perhaps not criminally liable for AIDS deaths”. In fact, as Cronje puts it: “It was presumably not Mbeki’s intent to kill hundreds of thousands of people but in this case the absence of intent does not alter the fact that the consequences of his negligence and indifference were foreseeable”.

126 Berer and Ray 8.

127 Berer and Ray 8.
when one or more serious illnesses related to HIV occurs, a person is said to have AIDS. Immune function can be measured by testing for the number of T4 cells (also called CD4+ lymphocytes) in the blood. Immune function is considered to be at an advanced stage of impairment when this count goes below 200 per cubic millimetres of blood. Foreman defines AIDS as the term which is used to refer to the physical condition resulting from infection by HIV. HIV slowly disables an important part of the body’s immune system by invading T-helper lymphocytes and macrophages cells in the bloodstream which normally help protect the body from attack from infection. AIDS, therefore, can be said to be a collection of diseases which explains why it is referred to as a ‘syndrome’. When a person dies of AIDS, one of these opportunistic diseases will be responsible for his or her death.

1.2 PURPOSE, PROBLEM STATEMENT AND MOTIVATION

This thesis seeks to explore the right to confidentiality in the context of HIV/AIDS through an interdisciplinary lens. This study indicates that whilst the right to confidentiality is important and indeed should be preserved in order to protect persons living with HIV/AIDS against stigmatisation, discrimination and victimisation, the protection of public health requires specific interventions to curb the further spread of the disease, which may include partner notification and criminalising the intentional infection others with HIV.

As the consideration of the legal issues cannot be divorced from the social context in which HIV/AIDS plays out in South African communities, the study will examine the difficulties faced by persons living with HIV/AIDS, such as discrimination, stigmatisation and victimisation. The study also traces some of the

128 Berer and Ray. See, also, Byer and Shainberg, who concur with this by stating that ‘an HIV infection is defined as a case of AIDS when the count of T4 lymphocytes, destroyed by HIV, drops below 200 per microliter (cubic millimeter) of blood. McQuoid-Mason, also, defines AIDS as standing for the acquired immune deficiency syndrome. This occurs where the HIV has so weakened the body that it can no longer defend itself against certain infections and diseases that are known as ‘AIDS-defining conditions or illnesses’ (e.g. severe diarrhoea, severe weight loss, severe pneumonia, brain infections, confusion and memory loss, severe skin rashes and pain and difficulty in swallowing). When a person suffers from this group of infections and diseases he or she is said to have developed AIDS.

129 Berer and Ray 8. See, also, Byer and Shainberg 164, who concur with this by stating that ‘an HIV infection is defined as a case of AIDS when the count of T4 lymphocytes, destroyed by HIV, drops below 200 per microliter (cubic millimeter) of blood. McQuoid-Mason 1, also, defines AIDS as standing for the acquired immune deficiency syndrome. This occurs where the HIV has so weakened the body that it can no longer defend itself against certain infections and diseases that are known as ‘AIDS-defining conditions or illnesses’ (e.g. severe diarrhoea, severe weight loss, severe pneumonia, brain infections, confusion and memory loss, severe skin rashes and pain and difficulty in swallowing). When a person suffers from this group of infections and diseases he or she is said to have developed AIDS.


131 Foreman 1.

132 The right to confidentiality is derived from the right to privacy that is granted by section 14 of the Constitution of 1996. This right will be discussed in detail in following chapters.

133 See, Gostin 8, who states that: “Two ‘rights’ issues were especially important in the civil rights and human rights
difficulties faced by families caring for a person living with HIV. According to the American Psychiatric Association, "[t]he AIDS epidemic presents potential conflicts between the rights of infected individuals and public interest in containing HIV disease." The duty to preserve patient confidentiality may conflict with the need to inform past and present contacts of an HIV-infected patient of possible exposure to the virus".

The study aims to show that any legal interventions aimed at curbing the spread of HIV will need to be mindful of intricate social and economic forces that impact on the duty to disclose a positive HIV-status. Insights gained from philosophical theories relating to Africanism, individualism, communitarianism and utilitarianism are valuable in facilitating a clearer understanding of these social and related factors that keep South African society locked in the present stalemate with regard to the disclosure of a positive HIV-status.

In order to achieve the above aim, the starting point of this study will be a review of the current legal framework relating to confidentiality in the context of HIV/AIDS in South Africa. Relevant international and foreign law comparisons will be drawn. The aim will also be to identify the challenges relating to the right to confidentiality in the context of HIV/AIDS and how this right may be justifiably limited in order to protect public health. The thesis will conclude by proposing recommendations and solutions that will seek to ensure that whilst confidentiality is respected, culturally and socially responsible legal interventions are made to address the spread of HIV. The right to confidentiality in the context of HIV/AIDS has many implications for persons living with the disease. It means, for instance, that a person diagnosed with HIV or AIDS has a right to disclose or refuse to disclose his or her HIV-status. The classical liberal notion of movements, privacy and antidiscrimination. Because persons living with HIV/AIDS experienced stigma and ostracism, they strove to keep their health status private. Unauthorised disclosures not only revealed the person’s health status but also generated speculation as to his sexual orientation or use of injection drugs. Invasions of privacy could have serious and enduring consequences, alienation from family or friends, loss of care or support and discrimination in employment, housing and public accommodation.” See, also, The World Bank Averting AIDS Crises in Eastern Europe and Central Asia-A Regional Support Strategy (2003, Washington DC: The World Bank) 127, which states that: “The problem is exacerbated by the fact that the majority of people affected by HIV/AIDS belong to groups that are marginalised. The primary groups affected by HIV/AIDS, injecting drug users, commercial sex workers and inmates have limited access to community service infrastructure.” See also the following cases: Jansen van Vuuren and Another v Kruger 1993 (4) SA 842 (A), Hoffman v South African Airways 2000 (11) BCLR 1211 (CC) and NM v Smith 2007 JDR 0231 (CC). These cases will be fully discussed under chapters 2 and 3 below.


Cameron E Confidentiality (Revised Second 2nd Draft) (1999, Lawyers Collective HIV/AIDS Unit: Judges’ Workshop Mumbai 7-8 January 1999) 51. Cameron highlighted some of the problems created by the right to confidentiality by saying that: “Despite the apparent strength of the doctrine in South Africa, the very concept of confidentiality has come under attack for a second reason, less directly related to the dispute about its practical application in relation to another's 'right to know'. The second line of controversy concerns the cultural origins of the concept and the appropriateness of applying it in South Africa in the midst of an epidemic which has taken a very different form, in much less affluent social circumstances to that in North America and Western Europe....This has led to calls for a 'shared confidentiality', as opposed to rigidly, individualised confidentiality, to be applied in Africa.”
confidentiality and privacy from an individualised perspective should also be reviewed in the context of HIV and AIDS.

As stated, one possible limitation is to introduce legislative measure to make HIV and AIDS notifiable diseases as is the case in Canada and the United States of America. Other limitations are the compulsory HIV testing; pre-marital HIV testing and partner notification laws in order to protect health of spouses and partners. In this regard, the study will briefly turn to disclosure and confidentiality in consensual sexual relationships, including traditional African marriages. Mswela correctly observes that the HIV/AIDS epidemic in South Africa is mainly regarded a heterosexual epidemic. There are many factors, therefore, that put women at increased risk of becoming infected with HIV, such as domestic violence, biological, psychological, economical and cultural practices (such as polygamy). Therefore, a discussion of socio-cultural issues, such as traditional attitudes, including a discussion of the role of women and their ability to insist on, for example, fidelity and condom use will be made.

The right to confidentiality in the context of HIV/AIDS is closely interwoven with other fundamental rights. These rights include, but are not limited to the following rights: human dignity, life, equality, freedom and security of the person, labour relations, environment, health care, food, water and social security, and education. If a person’s right to confidentiality is violated by an unauthorised disclosure, for instance, his or her rights to human dignity, life, equality, health care and freedom and security of the person are possibly violated. This study will not focus on these related fundamental rights.

There is a wealth of literature on the right to privacy and the protection of confidentiality generally. The context of HIV/AIDS is unique in South Africa, as the protection of these legal interests has to be explained and examined against the background of relevant cultural and socio-economic factors. Questions that arise, for example, are why some infected individuals continue to spread the disease by sleeping around

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138 Mswela LLM dissertation 10-11.
139 Mswela LLM dissertation 11.
whilst knowing that they may infect other parties.\textsuperscript{141} Others rape infants or girl children by claiming that they will be cured of the disease if they sleep with virgins.\textsuperscript{142} Others rape their own daughters and students, infecting them with HIV in the process.\textsuperscript{143}

Nelson Mandela once wrote: “Aids today in Africa is claiming more lives than the sum total of all wars, famines and floods and the ravages of such deadly diseases as malaria. We must act now for the sake of the world….AIDS is no longer a disease, it is a human rights issue”.\textsuperscript{144}

1.3 HYPOTHESIS

The right to privacy (and corollary confidentiality) are important in protecting persons who live with HIV and AIDS against discrimination, violence, victimisation and stigmatisation. It will be argued and submitted that whilst this right must be protected, however, there appears to be an overemphasis on confidentiality at the cost of other equally important interests. The consequences of keeping one’s HIV-status undisclosed are obvious. Disclosure on the other hand, which may have the positive effect of protecting third parties from potential infection, is unfortunately associated with cruel stereotypes, myths, stigma, victimisation and discrimination.\textsuperscript{145} A report by the World Bank points out that it is difficult to raise awareness or build consensus on an issue that cannot be discussed openly.\textsuperscript{146} In African states, including South Africa, confidentiality about a person’s HIV status, even after the death of the person, perpetuates beliefs of

\begin{thebibliography}{99}
\bibitem{141} The story of the councillor which is reported in the Sunday Times of 15 April 2007 page 1 is an example of how confidentiality of HIV-positive status may facilitate the spread of HIV/AIDS further in South Africa. (The paper depicted this as “HIV-positive councillor in hot water”). The paper reported that the woman who was allegedly deliberately infected by her lover with HIV said she went to the police to stop him from spreading the virus, after he allegedly told her that he would infect other women because it was a woman who had infected him. She said she got confirmation of his HIV status in June last year, after stumbling upon a document that showed his test results. She claimed that when she confronted him he initially told her he had withheld this information out of fear that she would dump him. See also Mswela LLM dissertation 10-11.
\bibitem{142} See, Daily Dispatch, September 15, 2005 page 15. (This paper depicted this as “Dispelling the virgin rape myth”). It reported that: “In February 2003, an HIV positive Potchefstroom man was sentenced to life imprisonment. He was perhaps the first person to have admitted raping a child to cleanse himself of HIV”.
\bibitem{143} See, Daily Sun, Thursday 7 December 2006 page 1 that depicted that: “Deadly Dad! HIV man who raped and infected his own daughter may be up for attempted murder”. See, also, Daily Dispatch, Wednesday September 2 2009 page 1 that stated that: “Teacher held for pupil’s rape”.
\bibitem{145} The World Bank 127, states that: “One reason societies are slow to come to grips with the HIV/AIDS crisis is that many aspects of the problem are considered taboo or are frowned on by the large segments of the population.”
\bibitem{146} The World Bank 127.
\end{thebibliography}
witchcraft amongst Africans, since people do not know the real cause of the death of the person. In the absence of clear facts, they speculate that he or she may have been bewitched and this sometimes leads to the killing of innocent people who are accused to be witches.

It will, therefore, be proposed that emphasis on the right to privacy (and confidentiality) should be balanced by encouraging disclosure of HIV status so as to lessen the stigma and myths about AIDS. The more people are willing to disclose their HIV status, the better and more effective AIDS awareness will become and this will eventually lead to less stigmatisation, discrimination and victimisation of persons living with HIV/AIDS. However, in order to reach the position where HIV disclosure may be made without fear, difficult social and cultural obstacles (such as erroneous perceptions or myths) will need to be overcome. Legislative measures aimed at reducing the spread of HIV should hence be cognisant of these cultural and socio-economic forces that reinforce the present unsatisfactory status quo regarding disclosure of a positive HIV-status.

This thesis draws on appropriate philosophical theories that will assist in providing a better understanding of confidentiality from an African point of view, one which is more aligned with African thoughts and practices generally.

1.4 CHOICE OF LEGAL SYSTEMS

Where relevant, the thesis will draw comparisons to relevant foreign legal systems, particularly those who are frequently consulted when fundamental rights in the Constitution of the Republic of South Africa, 1996, are interpreted. These legal systems, in addition, have unique ways of dealing with specific issues, such as partner notification and the criminalisation of intentional HIV transmission.

1.4.1 South Africa

This thesis will review current legislation case law and other relevant materials relating to the right to confidentiality in the context of HIV/AIDS. The purpose of this review will be to identify the weaknesses relating to the protection of the right to privacy (and confidentiality) in the context of HIV and AIDS. The
South African Constitution\textsuperscript{147} entrenches the right to privacy which is contained in section 14 of the Constitution. This section provides that everyone has the right to privacy.\textsuperscript{148} The South African Constitution, like the United States Constitution, guarantees everyone, including persons living with HIV/AIDS, the constitutional right to privacy.\textsuperscript{149} Implied in the right to privacy is the right to confidentiality. The right to confidentiality is further entrenched in the National Health Act.\textsuperscript{150} The right to privacy, including confidentiality, will be examined and compared to foreign provisions in order to determine which inferences may be drawn for the South African context relating to HIV and AIDS.

\textbf{1.4.2\quad Canada}

Canada is one of a number of countries where HIV and AIDS are notifiable diseases. AIDS, for instance, is legally notifiable in all Canadian provinces and territories. HIV infection is legally notifiable at the provincial and territorial levels in all Canadian provinces and territories, (except British Columbia). AIDS and HIV data are shared with the Centre for Infectious Disease Prevention Control (CIDPC) at the federal level by provinces and territories.\textsuperscript{151} Canada’s experience will briefly be considered in the discussion on whether HIV and AIDS should be made notifiable diseases in South Africa.

\textbf{1.4.3\quad United States}

The legal system of the United States of America is another legal system that endorses the legal notification of HIV/AIDS. According to Bobinski and LeMaistre:\textsuperscript{152}

Statutes governing AIDS/HIV information, including requirements for reporting information about the person infected to health authorities, vary from state to state. Florida requires full reporting information (name, address, sex, age and race) of AIDS or AIDS-related complex, an AIDS-like syndrome, but prohibits the reporting of HIV infection by name, address or identifying numbers or symbols. Colorado requires attending physicians and laboratories to report fully to the state or local health departments any ‘diagnosis of AIDS, HIV-related illness, or HIV infection, including death from HIV infection’. Other States go beyond requiring the reporting of HIV/AIDS. Minnesota extends the requirements to the reporting of any person who may be a ‘health threat to others’ and Georgia requires the reporting of any other person the physician or administrator reasonably believes to be at risk of being infected.

\textsuperscript{147} The Constitution of 1996.
\textsuperscript{148} Which includes the right not to have (a) their person or home searched; (b) their property searched; (c) their possessions seized; or the privacy their communications infringed.
\textsuperscript{149} Which is entrenched, as above mentioned, by section 14 of the Constitution. See \textit{Tshabalala-Msimang and Another v Makhanya and Others} (18656/07) [2007] ZAGPHC 161 (WLD) (hereafter referred to as the \textit{Tshabalala-Msimang} case) paragraph [27], where the right to confidentiality was emphasized by the court.
\textsuperscript{150} National Health Act 61 of 2003. Where section 14 provides that: (1) all information concerning a user, including information relating to his or her health status, treatment or stay in a health establishment, is confidential.
\textsuperscript{152} Bobinski and LeMaistre 24.
Both Canada and the United States provide an interesting point of comparison for South Africa with regard to making HIV and AIDS notifiable diseases. Care should be taken, however, not to make recommendations, based on foreign inferences, which will not be socially and culturally appropriate or relevant for South Africa.

1.5 STRUCTURE OF THE THESIS

Chapter 1
Introduction

Historical Background

Chapter one will trace the origins and spreading of HIV and AIDS around the world. It will also include an overview of HIV/AIDS epidemic in South Africa. The purpose, problem statement and motivation are described, as well as the research approach and the methodology.

Chapter 2

Stigmatisation, discrimination and victimisation of persons living with HIV/AIDS and the emphasis on confidentiality

This chapter focuses on the discrimination, stigmatisation and victimisation of persons living with HIV/AIDS and the emphasis on confidentiality. The discussion on discrimination considers discrimination in the family, by the family, at school, in the employment context; health context; restrictions on travel and finally, discrimination by insurance companies and government. This chapter outlines the reasons that prevent persons living with HIV/AIDS from disclosing their HIV-status.

Chapter 3

The right to privacy and confidentiality

The right to privacy, which includes confidentiality, as accorded by section 14 of the Constitution and section 14 of the National Health Act, in so far as they pertain to persons living with HIV and AIDS, will

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be discussed in this chapter. The protection of privacy in terms of the common law will also be discussed. Confidentiality as protected by ethical guidelines (eg the SAHPC and SAMA newest 2007 versions), the Oath of Hippocrates and other relevant instruments will be discussed in this chapter. This chapter will also review the effectiveness of these measures on the management of HIV and AIDS generally, as well as in consensual sexual relations. The protection of confidentiality after death is also explored.

Chapter 4

The limitation of the right to privacy and medical confidentiality

This chapter addresses the limitations of the right to privacy (and confidentiality) in terms of section 36 of the Constitution. Relevant provisions of the National Health Act and regulations, Children’s Act, as well as other statutes that relate to HIV and AIDS, are discussed in this chapter. The duty to inform third parties of a person’s HIV status is discussed. The question whether the duty to disclose is an ethical or legal one, is also canvassed. The chapter concludes with a discussion of the criminalisation of intentional HIV transmission.

Chapter 5

Individualism versus utilitarianism and communitarianism

Chapter five will examine some of the philosophical theories relating to Africanism, individualism, utilitarianism and communitarianism in the context of privacy and confidentiality. It is proposed that a consideration of these theories is relevant to counter the focus on the individualistic and Western notion of privacy. Chapter five also explores the issue of HIV and AIDS notification and whether this is viable in the South African context.

Chapter 6

Conclusion

In this final chapter, certain conclusions and recommendations are made, based on observations and interpretations that were made in the preceding chapters.

154 National Health Act 61 of 2003, which states at s14(1), that: ‘All information concerning a user, including information to his or her health status, treatment or stay in a health establishment, is confidential’.
1.6 RESEARCH APPROACH AND METHODOLOGY

1.6.1 Research methodology

The research method of this thesis is a literature study, which will be a critical review of existing literature concerning the topic. The literature study to be undertaken will be a review of books, legislations, cases, journals, newspapers and relevant internet sources. The study will include a comparative component, which will examine the right to confidentiality from the perspective of the United States and Canada.

1.6.2 Explanatory note on source referencing and bibliography

- The first textbook reference is cited in full: e.g. Author, Initial(s), Title of source (publishing date, place of publishing: Publisher’s name) page number, for example Squire C HIV in South Africa (2007, London and New York: Routledge) 25. Thereafter, only the author’s name and page number are stated in the subsequent citing, for example, Squire 25. In some publications, however, the place of publishing is not specified, in such instances therefore only the publishers name will be mentioned.

- In the Bibliography at the end of the thesis, a full citation of the textbooks will be given, but it will end with the year of publication, for example Squire C HIV in South Africa (Routledge London and New York 2007).

- In the footnotes and in the bibliography, the name of a single author will be listed as it is with initials, for two or three authors all their names will be listed, but for more than three authors only the name of the first author will be listed, followed by et al. For example Squire C HIV in South Africa (2007, London and New York: Routledge) 25 (single author), Ellison G, Melissa P and Campbell C Learning from HIV and AIDS (2003, Cambridge: Cambridge University Press) 47 (two or three authors) and Barret-Grant K et al HIV/AIDS and the Law - A Resource Manual (2001, The AIDS Law Project and The AIDS Legal Network) 11 (more than three authors).

- The title of reference of textbooks both in the footnotes and bibliography is written in italics, for example Squire C HIV in South Africa (Routledge London and New York 2007).

- The title of reference of journals, both in the footnotes and in the bibliography, will not be in italics, however, it will be placed between double inverted comas and the title of the journal, which will either be a full name or abbreviations, will be provided in italics both in the footnotes and in the bibliography, for example, Bayer R and Fairchild AL “Changing the paradigm for HIV testing-end of
exceptionalism" 2006 (355;7) *N Engl J Med* 647-649. Where abbreviations have been used, the full names of the journal will be provided in the table of contents.

- Case names in the main text and footnotes are written in italics, e.g. *Tshabalala-Msimang and Another v Makhanya and Others* (full citation for the first time). The *Tshabalala-Msimang* case (short citation for the second time).

- In the internet references, the full web address is given and the date when the website was visited.

- The citation of sources are given as follows:


  - South African cases, first time citation: *Jansen van Vuuren and Another v Kruger* 1993 (4) *SA* 842F-G (AD). Second time citation: The *Van Vuuren* case at 848A. First time citation of a South African case which has paragraphs: *Hoffman v South African Airways* 2001 (1) *SA* 1 (CC) (hereafter) paragraph [28]. Second citation of a case with paragraphs: The *Hoffman* case, paragraph [29].


• The bibliography will be a compilation of all the sources cited in full in the footnotes. Cases and statutes, however, will be listed separately.

• Short quotations in the main text and in the footnotes are placed between double inverted commas. Single quotations are use only to highlight certain terms and where the citation was taken from another source. Long quotations of more than three sentences are indented and inverted commas are not used.

1.7 CONCLUSION

The right to privacy (and impliedly confidentiality) is of crucial importance to persons living with HIV and AIDS. Violence, stigma, discrimination, victimisation and ostracism characterise the lives of many South Africans living with HIV and AIDS.
CHAPTER 2

STIGMATISATION, DISCRIMINATION AND VICTIMISATION OF PEOPLE LIVING WITH HIV/AIDS AND THE
EMPHASIS ON CONFIDENTIALITY

2.1 INTRODUCTION


1 Inoue Y et al “Sexual activities and social relationships of people with HIV in Japan” 2004 (16;3) AIDS Care 349-363 at 349 point out that HIV infection has social aspects such as stigma and these may greatly affect the social relationships of people with HIV. For example, expectation of, and anxiety over, discrimination leads to hiding of the disease as a stigma-copying response, increased cautiousness and wariness, and prevention of the formation of support networks, and these in turn reinforce internalisation of stigma, development of felt-stigma and self-restriction of daily activities. In addition, these aspects of the illness experience have been suggested to have major effects on quality of life. Timberg C In South Africa, Stigma Magnifies Pain of AIDS: Many Still see Disease as Fatal, Shameful http://www.washingtonpost.com/wp-dyn/articles/A7822-2005Jan13.html (visited 19 May 2010), relates the story of Sibusiso Mlangeni, who the very moment he learned he had contracted HIV, claimed he experienced his first taste of the stigma associated with HIV. Mlangeni was scolded by the nurse at the AIDS clinic: ‘You’ve been messing around and you are HIV-positive.’ See also Paxton et al "AIDS-related discrimination in Asia" 2005 (17;4) AIDS Care 413-424, 413, Hamra M et al "The relationship between expressed HIV/AIDS-related stigma and beliefs and knowledge about care and support of people living with AIDS in families caring for HIV-infected children in Kenya" 2005 (17;7) AIDS Care 911-922, 912, Fife BL and Wright ER "The dimensionality of stigma: A comparison of its impact on the self of persons with HIV/AIDS and cancer” 2000 (41) Journal of Health and Social Behaviour 50-67, 50, Kalichman SC and Simbayi L “Traditional beliefs about the cause of AIDS and AIDS-related stigma in South Africa” 2004 (16;5) AIDS Care 572-580, 572, Burkholder GJ et al “Social stigma, HIV/AIDS knowledge, and sexual risk” 1999 (4;1) Journal of Applied Biobehavioral Research 27-44, 28, Mbilinyi AJ Protection Against Unfair Dismissal of Employees Living with HIV/AIDS in the Workplace: A Comparative Study (Unpublished LLM dissertation UNISA 2009) 5, Terblanche-Smit M The Impact of Fear Appeal Advertising on Disposition Formation in HIV/AIDS Related Communication (unpublished PhD dissertation Stellenbosch University 2008) 165 and Green G “Stigma and Social Relationships of People with HIV: Does Gender Make a Difference?” in Sherr L, Hankins C and Bennet L (eds) AIDS as a Gender Issue: Psychological Perspectives (1996, London: Taylor & Francis) 46.


situation truly catastrophic. In many societies, especially in the rural areas and townships, people are still ignorant about how HIV is transmitted from one person to another, and as a result people do not understand that a person cannot get HIV by touching, hugging or using a bath that was used by someone who is HIV positive.

The association of HIV/AIDS with sexual behaviour and with the previously ostracised groups such as homosexuals, pre-and extramarital sex, sex workers and injecting drug users has also perpetrated stigma and discrimination. This means that education and awareness about HIV/AIDS still remains an important issue. Stigmatisation, discrimination and victimisation have driven many persons living with HIV and AIDS to keep their HIV status confidential in fear of the social consequences if they disclose their status.

This chapter will, therefore, discuss in detail about stigmatisation, discrimination and victimisation of people living with HIV/AIDS with the emphasis on confidentiality.

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5 See Timberg http://www.washingtonpost.com/wp-dyn/articles/A7822-2005Jan13.html (visited 19 May 2010), who tells the story of Sibusiso Mlangeni of Soweto, South Africa, who soon after being diagnosed of HIV was given his own set of dishes, a crude but common reaction from families under the false impression that HIV can spread through casual contact. Mlangeni, a volunteer at a hospice in the sprawling township outside Johannesburg said: “I had my own special plate, my own special cup, my own special blanket, everything.”


7 Terblanche-Smit 2008 PhD dissertation 165.
2.2 STIGMATISATION

Stigma has been defined in many ways and seems to have been as old as mankind. Etymologically, the concept of ‘stigma’ derives from a Greek word referring to a tattoo mark. It generally has two meanings, of which the first one originated from Christianity, meaning bodily marks which resemble those of the crucifixion of Jesus Christ and which are attributed to divine favour. The second meaning is secular, namely marks of disgrace, discredit, or infamy. In these days, stigma is applied more to refer to social disgrace than to any bodily signs. Stigma, therefore, is generally recognised as an attribute that is deeply discrediting that reduces the bearer from a whole and usual person to a tainted, discounted one.

Stigma is also used to set the affected persons or groups apart from the normalised social order and this separation implies devaluation. The HIV stigma, itself, is shaped not only by individual perceptions and interpretations of micro-level interactions but also by larger social and economic forces. It is a social construct, which has significant impact on the life experiences of individuals both infected and affected by HIV. Stigma includes prejudice and can lead to active discrimination directed toward persons either perceived to be or actually infected with HIV and the social groups and persons with whom they are associated. Stigma can be

8 Mbonu, Van den Borne and De Vries 2009 Journal of Tropical Medicine 2. Herek 2002 HeinOnline J.L. Med. & Ethics 594, points out that the English usage of ‘stigma’ dates back at least to the 1300s. The term derives from the same Greek roots as the verb ‘to stick,’ that is, to pierce or tattoo. See also The Southern Africa HIV & AIDS Information Dissemination (SAF AIDS) http://www.safaids.net (visited 09 March 2010), which observed that stigma has prehistoric roots, for instance, in ancient Greece, slaves or criminals would be branded or physically marked to show that they were outcasts and this is where the term “stigma” originated.

9 Mbonu, Van den Borne and De Vries 2009 Journal of Tropical Medicine 2. See also Herek 2002 HeinOnline J.L. Med. & Ethics 594-607 who points out that the earliest recorded English usage of stigma referred to the cluster of wounds manifested by Catholic saints, which corresponded to the wounds of the crucified Jesus. These stigmata were said to appear regularly, sometimes bleeding, in conjunction with important religious feast days. Religious stigmata signified holiness, but stigma more commonly had a thoroughly negative connotation. Literally, therefore, stigma refers to a visible marking on the body, usually made by a branding iron or pointed instrument. But the ‘mark’ could also be a nonphysical condition or attribute.

10 See Mbonu, Van den Borne and De Vries 2009 Journal of Tropical Medicine 2 and Greene 37 who points out that stigma has also been described as referring to an attribute that is deeply discrediting, spoiling, tainting, or making someone seem inferior in the eyes of others partly because he or she may fail to live up to others’ expectations. See also Okechukwu 2007 Benin Journal of Postgraduate medicine 64, and Fife and Wright 2000 Journal of Health and Social Behaviour 51.

11 Mbonu, Van den Borne and De Vries 2009 Journal of Tropical Medicine 2. Though it may be argued that some people even today still view tattoos as stigma and people who have them as disgrace.


external or internal.\textsuperscript{15} External stigma refers to the actual experience of discrimination, whereas, internal stigma (felt or imagined stigma) is the shame associated with HIV/AIDS and persons living with HIV/AIDS fear of being discriminated against.\textsuperscript{16} Internal stigma can be described as a powerful survival mechanism aimed at protecting oneself from external stigma and often results in thoughts or behaviour such as the refusal or reluctance to disclose a positive HIV status, denial of HIV/AIDS and unwillingness to accept help.\textsuperscript{17} This collective public denial in societies is reflected by avoidance of mentioning any terminal illness including HIV/AIDS, a need to keep hope alive for therapeutic success, stigma attached to HIV/AIDS, and unwillingness to confront matters related to sexuality.\textsuperscript{18}

Stigma, therefore, may be described as a strong, negative feeling against a person due to his certain characteristic or certain condition such as disability, mental-illness or HIV/AIDS disease.\textsuperscript{19} People who had certain conditions such as disability and those who suffered from certain diseases had long being stigmatised by the society even before HIV and AIDS were known. People, for instance, stigmatised and continue to stigmatise people who are physical disabled, mentally ill, or those who have incurable diseases such as Ebola or Congo fever, and recently multi-drug resistant tuberculosis (MDR-TB), extreme resistant tuberculosis (XDR-TB) and HIV/AIDS, itself. In the rural areas and townships, people who are suspected to be witches are also stigmatised and normally regarded as outcasts who deserve to die. However, if efforts to fight the spread of HIV/AIDS are to be successful, this stigma against this disease has to be carefully examined and addressed. The reason, as it

\textsuperscript{15} Inoue 2004 AIDS Care 349, and Fife and Wright 2000 Journal of Health and Social Behaviour 51.

\textsuperscript{16} Fife and Wright 2000 Journal of Health and Social Behaviour 51, point out that due to the reactions of others as to internalised self-feelings, stigmatised people’s life chances and opportunities are lessened, they are set apart from others, and they are considered to be inferior and to represent a danger to society, all of which lead to social rejection and social isolation.

\textsuperscript{17} Leickness 2007 Social Science & Medicine 1824.

\textsuperscript{18} Mbonu, Van den Borne and De Vries 2009 Journal of Tropical Medicine 3.

\textsuperscript{19} See Campbell C and Gibbs A “Stigma, Gender and HIV: Case Studies Inter-sectional” in Boesten J and Poku NK (eds) Gender and HIV/AIDS-Critical Perspectives from the Developing World (2009, England and USA: ASHGATE) 30, who define stigma as any negative thoughts, feelings or actions against people infected with or affected by HIV/AIDS. See also Zaccagnini http://www.avert.org/aidsstigma.htm (visited 27 February 2010) who defines AIDS-related stigma and discrimination as referring to prejudice, negative attitudes abuse and maltreatment directed at people living with HIV and AIDS. They can result in being shunned by family, peers and the wider community; treatment in healthcare and education settings; erosion of rights, psychological damage and can negatively affect the success of testing and treatment. Stigma involves negative thoughts or prejudices about people from particular groups or with certain characteristics. Self-stigma, involving feelings of shame, guilt and fear among infected persons, is the basis of all forms of stigma. Stigma and discrimination associated with HIV and AIDS are the great barriers to preventing further infections and providing adequate care, support and treatment, and are found in every country and region of the world. SAFAIDS http://www.safaids.net (visited 09 March 2010) also observed that much of the stigma, faced by PLWHA, builds on existing prejudices related to race, gender, socio-economic status, culture and other similar categories in society. See also Fife and Wright 2000 Journal of Health and Social Behaviour 51.
will be shown below, being that stigma undermines public health and perpetrates the spread of HIV/AIDS. This chapter will also consider the issue of HIV exceptionalism.

### 2.2.1 Why is there stigma related to HIV and AIDS?

The causes of stigma related to HIV and AIDS, as mentioned above, are usually due to ignorance and misconceptions about this disease.\(^{20}\) Foreman\(^ {21}\) observes that:

> Despite the best efforts of campaigns to prove the contrary, the misconceptions persists in both North and South that HIV can be transmitted from one person to another through casual contact. Time and again such fear emerges: in 1987, Washington DC police wore rubber gloves to arrest demonstrators at the International Conference on AIDS; in 1989 cleaning staff at York University in the UK caused a conference of people with HIV to be cancelled because they believed they were at risk. Also in 1989, a Brazilian official became extremely irritated when it was suggested that a child with the virus might sit in his chair. ‘Not in my chair,’ he shouted, adding: ‘Now we’re going to have to clean everything.’ In Pakistan, a woman who was HIV-positive had her home surrounded by policemen wearing gloves and masks who then whisked her away to prison; there she was isolated in a room which was sprayed daily with disinfectant. And in Uruguay in 1989, when a family with an HIV-positive member moved house, the new occupants disinfected the entire place and burned everything they left behind. In several countries, ‘spacemen’ suits have sometimes been worn by ambulance staff or others whose work brings them into contact with people who are seropositive.\(^ {22}\)

These are some of the examples that show that ignorance and misconceptions about HIV and AIDS are the ones that perpetuate the stigma about this disease. This ignorance about this disease has driven people to be afraid of people living with HIV/AIDS. Even in church people become afraid of hugging or drinking from a cup which was used by an HIV/AIDS-positive person.\(^ {23}\) Socially, people become afraid to be associated with people living with HIV/AIDS. They are even afraid to use utensils such as bath, shower, dishes and spoons that are used by people living with HIV/AIDS.\(^ {24}\) This fear of the contagion coupled with negative, value-based assumptions about people who are infected leads to high levels of stigma surrounding HIV and AIDS.\(^ {25}\) There are many factors that contribute to HIV/AIDS-related stigma, of which some are following: HIV/AIDS is a life-

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\(^{22}\) Foreman 20.

\(^{23}\) Salmon K Fighting against Stigma, Culture and Discrimination SHAAN online IPS e-zine on Gender and Human Rights [http://www.ipsnews.net/hivaids/section3_1.shtml](http://www.ipsnews.net/hivaids/section3_1.shtml) (visited 20 March 2011), cites Patricia Asero, a 33 year-old mother, widow and HIV/AIDS counselor as saying: “People point figures at me in the street and in the Church. They whisper. Neighbours tell my visitors: ‘You know she has AIDS, she’ll give it to you.’” Asero was just 22 when she found out that she was HIV positive.


threatening disease and therefore people react to it in strong ways. HIV infection is associated with behaviours (such as homosexuality, drug addiction, prostitution or promiscuity that are already stigmatised in many societies. Most people become infected with HIV through sex which often carries moral baggage. Religious or moral beliefs lead some people to believe that being infected with HIV/AIDS is the result of moral fault (such as promiscuity, ‘deviant sex’ or homosexuality) that deserve to be punished. HIV is often thought to be the result of personal irresponsibility.

Foreman observes that all of these factors, fear, hostility, denial and condemnation add up to the stigma of AIDS. People with HIV are seen in some way as a disgrace to society, although the reason for the disdain varies from culture to culture. In some societies, the disease may be associated with homosexuality or illegal drug use, both patterns of behaviour which are normally condemned. In others, where transmission is predominantly heterosexual, AIDS may be seen less as a mark of “perversion” than of irresponsibility. In yet other societies, it may be felt that by contracting the disease, an individual is letting the people down. In countries such as Tanzania, for instance, having AIDS somehow means a person has failed to be a good citizen; it is believed that by falling ill in this way a person is not contributing to the good of the country and to other Tanzanians. Stigma and discrimination fuel the HIV/AIDS epidemic by creating a culture of secrecy, silence, ignorance, blame, shame and victimisation and this has an effect on persons living with HIV/AIDS as individuals, and on their illnesses, behavior and perception of the health care they receive. This fear of hostility, ostracism and isolation by the family and the community often cause many people living with HIV/AIDS to conceal their HIV/AIDS positive status. Many of them, therefore, keep their health status confidential and may die not knowing what the real cause of their deaths was. This will be discussed further in the following chapter 3, below.

28 Parker and Aggleton 7, and Foreman 27.
30 Foreman 30 and Hamra 2005 AIDS Care 912.
31 Foreman 30.
32 Foreman 30.
2.2.2 The effects of stigma

The stigma related to HIV has many effects for those living with HIV/AIDS. The stigma, for instance, serves to deprive people with AIDS of the confidence and agency they need to access treatment, participate in programs and increase self-efficacy, all of which have positive health outcomes.\textsuperscript{34} The impact of the AIDS-related stigma and discrimination can be subtle, and can result in individuals hiding their secret and thus becoming withdrawn and isolated.\textsuperscript{35} This HIV/AIDS stigma has also been increasingly described as major driver of the HIV/AIDS pandemic through limiting people’s access to prevention, formal and informal care and more recently anti-retroviral treatment. Stigma inhibits many women from learning their HIV status for fear of abandonment or violence by their partners. Men who associate their ability to conceive children as a central and prized dimension of their masculinity may also deny or hide their status for fear that this will hinder the likelihood of them conceiving children, leaving them to die without having fulfilled their masculine life destiny of “leaving behind people who bear names.”\textsuperscript{36} This stigma has also been accused of hindering, in no small way, efforts stemming the epidemic. It complicates decisions about testing, disclosure of status and ability to negotiate prevention behaviours, including use of family planning services. The stigma around HIV/AIDS has had a profound effect on the epidemic’s course.

The World Health Organisation (WHO), for instance, cites fear of stigma and discrimination as the main reason why people are reluctant to be tested, to disclose HIV status or to take anti-retroviral drugs.\textsuperscript{37} All these factors, directly or indirectly, contribute to the expansion of the epidemic, as reluctance to determine HIV status or to discuss or practice safe sex means that people are more likely to infect others, as well as a higher number of AIDS-related deaths.\textsuperscript{38} This situation is exacerbated by the fact that it is culturally a taboo to speak about issues of sex.\textsuperscript{39} As a result and in addition to the stigma, therefore, many people living with HIV/AIDS are afraid to talk about sex to their partners, families or community members. This may partly explain why it is so difficult to curb the spreading of HIV/AIDS in Africa, compared to other countries, for instance, the United States of America, where the virus was first recognised. The fear of becoming stigmatised is the main reason why many people prefer to remain silent and confidential about their HIV/AIDS positive status.\textsuperscript{40} As a result, from the beginning of

\begin{footnotes}
\item[34] Campbell & Gibbs 29.
\item[35] Paxton 2005 AIDS Care 414.
\item[36] Campbell & Gibbs 30.
\item[38] Zaccagnini http://www.avert.org/aidsstigma.htm (visited 27 February 2010).
\item[39] Parker and Aggleton 2.
\item[40] See Zaccagnini http://www.avert.org/aidsstigma.htm (visited 27 February 2010), who cites UN Secretary-General
\end{footnotes}
This pandemic, it has always been clear that if persons living with HIV/AIDS fear the personal, social and economic consequences of being diagnosed with HIV/AIDS, they would forego testing, fail to discuss their health and risk behaviours with counsellors or health care professionals, and eventually refrain from entering the health care system for treatment.\textsuperscript{41}

This fear of being stigmatised, ostracised and isolated by the society often causes people living with HIV/AIDS to commit suicide rather than to live after their status has been disclosed or when they are suspected by community members to be HIV-positive.\textsuperscript{42} The stigma against persons living with HIV/AIDS is the main reason why people choose the safety net of confidentiality as opposed to disclosure. HIV/AIDS stigma, therefore, has a direct contributory impact on the spreading of HIV/AIDS in the world and this is the reason why it will be recommended, in chapter 6 below, that serious efforts must be directed towards addressing and ending this stigmatisation. Persons who fear social consequences if they disclose their HIV-positive status forego testing and do not discuss risk behaviours with health workers and do not access medical treatment which easily available at health centres. All of these undermine public health efforts to fight against the HIV/AIDS pandemic.

2.3 DISCRIMINATION

2.3.1 Introduction

The stigma against people living with HIV/AIDS goes hand in hand with discrimination, such as negative treatment and denied opportunities on the basis of their HIV status. Discrimination is bad enough without AIDS, but much worse with it.\textsuperscript{43} The discrimination that persons living with HIV/AIDS suffer may occur in all levels of a person’s daily life, for example, when people wish to travel, use healthcare facilities, seek employment, in the

\textsuperscript{41} Ban Ki Moon saying: “Stigma remains the single most important barrier to public action. It is the main reason why too many people are afraid to see a doctor to determine whether they have the disease, or to seek treatment if so. It helps make AIDS the silent killer, because people fear the social disgrace of speaking about it, or taking easily available precautions. Stigma is a chief reason why the AIDS epidemic continues to devastate societies around the world.”

\textsuperscript{42} Gostin and Webber 2000 HeinOnline J. Health Care L. & Pol’y 270. See City Press of 24 August 2008 page 1. (The paper depicted this as “The silent war kills 1000 a day”). In this paper it is observed that: “And although virtually every South African is affected by Aids, there remains a huge stigma about the disease. Only two weeks ago an Eastern Cape woman, Nokuzola Mfiki, distraught over rumours that she was HIV-positive, killed her four children before committing suicide. In a suicide note, Mfiki said she committed the killings because community members believed she was HIV-positive and were gossiping about her.”

\textsuperscript{43} Mugyenyi 113.
family, in the church, at school or at a community level. However, as it will also be shown below, fair
discrimination is allowed by the Constitution and only unfair discrimination is prohibited.

2.3.1.1 Differences between fair and unfair discrimination

Currie and De Waal define discrimination as a particular form of differentiation. Unlike ‘mere differentiation’, discrimination is differentiation on illegitimate grounds and there is a list of illegitimate grounds of differentiation in section 9(3) of the Constitution. However, the equality clause does not prohibit discrimination but unfair discrimination. Indeed, sections 9(3) and (4) prohibit ‘unfair discrimination’ and that clearly implies that ‘fair discrimination’ is allowed by the Constitution. The important implication of this terminology is that not all discrimination is unfair and fairness is a moral concept that distinguishes legitimate from illegitimate. What this means is that fair discrimination, such as affirmative action, is allowed by the Constitution. Affirmative action, for instance (often described as reverse discrimination) is considered fair in order to address the imbalances of the past. This is emphasised by section 6(2) of the Employment Equity Act, which provides that it not unfair discrimination to:
(a) take affirmative action measures consistent with the purpose of this Act; or (b) distinguish, exclude or prefer any

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45 See section 9(3) and (4) of The Constitution of the Republic of South Africa, Act 108 of 1996 (herafter referred to as The Constitution of 1996), which prohibits unfair discrimination by the state or person against anyone on one or more grounds in terms of subsection (3).
48 Currie and De Waal 243.
49 Currie and De Waal 244, Albertyn C "Constitutional Equality in South Africa" in Dupper O and Garbers C (eds) Equality in the Workplace: Reflections from South Africa and Beyond (2009, Cape Town: Juta & Co, Ltd) 78 and Mubangizi 76.
51 Currie and De Waal 244, and Cheadle, Davis and Haysom 105. See also Albertyn 79 who points out that it is generally understood that fairness in s 9 is a moral enquiry and a value judgment that distinguishes permissible from impermissible discrimination.
52 Mubangizi 74 and Grogan 117.
person on the basis of an inherent requirement of the job. However, Currie and De Waal\cite{CurrieAndDeWaal2005} argue and submit that it seems puzzling that not all discrimination is unfair. This is because, in everyday speech, the word discrimination carries pejorative associations. Most people say that it is wrong to discriminate and would be hard pressed to understand someone who said that sometimes discrimination is not wrong, or that only unfair discrimination is wrong.\cite{CurrieAndDeWaal2005}

Unfair discrimination is discrimination with an unfair impact. It has this impact where it imposes burdens on people who have been victims of past patterns of discrimination, such as women or black people, where it impairs to a significant extent the fundamental dignity of the complainant.\cite{CurrieAndDeWaal2005} Where the discriminating law or action is designed to achieve a worthy and important societal goal, it makes fair what would otherwise be unfair discrimination.\cite{CurrieAndDeWaal2005}

\section*{2.3.2 Discrimination in the family}
Families are the primary caregivers when a person falls ill. Many families, of course, play an important role in providing support and care for people living with HIV and AIDS. In fact, in most developing countries around the world, families are the main source of care and support for persons living with HIV/AIDS.\cite{ParkerAndAggleton2005} However, not all family responses are positive and HIV-infected members of the family often find themselves stigmatized and discriminated against within their own homes.\cite{ParkerAndAggleton2005} There is concern that women and non-heterosexual family members are more likely than children and men to be mistreated.\cite{ParkerAndAggleton2005}

\section*{2.3.3 Discrimination by the community}
Persons living with HIV/AIDS are often discriminated against by their communities. The causes of this discrimination, as mentioned above, are usually attributed to ignorance about HIV/AIDS and prejudice. Discrimination by communities often depends on the societal beliefs such as individualism or collectivism.\cite{ParkerAndAggleton2005} In societies, for instance, with cultural systems that place greater emphasis on individualism, HIV/AIDS may be perceived as the result of personal irresponsibility, and thus individuals are blamed for contracting the infection. In contrast, in societies where cultural systems place greater emphasis on collectivism, HIV/AIDS maybe

\begin{thebibliography}{99}
\bibitem{CurrieAndDeWaal2005} Currie and De Waal 245.
\bibitem{CurrieAndDeWaal2005} Currie and De Waal 245.
\bibitem{CurrieAndDeWaal2005} Currie and De Waal 246.
\bibitem{CurrieAndDeWaal2005} Currie and De Waal 246.
\bibitem{CurrieAndDeWaal2005} Currie and De Waal 246.
\bibitem{CurrieAndDeWaal2005} Currie and De Waal 246.
\bibitem{ParkerAndAggleton2005} Parker and Aggleton 8.
\bibitem{ParkerAndAggleton2005} Parker and Aggleton 8. Timberg http://www.washingtonpost.com/wp-dyn/articles/A7822-2005Jan13.html (visited 19 May 2010), relates the story of an HIV-positive Sibusiso Mlangeni whose father, a retired security guard who had badgered him about losing too much weight, declared to Mlangeni that: ‘You are going to die.’ Mlangeni’s sister, a nurse, asked him not to stand near her.
\bibitem{ParkerAndAggleton2005} Parker and Aggleton 3. See also Zaccagnini http://www.avert.org/aidsstigma.htm (visited 27 February 2010) cites an HIV-positive woman from Zimbabwe as saying: “When I was in hospital, my father came once. Then he shouted that I had AIDS. Everyone could hear. He said: this is AIDS, she is the victim. With my brother and his wife I wasn’t allowed to eat from the same plates, I got a plastic cup and plates and I had to sleep in the kitchen. I was not even allowed to play with the kids.” Parker and Aggleton 7.
\end{thebibliography}
perceived as bringing shame on the family and community.\textsuperscript{62} Furthermore, in societies where illness is believed to be the result of ‘immoral’ or ‘improper’ behaviour, HIV/AIDS may reinforce pre-existing stigma against those whose behaviour is considered to be ‘deviant’ such as homosexuals, drug users and prostitutes.\textsuperscript{63}

Discrimination of persons living with HIV/AIDS at a community level is found all over the world. It is commonly manifested in communities in the form of blame, scapegoating and punishment.\textsuperscript{64} A community’s reaction to somebody living with HIV/AIDS can have a huge effect on that person’s life. If the reaction is hostile, a person may be ostracised and discriminated against and be forced to leave their home, or change their daily activities such as shopping, socialising or schooling.\textsuperscript{65} However, in more extreme cases, it has taken the form of violence which has been reported in many countries such as attacks on men or women who are assumed to be gay or lesbian, violence against sex workers and street children in Brazil, and of HIV/AIDS-related murders in Colombia, India, Ethiopia, South Africa and Thailand.\textsuperscript{66} To fight this stigma and discrimination against persons living with HIV/AIDS, therefore, education of the communities about HIV/AIDS and how it is transmitted becomes of paramount importance.

Government, media and the society at large have to work together to make people aware of the impact the discrimination and stigma have on people who live with HIV/AIDS. The support of families and the community is very important to persons who are living with HIV/AIDS, as sick people who are supported by their families and communities live much longer. Stigmatisation and discrimination of persons living with HIV/AIDS, even by their own families and communities, often hasten their deaths.

\textbf{2.3.4 Discrimination at school}

Discrimination of HIV positive persons also occurs at a school level.\textsuperscript{67} This discrimination of children who are HIV positive, just like the others, is also fuelled by ignorance about how the disease is transmitted.

\begin{thebibliography}{99}
\bibitem{62} Parker and Aggleton 7.
\bibitem{64} Parker and Aggleton 7.
\bibitem{65} Zaccagnini http://www.avert.org/aidsstigma.htm (visited 27 February 2010).
\bibitem{66} Parker and Aggleton 7.
\bibitem{67} Parker and Aggleton 5.
\end{thebibliography}
Discrimination and stigma have led to teasing and name-calling by classmates of HIV-positive school children or children associated with HIV. The well-known story of a South African child who was discriminated against and expelled at his school due to his HIV infection, is that of Nkosi Johnson. Nkosi Johnson was born HIV-positive in 1989, having contracted the illness from his mother, Nonthlanthla Nkosi. She died of AIDS in April 1997. Nkosi was initially given nine months to live. He surpassed this prediction and at the age of three, he was adopted by Gail Johnson. He became a national figure after a school refused to admit him because he suffered from AIDS. He fought his exclusion, eloquently bringing his case and a demand for children’s rights to South Africa’s Parliament and during a meeting with Nelson Mandela.

Discrimination of children who are HIV positive constitutes a violation of their constitutional rights to equality, dignity and basic education and is an unfair discrimination. Children have a right to receive education irrespective of whether they are HIV positive or not.

2.3.5 Discrimination in the employment context

People living with HIV/AIDS are also discriminated against in the workplace. International documents and South African legislation such as the South African Constitution, Promotion of Equality and Prevention of Unfair Discrimination Act and labour laws, protect HIV/AIDS positive employees against discrimination in the workplace.

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68 Parker and Aggleton 5.
70 Smith A Champion of Resistance Nkosi Johnson at http://www.teacherlink.ed.usu.edu/..Nkosi.pdf (visited 11 September 2010). Nkosi addressed the myth that AIDS can be acquired through casual contact by pointing out that: “You can’t get AIDS by hugging, kissing, holding hands. We are normal human beings, we can walk, we can talk.”
71 See section 9 Equality, section 10 Human dignity and section 29 Education of the Constitution of 1996.
72 See section 29(1)(a)and(b) of the Constitution of 1996 which state that: Everyone has the right to a basic education including adult basic education; and to further education, which the state, through reasonable measures, must make available and accessible.
73 Dupper OC et al Essential Employment Discrimination Law (eds) (2004, Lansdowne: Juta & Co) 205, notes that HIV/AIDS is an important matter for employers, employees and the society at large. For employees, it is important as the rights of employees who live with HIV/AIDS are often adversely affected by irrational and unfair HIV/AIDS-related employment discrimination. The problem is equally important for employers as they are increasingly expected to ensure that the workplace is free from discrimination against employees with HIV/AIDS and that workers work in a safe working environment. See also Parker and Aggleton 6.
74 Such as an ILO code of practice on HIV/AIDS and the world of work of the International Labour Organisation 2001 (hereafter referred to as the ILO Code) found at http://www.ilo.org (visited 06 April 2011), C111 Discrimination (Employment and Occupation) Convention (1958 (1(1)) (hereafter referred to as Discrimination Convention) and International Guidelines on HIV/AIDS and Human Rights (UNAIDS 2006 (149)) which state that everyone has the right to work and to just and favourable conditions of work.
75 The Constitution of 1996, sections 9 and 23.
76 The Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000 (hereafter referred to as the Equality Act), the schedule to this Act (which is attached to section 29) lists unfair practices in certain sectors such as labour and employment as follows: (a) Creating artificial barriers to equal access to employment opportunities by using certain recruitment and selection procedures. (b) Applying human resource utilisation, development, promotion and retention practices which unfairly discriminate against persons from groups identified by the prohibited grounds. (c) Failing to respect the principle of equal pay for equal payment work. (d) Perpetuating disproportionate income differentials deriving from past unfair discrimination. See also Bonthuys E “Counting flying pigs: psychometric testing and the law” 2002 (23) I LJ 1175, who
workplace. Article 4.2 of the ILO Code of practice and the world of work states it clearly that in the spirit of decent work and respect for the human rights and dignity of persons infected by HIV/AIDS, there should be no discrimination against workers on the basis of real or perceived HIV status. Discrimination and stigmatisation of people living with HIV/AIDS inhibit efforts aimed at promoting HIV/AIDS prevention. Section 9 of the Constitution also protects all the employees in the workplace against any unfair discrimination. Furthermore, the Labour Relations Act also protects employees against unfair discrimination in the workplace. However, both section 9 of the Constitution and section 187 of the Labour Relations Act do not specifically mention HIV as a listed ground, though it may be argued that it could be recognised as unfair discrimination on an analogous ground. The Employment Equity Act, however, goes further in protecting employees against discrimination at the workplace by being the first law in South Africa to specifically list HIV status as a ground against discrimination.

emphasises the fact that [the Equality Act, which applies both to the state and individuals or companies now forbids discrimination on several bases, including race, gender, culture, language and social or ethnic origin. 77 Labour laws such as the Labour Relations Act 66 of 1995 (herafter referred to as the Labour Relations Act 1995 or LRA) and Employment Equity Act 55 of 1998 (herafter referred to as the Employment Equity Act or EEA). 78 The ILO Code. See Hodges J InFocus Programme on Social Dialogue, Labour Law and Labour Administration: guidelines on addressing HIV/AIDS in the workplace through employment and labour law (International Labour Office Geneva (2004 (20)), who notes that one of the pillars of the ILO Code is the right not to be discriminated against on the basis of real or perceived HIV/AIDS status. 79 Gostin and Webber 2000 HeinOnline J. Health Care L. & Pol'y 270. 80 The Constitution of 1996. 81 Section 9 of the constitution states that: (1) Everyone is equal before the law and has the right to equal protection and benefit of the law. (2) Equality includes the full and equal enjoyment of all rights and freedoms. To promote the achievement of equality, legislative and other measures designed to protect or advance persons, or categories of persons, disadvantaged by unfair discrimination may be taken. (3) The state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth. (4) No person may unfairly discriminate directly or indirectly against anyone on one or more grounds in terms of subsection (3). National legislation must be enacted to prevent or prohibit unfair discrimination. 82 Labour Relations Act 66 of 1995, Section 187(1)(f) provides that a dismissal is automatically unfair if the reason for the dismissal is that the employer unfairly discriminated against an employee, directly or indirectly, on any arbitrary ground, including, but not limited to race, gender, sex, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, political opinion, culture, language marital status or family responsibility. 83 Labour Relations Act 1995. 84 Currie and De Waal 259. 85 Employment Equity Act. 86 See Basson AC et al Essential Labour Law 4th ed (2005, Centurion: Labour Law Publications) 144, who points out that: “In other countries equity and discrimination issues surrounding HIV/AIDS fall within the ambit of the disability legislation. In South Africa, however, the HIV/AIDS status of a worker is specifically protected in section 6(1) of the EEA.” See also Christianson M “Incapacity and Disability: A Retrospective and Prospective overview of the past 25 years’ 2004 (25) ILJ 879, who concurs with this by stating that: “In many international jurisdictions HIV/AIDS falls within legislation protecting employees against unfair discrimination of people with disabilities. South African legislation has chosen to treat HIV status as a separate ground of unfair discrimination in s 6(1) of the EEA.” See Mauro v Borgess Medical Center, 137 F.3d 398 (6th Cir. 1998), where Mauro, who was denied his work as a surgical technician due to his HIV-positive status, brought claims under the Americans with Disabilities Act of 1990 (ADA). See also Bragdon v Abbot 118 Sct 2196 (1998),
Section 5 provides that every employer must take steps to promote equal opportunity in the workplace by eliminating unfair discrimination in any employment policy or practice. Section 6(1) provides that no person may unfairly discriminate, directly or indirectly, against an employee, in any employment policy or practice, on one or more grounds, including race, gender, sex, pregnancy, marital status, family responsibility, ethnic or social origin, colour, sexual orientation, age, disability, religion, HIV status, conscience, belief, political opinion, culture, language and birth.

However, unfair discrimination at the workplace persists, despite the protection afforded in international documents and South African legislation, referred to above. The Employment Equity Act, in particular, is a very important piece of legislation in protecting HIV positive employees against any discrimination in the workplace. Its Code of Good practice on key aspects of HIV/AIDS and employment strengthens this protection by declaring that no person may unfairly discriminate against an employee, or an applicant for employment, on the basis of his or her HIV status. In analysing section 7 of the Employment Equity Act, Rodgers AJ, in Irvin & Johnson Ltd v Trawler & Line Fishing Union & Others observed that “[s]ection 7 forms part of a chapter dealing with the prohibition of unfair discrimination. One of the main purposes of the Act is to achieve equity in the workplace by promoting equal opportunity and fair treatment in employment through the elimination of unfair discrimination. In this context, the purpose of s 7 seems to me to be clear. An employer should not unfairly discriminate against an employee on the basis that the latter suffers from some or other medical condition.”

However, under certain circumstances, such as dismissal for incapacity by the employer of an employee with HIV/AIDS who is no longer able to perform to the required standard, or is too ill to continue working, or
termination of the employment contract of the employee by the employer due to the fact that employee is a health risk to the patients, the court may regard such a dismissal to be a fair discrimination on the part of the employer. Similarly, an inherent requirement of a particular employment may also be held to be a fair discrimination especially if the employee may not carry out the employment without endangering the safety of other employees.

Persons living with HIV/AIDS are normally discriminated against by employers and their employees respectively, and may suffer stigma such as social isolation and ridicule, or experience discriminatory practices, such as termination or refusal of employment. Fear of an employer’s reaction can cause a person living with HIV anxiety. This fear will in many cases drive many workers who are living with HIV/AIDS to remain silent and confidential about their HIV status in fear of prejudice, discrimination and victimisation by their employers. The other vulnerable group that has suffered a double burden in the employment workplace, is women. Women, especially young women, bear the brunt of the HIV/AIDS epidemic. Women’s low social status, deriving from legal, economic and social inferiority, is the driving force of women’s greater risk of contracting HIV. Despite which provides that states should ensure that persons with HIV are allowed to work as long as they can carry out functions of the job. See also The Hoffman case, paragraphs [30-32].

93 See Doe v University of Maryland Medical System Corporation, et al 50 F.3d 1261, where the court found that Dr. Doe, who was a carrier of the human immunodeficiency virus (HIV), was not a ‘qualified individual’ with a disability under section 504 of the Rehabilitation Act, 29 U.S.C.A. 794 (West Supp. 1994) and the Americans with Disability Act (ADA) U.S.C.A. (West Supp. 1994). The court held that a hospital does not violate Sec. 504 of the Rehabilitation Act or Title II of the ADA when it terminates an HIV-positive neurosurgical resident based upon the risk of transmission of the disease during performance of exposure-prone procedures. Such individuals pose a significant risk to the health or safety of their patients that cannot be eliminated by reasonable accommodation. This means, therefore, that the court held the termination of Dr. Doe’s employment to be a fair discrimination on the part of the hospital in order to protect the patients from infection of HIV. The court had the view that it was better for the hospital to err on the side of caution in protecting its patients.

94 See X v The Commonwealth [1999] HCA 63 paragraphs [30] and [73], where X, who was a soldier in the Australian Regular Army was discharged from the army because he had tested positive to HIV. The court observed that although the dismissal of X was prima facie unlawful, it was open to the Commission on the facts of the case to find that the discrimination was not unlawful because the discharge of X fell within the provisions of s 15(4) of the Disability Discrimination Act 1992 (Cth). Given the findings of risk to fellow soldiers made by the Commission, it was open to the Commission to find that, without assistance, X could not carry out the ‘inherent requirements’ of his employment and ‘would in order to carry out those requirements, require services or facilities which would impose an unjustifiable hardship’ on the Commonwealth. However, the court reasoned further by noting that even if the Commission finds that, without assistance, X poses a real risk to soldiers and other persons, his dismissal will be unlawful unless the Commission also finds that the risk cannot be eliminated or appropriately nullified by the provision of services or facilities which can be provided without unjustifiable hardship.

Zaccagnini http://www.avert.org/aidsstigma.htm (visited 27 February 2010), cites a head of Human Resource Development, in India, stating that: “Though we do have a policy so far, I can say that if at the time of recruitment there is a person with HIV, I will not take him. I’ll certainly not buy a problem for the company. I see recruitment as buying-selling relationship. If I don’t find the product attractive, I’ll not buy it’ and an HIV positive woman from United Kingdom (UK) saying: “It is always in the back of your mind, if I get the job, should I tell my employer about my HIV status? There is fear of how they will react to it. It may cost your job; it may make you so uncomfortable it changes relationships. Yet you would want to explain about why you are absent, and going to the doctors.”

many constitutional guarantees, women are still being discriminated against in the labour market, are paid less than men and more frequently perform work with no or little security or benefits.97

In South Africa, indeed, there are many cases of employees who were denied employment or dismissed by their employers once they were found to be HIV positive. Many of these cases had ended up in the courts,98 including the Constitutional Court. It is encouraging to note that in most of these cases the courts have protected persons living with HIV/AIDS against discrimination. In the case of Hoffman v South African Airways,99 Hoffman, the applicant, who was HIV-positive, was refused employment as a cabin attendant by South African Airways (SAA) because of his HIV-positive status. He unsuccessfully challenged the constitutionality of the refusal to employ him in the Witwatersrand High Court (the High Court), on various constitutional grounds. The High Court issued a positive certificate and the Constitutional Court granted him leave to appeal directly to it. In making his judgment Ngcobo J observed that:

The appellant is living with HIV. People who are living with HIV constitute a minority. Society has responded to their plight with intense prejudice. They have been subjected to systemic disadvantage and discrimination. They have been stigmatised and marginalised. As the present case demonstrates, they have been denied employment because of their HIV positive status without regard to their ability to perform the duties of the position from which they have been excluded. Society’s response to them has forced many of them not to reveal their HIV status for fear of prejudice. This in turn has deprived them of the help they would otherwise have received. People who are living with HIV/AIDS are one of the most vulnerable groups in our society. Notwithstanding the availability of compelling medical evidence as to how this disease is transmitted, the prejudices and stereotypes against HIV positive people still persist. In view of the prevailing prejudice against HIV positive people, any discrimination against them can, to my mind, be interpreted as a fresh instance of stigmatisation and I consider this to be an assault on their dignity. The impact of discrimination on HIV positive people is devastating. It is even more so when it occurs in the context of employment. It denies them the right to earn a living. For this reason, they enjoy special protection in our law. There can be no doubt that SAA discriminated against the appellant because of his HIV status. Neither the purpose of the discrimination nor the objective medical evidence justifies such discrimination.100

Ngcobo J concluded by holding that the denial of employment to the appellant (because he was living with HIV) impaired his dignity and constituted unfair discrimination, and that the refusal by SAA to employ the appellant as a cabin attendant because of his HIV-status violated his right to equality guaranteed by section 9 of the Constitution.101 The court furthermore ordered SAA to employ the appellant as a cabin attendant with effect from the date of the court order. This judgment of Ngcobo J is welcomed, especially because he emphasised

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98 See, for instance the Bootes and the Hoffman cases.
99 The Hoffman case.
100 The Hoffman case, paragraphs [28-29].
101 The Hoffman case, paragraphs [40-41].
that due to the stigma and discrimination which is suffered by people who are living with HIV/AIDS and which have a devastating impact, "they enjoy special protection in our law."\textsuperscript{102}

In \textit{Bootes v Eagle Ink Systems KZ Natal (Pty) Limited},\textsuperscript{103} the court had to determine whether the employee was dismissed for misconduct, his HIV status, or both. The employee, Brian Thomas Bootes, the applicant, was employed by the respondent, Eagle Ink Systems KZN (Pty) LTD, as a technical sales representative from 1 October 1999 to 16 May 2005. The court sought first to establish whether the employee committed misconduct.\textsuperscript{104} The employee was charged of misconduct on three counts. Firstly, he was charged for gross dishonesty in that he misused the company petrol card in November 2004 by utilising it for a motor vehicle other than his. Secondly, for buying and selling, in the first quarter of 2005, used printing blankets during company hours to clients of the company without prior permission or agreement with the management. Thirdly, that due to the above, a serious breach of the trust relationship with his employer resulted, leading to the irreparable breakdown of the employment relationship. The hearing proceeded on 10 May 2005. On 16 May 2005 Eagle dismissed the employee on the second and third charges. The court found that the allegations against the employee constituted an offence that resulted in a breach of trust. He was therefore guilty of the misconduct for which he was charged in the second and third paragraphs of the disciplinary notice.\textsuperscript{105} Having established that the employee was guilty of the misconduct, the court then proceeded to look at the employee’s HIV-positive status. The employee was hospitalised on 10 January 2005. On 21 January 2005 he was diagnosed with full-blown AIDS. His managers Gandy and Rose visited him in hospital. He had informed Gandy of his status. Gandy was concerned about the customers that the employee served. The employee testified that if, as Gandy surmised, his status was likely to impair the deal being negotiated with Nampak, Gandy should disclose his status to Nampak. On Gandy’s version, even though the employee requested him to disclose his status to all the customers he served, Gandy informed only a few customers who needed to know.\textsuperscript{106}

The employee returned to work on the 14 February 2005. He sought and was granted permission to address the staff about his status. On his return, the employer offered him an internal position at the same package he was receiving in the capacity as a technical sales representative. His manager, Gandy, informed him that he and the directors of Eagle felt that Nampak, amongst other customers of Eagle, would be uncomfortable working with a sales representative who had AIDS. He was hence placed in desk-bound position. The employee

\textsuperscript{102} The Hoffman case, paragraphs [28-29].
\textsuperscript{103} The Bootes case.
\textsuperscript{104} The Bootes case, paragraph [20].
\textsuperscript{105} The Bootes case, paragraph [29].
\textsuperscript{106} The Bootes case, paragraph [31].
rejected this desk-bound position and wanted to continue with his normal position of sales representative, but was subsequently placed on an involuntary paid leave “until it was all over”. On 5 May 2005 the employee was summoned to work and served with the notice to attend the disciplinary inquiry on 10 May 2005. The inquiry concluded with the dismissal of the employee.\textsuperscript{107}

The court found that Eagle had dismissed the employee because it did not want to employ an HIV-positive technical sales representative.\textsuperscript{108} The court, further, observed and found that:

Today many jurisdictions prohibit discrimination based on a person’s HIV status. Dismissal of employees because of their HIV status is widely acknowledged as discrimination unless the employer can show that being free of HIV is an inherent requirement of the job. Some jurisdictions elevate the protection of persons with HIV to constitutional or statutory law, whilst for others it remains soft law in codes and policy.\textsuperscript{109} Despite these formal advances in South Africa internationally, in reality, dismissal remains a major side effect of HIV infection. The pressure to dismiss may be external e.g. from customers or internal e.g. when other employees in the enterprise demand the dismissal of an infected employee. Often these demands stem from fear that is either rational or irrational.\textsuperscript{110} Camouflaging discrimination under the cloak of misconduct is one of the insidious forms of unfair labour practices. Quick to perceive the unfairness, employees struggle to prove it. As Eagle denied that the reason for dismissing the employee was his HIV positive status, it bore the onus of proving the true reason for dismissing the employee to justify its fairness. It failed to prove that misconduct was the real reason for dismissing the employee. Eagle’s management created a pattern of conduct that leads to only one reasonable conclusion: Eagle’s dismissal of the employee on account of his HIV status. As it denied that that was its reason for the dismissal, questions of rationality and justification do not arise. In the circumstances, Eagle failed to discharge the constitutional and statutory onus of proving that the dismissal was not discriminatory.\textsuperscript{111} HIV remains a highly stigmatised infection that continues to marginalise its weak and vulnerable victims. Employers must be deterred from discriminating against employees on the basis of their HIV positive status.\textsuperscript{112}

The court, therefore, ordered that the dismissal of the applicant was automatically unfair. The employee was awarded compensation being the equivalent amount of sixteen months’ remuneration, plus costs.\textsuperscript{113} It is encouraging to observe that the courts have taken such a proactive stance in protecting people who are living with HIV/AIDS against unfair dismissal and discrimination due to their HIV positive status. It is realities like the one presented in the case above that make many employees who are infected with HIV reluctant to disclose their status to their employers and other employees for the fear that they would be dismissed or discriminated against if the employers and employees, respectively, find out about their HIV status.\textsuperscript{114} This is a fatal blow to
efforts to prevent the spreading of HIV/AIDS. It is hoped that future court decisions will be similarly aware of and sensitive to the subtle and hidden nature that discrimination against persons who are living with HIV/AIDS may take, this will deter employers from discriminating against them and enhance the fight against AIDS. It will also go a long way to end the stigma and discrimination against persons living with HIV/AIDS in South Africa.

2.3.6 Discrimination in the healthcare context

People living with HIV/AIDS are sometimes discriminated by the very same people who are supposed to take care of their health, that is, healthcare workers in the healthcare facilities such as clinics and hospitals. They can experience stigma and discrimination such as being refused medicines or access to facilities, receiving HIV testing without consent, and lack of confidentiality.115 Such responses are often fuelled by ignorance of HIV transmission routes amongst doctors, midwives, nurses and hospital staff.116 That medical staff should perhaps have a better understanding of HIV makes discrimination in healthcare settings all the more damaging.117 Many people living with HIV/AIDS do not get to choose how, when and to whom to disclose their HIV status. Studies by WHO in India, Indonesia, the Philippines and Thailand found that 34% of respondents reported breaches of confidentiality by health workers.118 Medical confidentiality, as will be discussed in detail in chapter 3 below, is very important if patients are to trust healthcare workers and sign up for treatment. It is even more important in the fight against HIV/AIDS. If patients do not trust healthcare workers such as doctors and nurses, it would mean they will not go to hospitals and clinics for testing and treatment of HIV/AIDS.119 This underlines the importance of ensuring that healthcare workers are aware of patients’ rights and the consequences that may follow if they do not respect those rights. The patients’ fundamental rights are contained in the Constitution120 and they include rights such as the right to equality, dignity and privacy.121

thanked me for my time and service. I thought I was doing the right thing but it seems I was only placing myself in a ring of fire. I felt I had to tell the head of school that I was ill because I was often absent from school.” See also Sunday Sun of 6 July 2008, at 1. (The paper depicted this as “My deadly secret”). The paper reports about an HIV-positive man who was suffering heavy guilt, because HIV has cost him his job, and because he had not told his wife about his HIV-status. He was reported as having said that “After the test, my life became a living hell at work. They called me names and I was unfairly dismissed.” He lodged a complaint with the CCMA. But he claimed that “they didn’t help as I was granted a mere R13 200 as a settlement. I was discriminated against and my rights were violated.”

115 Parker and Aggleton 6, and Zaccagnini http://www.avert.org/aidsstigma.htm (visited 27 February 2010).
116 See Salmon SHAAN online http://www.ipsnews.net/hivaids/section3_1.shtml (visited 20 March 2011), who notes that however the stigma and resulting discrimination that people with HIV or AIDS meet is not just the result of ignorance.
120 The Constitution of 1996.
121 Section 9 (equality), section 10 (dignity), section 14 (privacy), section 24 (environment) and section 27 (health and medical treatment).
A violation of patients’ rights may lead to litigation, as was the case in *Jansen van Vuuren v Kruger*. In this case, the patient Van Vuuren, sued his doctor for the breach of confidentiality. Though the doctor of Van Vuuren had disclosed his HIV positive status to two other medical practitioners, the court found that that the communication was unreasonable and therefore unjustified and wrongful because his doctor had no moral duty to transfer the information. The court then awarded the estate of Van Vuuren with a sum of R5 000 plus costs, as he was already deceased by the time the case was concluded. It is important, therefore for the healthcare workers to uphold the rights of their patients, especially those of persons living HIV/AIDS.

The *Van Vuuren* case and other relevant cases, such as the case of *NM v Smith*, will be discussed in detail in chapter 3, below. The Health Professions Council of South Africa’s National Patients’ Rights Charter refers to persons with HIV as those with special needs.

### 2.3.7 Restrictions on travel and stay

Persons living with HIV are normally restricted by laws that limit their entry, stay and residence. Many countries impose restrictions on people living with HIV/AIDS entering their country. These restrictions may apply to short-term visitors (travelers or tourists) or long-term (students, workers, refugees, immigrants). Protection of the public from communicable diseases is a traditional excuse to deny would-be visitors or immigrants entrance to countries. In general, national governments have the legal authority and discretion to restrict entry into their countries, so long as these restrictions do not contradict international treaties to which they are members or violate domestic laws. A common approach used by these countries requires those seeking to enter the country to declare their HIV status or submit to an HIV test and they normally target long-term residents, usually six months or more or permanent residency for HIV-positive people. However, a few countries, including the United States of America, prevent any person who declares that he or she is HIV-positive from entering the country, usually with the opportunity to apply for a waiver. There are approximately

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122 *Jansen van Vuuren v Kruger* 1993 (4) SA 842 (AD) or [1993] All SA 619 (A) (herafter the *Van Vuuren* case).

123 The *Van Vuuren* case, paragraph [38].

124 The *Van Vuuren* case, paragraph [47].

125 *NM v Smith* (CCT69/05) [2007] ZACC 6 (4 April 2007).


127 Par 2.3(c).

128 Parker and Aggleton 5.


130 Gable 69.

131 Gable 69.
sixty countries, territories and areas that have restrictions that specifically apply to HIV or AIDS, based on positive status alone.\textsuperscript{132} This number does not include those countries where the legislation uses language such as: “contagious” or “transmissible diseases” if HIV and AIDS are mentioned specifically. UNAIDS has identified around a dozen restrictions applying to HIV-positive people regarding entry, stay and residence.\textsuperscript{133}

Six countries, including China, require a declaration of HIV status which can result in HIV-positive people denied entry or stay, or need for discretionary approval.\textsuperscript{134} Twenty-six countries, including Egypt, Russia, China, Korea and the United States (US) deport foreigners based on their positive status alone.\textsuperscript{135} Some countries have policies that could violate confidentiality of status if, for example, a stamp is required on a waiver or passport in order to gain entry or stay. Students living with HIV are barred from applying to study in certain countries, including Malaysia, the United States and Syria.\textsuperscript{136} Most of the laws that restrict persons living with HIV are unnecessary and they might also be influenced by ignorance of the manner in which HIV is transmitted and are tantamount to discrimination persons living with HIV/AIDS.

The countries that use these entry restrictions based on the HIV status generally justify them on public health grounds.\textsuperscript{137} They argue that by testing and screening persons with HIV, a country could prevent the introduction and spreading of the disease within the country. Furthermore, because many people with HIV are asymptomatic, testing may provide early detection and the ability to seek treatment earlier in the course of the disease. A second justification is that limiting entry of HIV-positive persons will reduce the cost of treatment and care for HIV and AIDS that long-term visitors or immigrants will incur within the health system.\textsuperscript{138}

However, it can be argued on the other hand that entry restrictions and requirements are particularly unhelpful from a public health view.\textsuperscript{139} Unlike many other communicable diseases that may justify entry restrictions, HIV cannot be transmitted through casual contact. There is also no evidence that entry restrictions have a significant effect on the prevention of HIV transmission. Most countries do not screen or exclude returning nationals for HIV. Furthermore, testing may produce false positive or negatives and may not detect persons recently infected with HIV because they have not yet produced HIV antibodies. While long-term visitors and

\textsuperscript{132} Zaccagnini http://www.avert.org/aidsstigma.htm (visited 27 February 2010).
\textsuperscript{133} Zaccagnini http://www.avert.org/aidsstigma.htm (visited 27 February 2010).
\textsuperscript{134} Hodges 21 points out that some countries, in their general AIDS laws require foreigners to declare their HIV status.
\textsuperscript{135} Zaccagnini http://www.avert.org/aidsstigma.htm (visited 27 February 2010).
\textsuperscript{136} Zaccagnini http://www.avert.org/aidsstigma.htm (visited 27 February 2010).
\textsuperscript{137} Gable 69.
\textsuperscript{138} Gable 69.
\textsuperscript{139} Gable 70.
immigrants who are HIV positive may indeed require public health care services and therefore add to the charges on the state’s public health budget, such a financial argument to justify the entry exclusion would be discriminatory as there are no entry exclusions for people with other high-cost diseases such as, for example, cancer.\(^\text{140}\)

In the case of *Kiyutin v Russia*,\(^\text{141}\) the applicant, Mr Viktor Viktorovich Kiyutin, born in the Uzbek SSR of the Soviet Union in 1971, acquired citizenship of Uzbekistan upon the collapse of the USSR. In October 2002, his brother bought a house with a plot of land in the village of Lesnoy in the Oryol Region of Russia. In 2003 the applicant, his half-brother and their mother arrived from Uzbekistan to live there. On 18 July 2003 the applicant married a Russian national and they had a daughter in January 2004. In the meantime, in August 2003, the applicant applied for a residence permit. He was required to undergo a medical examination during which he tested positive for HIV. On account of that circumstance, his application for a residence permit was refused. The refusal was upheld at final instance by the Oryol Regional Court on 13 October 2004.\(^\text{142}\) In April 2009 the applicant filed a new application for a temporary residence permit. Following his application, on 6 May 2009 the Federal Migration Service determined that he had been unlawfully resident in Russia and imposed a fine of 2,500 Russian roubles. By a decision of 26 June 2009, the Oryol Region Federal Migration Service rejected his application for a residence permit by reference to section 7 § 1 (13) of the Foreign Nationals Act, which restricted the issue of residence permit to foreign nationals who could not show their HIV-negative status. The decision indicated that the applicant was to leave Russia within three days or be subject to deportation. The applicant challenged the refusal in court.\(^\text{143}\)

On 13 August 2009 the Severnity District Court of Oryol rejected his complaint due to the fact that he was HIV-positive. The applicant lodged an appeal, relying on the Constitutional Court’s decision of 12 May 2006 and the UN documents on AIDS prevention. On 16 September 2009 the Oryol Regional Court rejected his appeal in a summary fashion. On 20 October 2009 the applicant underwent a medical examination at the Oryol Regional Centre for AIDS Prevention. He was diagnosed with the progressive phase of HIV, Hepatitis B and C, and prescribed highly active antiretroviral therapy (HAART) for life saving indications. On 25 November 2009 the Oryol Regional Court refused to institute supervisory review proceedings and upheld the previous judgments as

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\(^{140}\) Gable 70.

\(^{141}\) The *Kiyutin* case.

\(^{142}\) The *Kiyutin* case, paragraphs [6-9].

\(^{143}\) The *Kiyutin* case, paragraphs [10-11].
lawful and justified. The applicant complained to the European Court of Human Rights under Articles 8, 13, 14 and 15 of the European Convention on Human Rights that the decision to refuse him authorisation to reside in Russia had be disproportionate to the legitimate aim of the protection of public health and had disrupted his right to live with his family. The applicant, therefore, alleged, in particular, that he had been victim of discrimination on account of his health status in his application for a Russian residence permit.

The Court noted that the focal point of the present application was the difference of treatment to which the applicant was subjected on account of his health status when applying for a residence permit. Having regard to the circumstances of the case and bearing in mind that it is master of the characterisation to be given in law to the facts of the case, the Court considered it appropriate to examine the applicant’s grievances from the standpoint of Article 14 of the Convention, taken in conjunction with Article 8. The Court noted that from the onset of the epidemic in the 1980’s, people living with HIV/AIDS have suffered from widespread stigma and exclusion, including within the Council of Europe region. In the early years of the epidemic when HIV/AIDS diagnosis was nearly always a lethal condition and very little was known about the risk of transmission, people were scared of those infected due to the fear of contagion. Ignorance about how the diseases spread has bred prejudice which, in turn, has stigmatised or marginalised those who carry the virus. As the information on ways of transmission accumulated, HIV infection has been traced back to behaviours, such as same-sex intercourse, drug injection, prostitution or promiscuity, that were already stigmatised in many societies, creating a false nexus between infection and personal irresponsibility and reinforcing other forms of stigma and discrimination, such as racism, homophobia or misogyny.

In recent times, despite considerable progress in HIV prevention and better access to HIV treatment, stigma and related discrimination against people living with HIV has remained a subject of great concern for all international organisations active in the field of HIV/AIDS. The Court therefore considered that people living with HIV are a

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144 The Kiyutin case, paragraphs [10-11].
146 The Kiyutin case, paragraph [39].
147 The Kiyutin case, paragraph [3].
148 The Kiyutin case, paragraph [39]. According to the Court, Article 8 of the Convention reads as follows:
1. Everyone has the right to respect for his private and family life, his home and his correspondence. 2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others. And Article 14 provides that: The enjoyment of the rights and freedoms set forth in [the] Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with national minority, property, birth or other status.
149 The Kiyutin case, paragraph [64].
vulnerable group with a history of prejudice and stigmatisation and that the state should be afforded only a narrow margin of appreciation in choosing measures that single out this group for differential treatment on the basis of their HIV status.  

The Court, further, noted that admittedly, travel restrictions are instrumental for the protection of public health against highly contagious diseases with a short incubation period, such as cholera or yellow fever or, to take more recent examples, severe acute respiratory syndrome (SARS) and ‘bird flu’ (H5N1). Entry restrictions relating to such conditions can help to prevent their spread by excluding travellers who may transmit these diseases by their presence in a country through casual contact or airborne particles. However, the mere presence of a HIV-positive individual in a country is not in itself a threat to public health: HIV is not transmitted casually but through specific behaviours that include sexual intercourse and sharing of syringes as the main routes of transmission. This does not put prevention exclusively within the control of the HIV-infected non-national but rather enables HIV-negative persons to take steps to protect themselves against infection.

Furthermore, it appeared that Russia did not apply HIV-related travel restrictions to tourists or short-term visitors. Nor does it impose HIV tests on Russian nationals leaving and returning to the country. Taking into account that the methods of HIV transmission remain the same irrespective of the duration of a person’s presence in the Russian territory and his or her nationality, the Court saw no explanation for a selective enforcement of HIV-related restrictions against foreigners who apply for residence in Russia but not against the above-mentioned categories, who actually represent the great majority of travellers and migrants. There was no reason to assume that they were less likely to engage in unsafe behaviour than settled migrants. It followed that the application of HIV-related restrictions only in the case of prospective long-term residents was not an effective approach in the prevention of HIV by HIV-positive migrants. The differential treatment of HIV-positive long-term settlers as opposed to short-term visitors may be objectively justified by the risk that the former could potentially become a public burden and place an excessive demand on the public-funded health care system, whereas the latter would seek treatment elsewhere. However, this was not the case in Russia as non-Russian nationals had no entitlement to free medical assistance, except emergency treatment, and had to pay themselves for all medical services. Thus, irrespective of whether or not the applicant obtained a residence permit in Russia, he would not be eligible to draw on Russia’s public health care system. Accordingly, the risk

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150 The Kiyutin case, paragraph [64].
151 The Kiyutin case, paragraph [68].
152 The Kiyutin case, paragraphs [69].
that he would represent a financial burden on Russian health care funds was not convincingly established.\textsuperscript{153} The Court, therefore, correctly found that in the light of the foregoing, although the protection of public health was indeed a legitimate aim, the Government was unable to adduce compelling and objective arguments to show that this aim could be attained by the applicant's exclusion from residence on account of his health status.\textsuperscript{154}

Furthermore, that taking into account that the applicant belonged to a particularly vulnerable group, that his exclusion has not been shown to have a reasonable and objective justification, and that the contested legislative provisions did not make room for an individualised evaluation, the Court found that the Government overstepped the narrow margin of appreciation afforded to them in the instant case. The applicant has therefore been a victim of discrimination on account of his health status, in violation of Article 14 of the Convention taken together with Article 8.\textsuperscript{155} The Court therefore declared the complaint concerning the refusal of a residence permit admissible and held that there had been a violation of Article 14 of the Convention taken in conjunction with Article 8.\textsuperscript{156}

This judgment by the European Court, indeed, has to lauded, because it was clear to the court that there was no justified refusal of residence to Kiyutin, except for the prejudice, ignorance, stigmatisation and discrimination against people living with HIV/AIDS. As the court correctly, indicated HIV is not transmitted through casual contact and there is absolutely no reason why long-term residents should be excluded, if the other categories such as tourists and returning nationals are not screened for HIV. It is only hoped that other courts will follow the example set out by this European Court case in protecting people living with HIV/AIDS against unreasonable restrictions when they seek permanent residence in other countries.\textsuperscript{157}

Fortunately, there are few countries, however, which do not have entry restrictions against people who are living with HIV/AIDS. Iceland is one of the countries that has one of the most progressive and accommodating

\begin{flushright}
\textsuperscript{153} The Kiyutin case, paragraph [70].  \\
\textsuperscript{154} The Kiyutin case, paragraph [72].  \\
\textsuperscript{155} The Kiyutin case, paragraph [74].  \\
\textsuperscript{156} The Kiyutin case, paragraphs [84.1-2].  \\
\textsuperscript{157} In fact as the Court reasoned further in the Kiyutin case, paragraphs [71], it noted that travel and residence restrictions on persons with HIV may not only be ineffective in preventing the spread of the disease, but may also be actually harmful to the public health of the country. Firstly, migrants would remain in the country illegally so as to avoid HIV screening, in which case their HIV-status would be unknown both to the health authorities and to migrants themselves. This would prevent them from taking the necessary precautions, avoiding unsafe behaviour and accessing HIV prevention information and services. Secondly, the exclusion of HIV-positive foreigners may create a false sense of security by encouraging the local population to consider HIV/AIDS as a 'foreign problem' that has been taken care of by deporting infected foreigners and not allowing them to settle, so that the local population feels no need to engage in safe behaviour.
\end{flushright}
programs for travelers and immigrants with HIV. There are no travel restrictions for people with HIV, and neither a declaration nor a test is required. A health examination is required when a person applies for a permit to become a permanent resident. However, if health authorities determine that someone has tested positive for HIV during this process, he or she is not restricted from obtaining permanent resident status. Instead, he or she is immediately enrolled in the national health care services and the usual six months residency requirement for entry into the health services is waived. Cambodia, also, does not restrict residency or travel on the basis of HIV.

Countries such as Iceland and Cambodia are to be commended for their fair treatment of people living with HIV/AIDS. Furthermore, international instruments such as the International Guidelines on HIV/AIDS and Human Rights protect persons living with HIV/AIDS against discrimination when they seek asylum from other countries. Article 131 of the Guidelines provides that the Human Rights Committee has confirmed that the right to equal protection of the law prohibits discrimination in law or in practice in any field regulated and protected by public authorities. These would include travel regulations, entry requirements, immigration and asylum procedures. Therefore, although there is no right of aliens to enter a foreign country or to be granted asylum in any particular country, discrimination on the grounds of HIV status in the context of travel regulations, entry requirements, immigration and asylum procedures would violate the right to equality before the law. Countries, therefore, should put an end to the practice of having unjustifiable restrictions and requirements for persons living with HIV/AIDS.

**2.3.8 Discrimination by insurance companies**

People living with HIV/AIDS are sometimes discriminated against when they apply for an insurance policy by insurance companies. Insurance companies usually require their potential clients to take an HIV test when they apply for insurance policies. If a person refuses to take an HIV test, he or she will probably be refused

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158 Gable 70.
159 Gable 70.
160 Gable 70.
162 See Life Offices’ Association (LOA) (an association of life insurance companies), Code of Conduct HIV Testing Protocol, 22 November 2006, which is binding on all member offices. According to LOA Code of Conduct-HIV Testing Protocol-HIV Testing Information Sheet (Annexure 2) 29 May 2008, you have the following rights: 1. Not to be tested for the AIDS virus without your free and informed consent. 2. To be given all relevant information on the harms, risks and benefits of taking, or not taking, the AIDS test. 3. To refuse to take the test. If you do this, your application for insurance may be denied. 4. To receive pre-test counseling which is private and confidential, and which will inform you more about the test and its implications before you give consent. 5. To have your test results treated confidentially. 6. To post-test counseling if the test is positive.
insurance. Every year, over a million people agree to have HIV tests at the request of the insurance industry.\textsuperscript{163} For many people, this is when they first find out about their HIV status.\textsuperscript{164} Often, persons are refused life insurance when they test HIV-positive, and for many, this is just the start of their problems.\textsuperscript{165} They may find that there has been a breach of their privacy when their HIV status is disclosed without their permission,\textsuperscript{166} or that they are not able to get a home loan because they cannot get life insurance.\textsuperscript{167} Faced with these problems, the question that arises is whether it is fair for the insurance industry to exclude people with HIV, and what their rights are under these circumstances.\textsuperscript{168}

Insurance companies claim that they test for the AIDS virus because underwriting is the basis of assurance to ensure that applicant pays a premium appropriate to the risk. The insurance company therefore requires information from the applicant to assist it in assessing the risk of granting the insurance and to establish an appropriate premium. Insurance companies screen applicants for serious diseases or habits that may affect their state of health. This may be done through questionnaires, medical examinations and other tests including a test for the AIDS virus.\textsuperscript{169} Medical impairments such as HIV/AIDS, blindness, cancer, kidney failure, account the substantial risks, that means with higher-than-average mortality and shorter life expectancy, and are therefore declined, hence the distinction between insurable and non-insurable risks.\textsuperscript{170}

Risk is the foundation of insurance. Insurance companies consider HIV/AIDS as a catastrophic risk because persons suffering from AIDS are likely to die shortly after they have been infected.\textsuperscript{171} Though, it may be argued that this is no longer the case in all HIV/AIDS patients, because of the life-prolonging effect of anti-retrovirals (ARVs), many patients live much longer than they would without treatment. In South Africa, life expectancy for HIV-positive persons is estimated between eight to ten years. This means that even if the cost of insurance for

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\item See the Van Vuuren case, paragraph [3], where reference is made to the plaintiff, Van Vuuren, who applied for a life insurance policy from Liberty Life Insurance company. He was informed by the insurance company that he had to take an HIV test. He agreed to take the test and went to his doctor to have the test done. He was then informed by his doctor that his results showed that he was HIV-positive. Barret-Grant 294.
\item Barret-Grant 294. Though, Barret-Grant also points out at 299, that “[F]ew companies offer special policies for people with HIV. Most insurers charge high premiums and often limit the amount that a person’s life can be insured for.”
\item See the Van Vuuren case, paragraph [38], where Van Vuuren’s doctor violated his privacy by informing two other medical doctors. Barret-Grant 294.
\item Barret-Grant 294.
\item Ramaroson M The human right of HIV positive persons to non-discrimination in getting life insurance in South Africa (Unpublished LLM dissertation University of Pretoria 2003) 11.
\item Ramaroson LLM dissertation 13. Furthermore, Barret-Grant at 299, also points out that insurance companies claim that they screen for HIV because people with HIV will probably die or become incapacitated at a younger age and that the risk of insuring this category is too great.
\end{itemize}
HIV-positive persons can be calculated, insurance is not practical because the premium that is determined by the insurer would be too high and consequently the individual will not be able or willing to pay for it.\textsuperscript{172} This seems to be a dilemma for persons living with HIV/AIDS, as it could be argued that instead of insurance companies excluding them from being covered by their insurance policies, the companies should rather increase their premiums in order to include HIV/AIDS positive people. Sadly, the majority of persons living with HIV/AIDS are poor and many survive on social grants. They would not be able to afford high premiums that are charged by insurance companies.

This problem is also exacerbated by the fact that, as Ramaroson points out,\textsuperscript{173} it seems clear that it is neither in the interest of insurance companies to issue a life insurance policy to an individual who seems likely to pay only a few premiums, nor is it in their interest to insure an individual whose benefits are likely to be paid out soon after the policy has been issued. It is rather in the interest of insurance companies to insure only individuals whose life expectancy is high. Moreover, insurance companies are under no obligation to accept proposals for insurance, be it life insurance or any other type. They rather have to ensure that their policies are actuarially sound and that the premiums distinctions are actuarially justified.\textsuperscript{174} However, as Ramaroson argues,\textsuperscript{175} refusal of the benefits of a life cover to persons living with HIV/AIDS and their family amounts to unfair discrimination on the part of the insurance companies mainly because of its impact\textsuperscript{176} on them and their families. Such a refusal is very likely to lead them to their financial ruin and deny financial security to their families. Such practice \textit{unfairly discriminates against persons living with HIV/AIDS and it is all the more discriminatory as the insurance industry seems to only put forward financial and economic motivations while the persons living with HIV/AIDS merely claim their human rights.}\textsuperscript{177} It is also regarded as one of unfair practices listed by the Promotion of Equality and Prevention of Unfair Discrimination Act.\textsuperscript{178}

Discrimination by insurance companies of persons living with HIV/AIDS due to their HIV status can be said to be an unfair discrimination.\textsuperscript{179} Such discrimination against persons living with HIV/AIDS may only lead to many of

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  \item \textsuperscript{172} Ramaroson \textit{LLM} dissertation 13.
  \item \textsuperscript{173} Ramaroson \textit{LLM} dissertation 13.
  \item \textsuperscript{174} Ramaroson \textit{LLM} dissertation 15.
  \item \textsuperscript{175} Ramaroson \textit{LLM} dissertation 33.
  \item \textsuperscript{176} See the \textit{Hoffmann} case, paragraph [28], where Ngcobo J observed that: “The impact of discrimination on HIV positive people is devastating.”
  \item \textsuperscript{177} Ramaroson \textit{LLM} dissertation 33.
  \item \textsuperscript{178} See Section 29 Schedule to the Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000 which provides at 5(c) that it is unfair practice to unfairly disadvantage a person or persons, including unfairly and unreasonably refusing to grant services, to persons solely on the basis of HIV/AIDS status.
  \item \textsuperscript{179} See International Labour Conference 2009 Article 160.
\end{itemize}
them being afraid to go for HIV testing and also for them not to benefit from insurance cover. It may be understandable that insurance companies need to be financially competitive like all other businesses, hence they will put their financial interests first, rather than human rights of persons living with HIV/AIDS. However, HIV/AIDS is one of the most devastating illnesses in the history of South Africa. In view of this, insurance companies should balance their financial interests with the contribution to society that they can make in the fight against this pandemic and to lessen the stigma and discrimination against this disease. This will happen if they start providing cover for people living with HIV/AIDS. It is encouraging that there are few insurance companies, such Old Mutual and Metropolitan Life, which already grant life cover to HIV-positive individuals.

It is hoped that other insurance companies will in future review their policies on exclusion of persons living with HIV/AIDS and follow the example of the two insurance companies by granting life cover to one of the most vulnerable groups in society.

2.3.9 Discrimination by the government

Government laws and policies, as was the case with apartheid laws, may have the effect to discriminate against its own citizens. This is evident in countries where laws are promulgated to discriminate against people who are living with HIV/AIDS. Indeed, there are many ways that the government may directly or indirectly discriminate against people or communities with (or suspected of having) HIV/AIDS. Examples of discriminatory measures include compulsory screening and testing; compulsory notification of AIDS cases; restrictions of the right to anonymity; prohibition of persons living with HIV/AIDS from certain occupations, as well as medical examination, isolation, detention and compulsory treatment of infected persons. Compulsory testing, for example, will not be necessary in a society where no stigma is attached to a specific condition, as individuals would not be unwilling or hesitant to be tested out of fear for ostracism or unfair discrimination. As discussed above, there is a difference between fair and unfair discrimination and other laws may discriminate in a fair manner against

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180 As Ramaroson 33, states above.
181 Ramaroson 19.
182 In fact according to International Labour Conference 2009 Article 167, African Life lifted HIV/AIDS exclusions on life insurance policies in 2004. In addition, the 36 member companies of the South African Life Offices Association have scrapped HIV exclusion clauses for clients applying for new policies, removed HIV exclusion clauses from existing and new life policies.
183 Parker and Aggleton 5.
184 Parker and Aggleton 5.
persons living with HIV/AIDS. Many of these laws may sometimes be justified on the grounds that AIDS poses a public health risk.\(^{185}\)

### 2.3.10 Legal opinions regarding discrimination

The South African government is bound by the Bill of Rights which is entrenched in the Constitution.\(^{186}\) The government is required to make laws that comply with the Constitution\(^{187}\) and any law that is inconsistent with it, will be invalid.\(^{188}\) Section 9 of the Constitution is the Equality Clause. Section 9 states that:

- Everyone is equal before the law and has the right to equal protection and benefit of the law.
- Equality includes the full and equal enjoyment of all rights and freedoms. To promote the achievement of equality, legislative and other measures designed to protect or advance persons, or categories of persons, disadvantaged by unfair discrimination may be taken.
- The state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth.
- No person may unfairly discriminate directly or indirectly against anyone on one or more grounds in terms of subsection (3). National legislation must be enacted to prevent or prohibit unfair discrimination.

What this section means to people who are living with HIV and AIDS, is that they are equal with anyone in South Africa before the law and have the right to equal protection and benefit of the law. It also means that they may not be unfairly discriminated against by either the government or anyone due to their HIV status. Regrettably, HIV/AIDS is not listed as one of the grounds for non-discrimination. The equality clause furthermore stipulates that no person may discriminate against someone using other grounds not listed in section 9.\(^{189}\) The idea is to prohibit unfair discrimination based on “other” grounds that may not be specifically listed, but that are used to unfairly discriminate, such as HIV infection.\(^{190}\) Whether there is discrimination on an unlisted ground depends upon whether, objectively, the ground is based on attributes and characteristics which have the potential to

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\(^{185}\) Zaccagnini http://www.avert.org/aidsstigma.htm (visited 27 February 2010).

\(^{186}\) The Constitution of 1996, chapter 2.

\(^{187}\) See Section 2 of the Constitution of 1996 which declares that: “This Constitution is the supreme law of the Republic; law or conduct inconsistent with it is invalid, and the obligations imposed by it must be fulfilled.”

\(^{188}\) See S v Makwanyane 1995 (3) SA 391 (CC) paragraph [146], where the Constitutional Court declared the death sentence to be inconsistent with section 11(2) of the interim Constitution and S v Williams 1995 (7) BCLR 861 (CC) paragraph [96], where the Constitutional Court declared corporal punishment to be invalid and of no force and effect. See also the Namibian case of Ex Parte Attorney-General, Namibia: in re Corporal Punishment by Organs of State 1991 (3) 76 (NmSC), where the Namibian Supreme Court held that the imposition of any sentence by any judicial or quasi-judicial authority, or directing any corporal punishment upon any person is unlawful and in conflict with art 8 of the Namibian Constitution.

\(^{189}\) Section 9(4) of the Constitution of the Republic of South Africa Act 108 of 1996.

\(^{190}\) Currie and De Waal 243, Barret-Grant 67 and Cheadle, Davis and Haysom 96.
impair the fundamental human dignity of persons as human beings or affect them adversely in a comparably serious manner.\textsuperscript{191}

The equality clause also compelled the government to promulgate national legislation to prevent or prohibit unfair discrimination and such legislation was subsequently made in the form of the Promotion of Equality and Prevention of Unfair Discrimination Act (hereafter the Equality Act).\textsuperscript{192} However, the Equality Act also does not list HIV status separately from disability as a ground for non-discrimination.\textsuperscript{193} The Equality Act recognises the fact that in view of the overwhelming evidence of the importance, impact on society and link to systemic disadvantage and discrimination on the grounds of HIV/AIDS status, socio-economic status, nationality, family responsibility and family status, the Minister must give special consideration to adding HIV/AIDS and these other grounds to the list of prohibited grounds.\textsuperscript{194} The legislation that seems to be specific on prohibition of unfair discrimination based on the ground of HIV, albeit only in the work environment, is the Employment Equity Act.\textsuperscript{195} Section 6(1) of the Employment Equity Act states that:

\begin{quote}
No person may unfairly discriminate, directly or indirectly, against an employee, in any employment policy or practice, on one or more grounds, including race, gender, sex, pregnancy, marital status, family responsibility, ethnic or social origin, colour, sexual orientation, age, disability, religion, HIV status, conscience, belief, political opinion, culture, language and birth.
\end{quote}

Although the Employment Equity Act should be praised for recognising HIV/AIDS as a ground for non-discrimination in the workplace, it is, however, disappointing that a country such as South Africa that is one of the countries with the highest number of HIV-infected persons, omitted to have HIV listed as a ground for non-discrimination in both the Constitution and the Equality Act.\textsuperscript{196}

\begin{itemize}
\item HIV/AIDS is a national epidemic that affects an increasingly large number of people in South Africa.
\item People living with or affected by HIV or AIDS face a wide range of unfair discrimination and stigmatisation in all aspects of life, and the Equality Act should recognise this to ensure non-discrimination on the basis of HIV/AIDS.
\end{itemize}

\begin{footnotes}
\item[192] Promotion of Equality and Prevention of Unfair Discrimination Act, of 2000 (hereafter referred to as the Equality Act).
\item[193] Barret-Grant 69. See The Hoffman case, paragraph [40], where the Constitutional Court having declared that the denial of employment to the appellant because he was living with HIV impaired his dignity and constituted unfair discrimination, however avoided to consider whether the appellant was discriminated against on a listed ground of disability.
\item[194] Section 34(1)(a) of the Equality Act.
\item[195] Employment Equity Act 55 of 1998 section 6(1). See also the Code of Good Practice on Key Aspects of HIV/AIDS and Employment Section 6(1) of the Employment Equity Act which states that "[n]o person with HIV or AIDS shall be unfairly discriminated against within the employment relationship or any employment policies or practices." See also Grogan 135.
\item[196] Barret-Grant 69. Barret-Grant argues that there are strong reasons for HIV to be treated as a separate listed ground for non-discrimination under the Equality Act:
\item HIV/AIDS is a national epidemic that affects an increasingly large number of people in South Africa.
\item People living with or affected by HIV or AIDS face a wide range of unfair discrimination and stigmatisation in all aspects of life, and the Equality Act should recognise this to ensure non-discrimination on the basis of HIV/AIDS.
\end{footnotes}
It is recognised in the Employment Equity Act, Code of Good Practice on Key Aspects of HIV/AIDS and Employment, in section 1(1.1), that HIV and AIDS are serious public health problems which have socio-economic, employment and human rights implications. This means that HIV and AIDS also need a more stern approach from the law-makers if the spread of this epidemic is to be curbed. If HIV status is made a separate prohibited ground, it would be easier for a person living with HIV or AIDS to show in a court of law that they were unfairly discriminated against. They would only need to prove that there was discrimination, and the person accused of discrimination would need to prove that it was not unfair discrimination.

One of the reasons why HIV/AIDS is not listed separately as a ground of non-discrimination could have been influenced by the debate regarding HIV/AIDS ‘exceptionalism’. Some authors argue that with regard to the prevention of HIV, South Africa took its lead from Europe and North America where so-called HIV ‘exceptionalism’ had taken root. Listing HIV/AIDS as a ground for non-discrimination, for instance, would be regarded by some as treating the disease in an exceptional manner compared to other diseases, which may perpetuate the stigma of AIDS instead of ending it. There are authors who believe HIV/AIDS should be

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198 Barret-Grant 69.
199 See Spencer D “Medical ethics and the politics of the South African HIV/AIDS epidemic” 2006 The Southern African Journal of HIV Medicine 47-52, who at 51 points out that case isolation, quarantine, contact identification, notification and the provision of treatment underpin the effective public health response to a serious communicable disease. However, South with regard to HIV prevention took its lead from Europe and North America where HIV exceptionalism had taken root. Notification and identification were deemed to be an infringement of individual’s rights and likely to drive the epidemic underground. See also Richter M, Francois WD and Gray A “Issues in public health: Home self-testing for HIV: Aids Exceptionalism gone wrong” 2010 (100;10) SAMJ 636-642, 636.
treated exceptional to other diseases and there are those who are against exceptionalism. AIDS exceptionalism will be discussed in detail below.

In *Harksen v Lane NO*, the Constitutional Court clearly tabulated the stages of constitutional enquiry when an allegation of an infringement of section 8 (the predecessor of section 9 of the present Constitution) of the interim Constitution is made. These are the following:

(a) Does the provision differentiate between people or categories of people? If so, does differentiation bear a rational connection to a legitimate government purpose? If it does not, then there is violation of s 8(1). Even if it does bear a rational connection, it might nevertheless amount to discrimination.

(b) Does the differentiation amount to unfair discrimination? This requires a two stage analysis:
   (b)(i) Firstly, does the differentiation amount to ‘discrimination’? If it is on a specified ground, then discrimination will have been established. If it is not on a specified ground, then whether or not there is discrimination will depend upon whether, objectively, the ground is based on attributes and characteristics that have the potential to impair the fundamental human dignity of persons as human beings or to affect them adversely in a comparably serious manner.
   (b)(ii) If the differentiation amounts to ‘discrimination’, does it amount to ‘unfair discrimination’? If it has been found to have been on a specified ground, then unfairness will be presumed. If on an unspecified ground, unfairness will have to be established by the complainant. The test of unfairness focuses primarily on the impact of the discrimination on the complainant and others in his or her situation. If at the end of this stage of the enquiry, the differentiation is found not to be unfair, then there will be no violation of s 8(2).

(c) If the discrimination is found to be unfair then a determination will have to be made as to whether the provision can be justified under the limitation clause (section 33 of the interim Constitution).

Looking at the *Harksen*’s test, above, it becomes clear why it may be argued and submitted that HIV/AIDS should have been made a specified ground in the Constitution and the Equality Act. It is easier for a complainant to prove discrimination or unfair discrimination if the differentiation is on a specified ground than when it is on an unspecified ground. On a specified ground, the complainant only has to allege differentiation and discrimination is established and it will also be presumed to be unfair discrimination. However, on an

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202 See AIDS exceptionalism at 2.3.9.1. below.

203 The *Harksen* case, paragraph [53]. See also Currie & De Waal 235.

204 The *Harksen* case paragraph [53].

205 See President of the Republic of South Africa and Another v Hugo 1997 (6) BCLR 708 (CC) paragraph [33]
unspecified ground, the complainant has to establish that there was discrimination and that it was unfair. In *President of the Republic of South Africa v Hugo*, the Constitutional Court correctly held that:

> The prohibition on unfair discrimination in the interim Constitution seeks not only to avoid discrimination against people who are members of disadvantaged groups. It seeks more than that. At the heart of the prohibition of unfair discrimination lies a recognition that the purpose of our new constitutional and democratic order is the establishment of a society in which all human beings will be accorded equal dignity and respect regardless of their membership of particular groups. The achievement of such a society in the context of our deeply inegalitarian past will not be easy, but that that is the goal of the Constitution should not be forgotten or overlooked.

The society in which all human beings are accorded equal dignity and respect also include persons living with HIV/AIDS. People should not be unfairly discriminated against as a result of their health status. As Gostin points out:

> Every major governmental, medical, public health organization to issue a report on the HIV epidemic has condemned discrimination because it violates basic tenets of individual justice and is detrimental to public health. Discrimination based on an infectious condition is just as inequitable as discrimination based on race, gender or disability. People are treated inequitably not because they lack inherent ability, but solely because of a health status. As a result, complex and often pernicious mythologies develop about the nature, cause and transmission of disease. Discrimination also undermines public health. If individuals fear social and economic repercussions, they may forego testing or fail to discuss their health and risk behaviours with counselors or health care professionals and, even more importantly, with their sex or needle-sharing partners.

Gostin correctly concludes that discrimination based on an infectious condition is just as inequitable as discrimination based on race, gender, disability or other health conditions. In each case, people are treated inequitably not because they lack inherent ability, but solely because of a status over which they have no control. Discriminating against people based on conditions or status that they do not have control over, such as illness and disability, therefore, is unfair discrimination and it must be addressed. Discrimination based on a

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206 The *Hugo* case, paragraph [41].
207 Gostin 48.
208 Gostin 48-9.
210 Gostin and Webber 2000 *HeinOnline J. Health Care L. & Pol’y* 270.
person’s status leads to intolerance, violence and increase the stigma that people with HIV face regularly.\textsuperscript{211} HIV infection, therefore, must also be treated just like these other specified grounds.\textsuperscript{212} HIV infection is an even more crucial ground than those grounds specified in the Constitution or the Equality Act because AIDS kills approximately a thousand persons a day.\textsuperscript{213}

Discrimination against persons living with HIV/AIDS also undermines public health.\textsuperscript{214} As long as there is a perception that a HIV-positive status will lead to these persons becoming ostracised, marginalised and isolated, people will be reluctant to go for testing and will then not know their status. The danger of an undiagnosed status is that such a person, if already infected, may infect others. A person who fears discrimination by either his or her family, community or employer, will in most cases not disclose his or her status to his or her sex partner(s) or needle-sharing partners,\textsuperscript{215} infecting these persons in the process.\textsuperscript{216} All of these factors, therefore, have a direct impact on the spreading of HIV/AIDS in South Africa. More stringent efforts are required by the government and all South African citizens to end discrimination against persons living with HIV/AIDS.

2.3.10.1 AIDS exceptionalism

Since recognition of the first cases of HIV in 1981, AIDS has been treated differently from other infectious diseases.\textsuperscript{217} This exceptional treatment of this disease from other diseases led to what is referred to as ‘aids exceptionalism’.\textsuperscript{218} The word “exception” (noun) is defined by the Oxford Advanced Dictionary of Current

\textsuperscript{212} Gutto 228-30.
\textsuperscript{213} Brown LT and Ebert C “The endemic Epidemic: New challenges in the battle against HIV/AIDS in South Africa” 2007 (4;1) \textit{International Health} 26-30, 26, Terblanche-Smit PhD dissertation 155 and City Press of 24 August 2008 page 1 (The paper depicted this as ”The silent war kills 1000 a day”). See World Health Organisation \textit{Fight AIDS, Fight TB, Fight Now: TB/HIV Information Pack} (2004, France: World Health Organisation) 8, which points out that globally, 40 million people were infected with HIV/AIDS. Every single day AIDS kills 8000 people and orphans thousands of children. Heavily affected countries face total social and economic collapse within just a few generations if decisive steps are not taken.
\textsuperscript{214} Gostin 49.
\textsuperscript{215} Gostin 49.
\textsuperscript{216} See Sunday Sun of 6 July 2008 page 1. (The paper depicted this as “My Deadly Secret”). Sunday Sun reported about a guy who four years ago tested for HIV, but never told his wife. This tormented HIV-positive guy was suffering heavy guilt. The HIV cost him his job but he had not told his wife. And he still continued to have sex with her. The migrant worker quietly took ARV treatment and hid the tablets whenever he visited his home in Mpumalanga. See also Sunday Sun of 6 July 2008 page 1. (The paper depicted this as “My HIV+Shame”). It reported about Reply Ncube, the man credited with late kwaito star Lebo Mathosa’s hit who had AIDS. He feared that he had spread it. He wanted to apologise to his sex partners. He was reported as saying: “This is hell for me. I am sorry to all the women I slept with while knowing that I was HIV positive.”
\textsuperscript{217} De Cock and Johnson 1998 \textit{BMJ} 290, and De Cock, Mbori-Ngacha and Marum 2002 \textit{The Lancet} 67-72.
English as excepting, which means not including someone or something but it also means to treat someone or something as a special case and also something that does not follow the rule. To a certain extent, as will be shown below, the treatment of AIDS as an exception complied with these definitions. The word ‘exceptionalism’ is not found in most dictionaries. Exceptionalism means to treat or to give something the status of being exceptional and can be positive or negative depending on the context or circumstances.

As far as AIDS exceptionalism is concerned, authors seem to agree on its history, that is, on how it came about that this disease had to be treated exceptionally from other diseases and also agree that it arose as a Western response to the originally terrifying and lethal nature of the virus, which has disproportionately affected specific groups, such as homosexuals and intravenous-drug users, and also that it was due to the fear of discrimination and stigmatisation of these groups. As a result of this fear, therefore, the first activists argued that HIV/AIDS required an exceptional response in order to protect the rights of those infected, to generate resources to assist them and to curb a then mysterious epidemic. The gay rights movement, also, building on the momentum it had gained in the preceding decades, began campaigning for HIV/AIDS to be viewed as a human rights issue. Advocates argued that infection was not the only risk; if found positive, but individuals also faced harmful discrimination. In this they were supported by public health officials, who feared that stigma would prevent those at risk from getting tested, and those infected from accessing health services. It was critical at the time to avoid compulsory measures such as isolation and quarantine, which were so much part of public health tradition, since the persons with increased risk, that is, gay and bisexual men, drug users and their sexual partners, were already socially vulnerable. Policies and practices that appeared to threaten such

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220 Hornby 295.
221 Whiteside HEARD 4.
222 Whiteside HEARD 4.
224 Smith and Whiteside 2010 Journal of the International AIDS Society 47. See also Whiteside HEARD 1, who points out that fear was amongst the first responses to AIDS.
persons could only drive the epidemic underground and make it more difficult to work with the population within which HIV was spreading.229

Recognising the unique needs of populations at risk of HIV infection, an exceptionalist alliance, including the gay community, liberal and left-wing parties, and healthcare and psychosocial professions, was formed to advocate for an exceptional response.230

Responding to these campaigns, therefore, in the 1980’s public health generally adopted a human rights framework that took societal-based vulnerability into consideration and increasingly became involved in societal transformation efforts.231 HIV/AIDS was positioned as not only a health condition, but also as a social issue that required a political, as well as a medical, response. As a result, the scientific establishment’s control on the public health initiative was called for: one that provided counseling, protected privacy, and empowered the patient.232 In South Africa, in particular, an exceptionalist approach to HIV/AIDS led to a novel methodology in the diagnosis of HIV: voluntary counseling and testing (VCT), which includes pre- and post-test counseling, express and informed consent that an HIV test would be conducted on the patient, and assurances of the confidentiality of the test results.233 Exceptionalism, therefore, posited that in the early years of the HIV epidemic, HIV was considered so different, so exceptional in comparison to other communicable diseases that its advocates and public health officials agreed that HIV policy cater to the uniqueness of the epidemic rather than treat it like all other communicable diseases.234 HIV/AIDS in its early years, therefore, was treated as an exceptional disease to all other diseases.

More recently, however, AIDS exceptionalism came to refer to the disease-specific global response. This international response was unprecedented, as the commitment of resources exceeded any other health cause.
International organisations, such as the Joint United Nations Programme on HIV/AIDS (UNAIDS), the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) and the United States President’s Emergency Plan for AIDS Relief (PEPFAR), were formed to specifically address HIV/AIDS.\textsuperscript{235} Whiteside\textsuperscript{236} argues that when AIDS was first identified, it was treated as an exceptional disease for good reasons. It was not clear how the virus was transmitted, or how far it would spread. There were concerns over the challenge of a new, apparently rampant, infectious disease; the sexual nature of transmission; apparently inevitable mortality; and its location, primarily among gay men in the west. However there was also hysteria stoked by the media.\textsuperscript{237}

However, proponents against HIV exceptionalism dispute the fact that exceptionalism is still relevant nowadays where modern treatment in the form of anti-retrovirals and new measures implemented to control the disease are available.\textsuperscript{238} Burr,\textsuperscript{239} for instance, argues that however legitimate the civil-liberties it sought to address may have been more than a decade ago, the exceptionalist orthodoxy is now fundamentally wrong as a matter of good public health and medicine. In any event, evidence shows that new medical treatments are making HIV less infectious than ever before.\textsuperscript{240} Burr\textsuperscript{241} concludes by indicating that medical interventions make a palpable difference and is all the more reason to start subjecting AIDS, from a public-health perspective, to more-systematic procedures. In the end AIDS would be unlikely to prove resistant to good basic public-health

\textsuperscript{235} Smith and Whiteside 2010 \textit{Journal of the International AIDS Society} 47.

\textsuperscript{236} Whiteside \textit{HEARD} 4. See also Burr 1997 \textit{The Atlantic online}, who points out that AIDS exceptionalism has been justified in the mid-1980s based on four arguments which were regularly heard for exempting AIDS from standard public-health practices. These were the following: 1) There had never before been a disease that seemed to constitute a defacto marker for homosexuality, with all the social stigma that this label carries. 2) The confidentiality of testing would inevitably be violated, precisely because AIDS is more stigmatised than any other disease. 3) Given the large number of sex partners of many of those who have become HIV-infected, contact tracing would be ineffectual. 4) Because there is no cure for AIDS, and no treatment to render the infected uninfectious, it was pointless to report HIV infection as is done for other infections.


\textsuperscript{238} See Burr 1997 \textit{The Atlantic online}, who challenges the exceptionalist arguments, stated above at note 234, by pointing out that the argument that AIDS is a unique marker for homosexuality is incorrect, and always was so. Rectal gonorrhoea in men has been almost exclusively a disease of the gay population, and is a more reliable marker for homosexuality, if anyone were to look for such a marker, than AIDS ever was. And yet cases of rectal gonorrhoea have appeared for decades, by name and date, in confidential case reports sent to state public-health departments. The argument on confidentiality has met a serious counter-argument in the form of reality: the experience of Minnesota and Colorado, which have since 1985 mandated the confidential reporting by name of both HIV and AIDS. The argument on contact tracing ignores the fact that many of those infected with syphilis and gonorrhoea, other diseases for which gay men are at increased risk, have also had large number of sex partners, and yet contact tracing has been standard procedure for these diseases for decades. Finally, the argument on name reporting has always been open to question on a number of grounds. Yes, the statement may have a certain logic from the perspective of a given individual concerned only about his or her fate. But if infected people can be identified, education and counselling may at the very least prompt changes in their behaviour which will diminish the risk that they go on to infect others; contact tracing, in turn, extends the possibility of risk-diminishing behavioural change even more widely. Knowing who is infected is essential in helping to prevent new infections, even if the infected person himself cannot be helped.


\textsuperscript{240} Burr 1997 \textit{The Atlantic online}.
policies. It may survive if it can circumvent good sense.\textsuperscript{242} These proponents against exceptionalism have therefore argued that HIV/AIDS should be normalised and treated like other diseases.\textsuperscript{243} Certain authors have suggested that the time has come to end HIV exceptionalism,\textsuperscript{244} whereas some are convinced that exceptionalism has come to an end.\textsuperscript{245}

Bayer and Fairchild\textsuperscript{246} point out that the Centers for Disease Control and Prevention (CDC) were poised to issue new recommendations for the testing if HIV in adults, adolescents and pregnant women. In fact, CDC already recommended routine testing among high-risk groups and in high-prevalence settings. This radical departure was the extension of routine testing to the entire population and reconceptualisation of the requirements for consent. Patients would be told that HIV testing was a routine part of care and given the opportunity to opt out.\textsuperscript{247} These moves signal the end of the exceptionalism that has distinguished public health policy with regard to AIDS from approaches to other communicable and sexually transmitted diseases.\textsuperscript{248} Bayer points out that as AIDS had become less threatening, the claims of those who argued that the exceptional threat would require exceptional policies have begun to lose their force and inevitably, HIV exceptionalism will be viewed as a relic of the epidemic’s first years.\textsuperscript{249} Furthermore, according to these advocates of change, the transformation of HIV disease into a complex chronic condition requiring long-term, on-going clinical management means that limits imposed when medicine had little to offer have outlived their justification.\textsuperscript{250} They accordingly argue that now that there is treatment to treat HIV/AIDS and its patients live much longer than before, HIV exceptionalism has come to an end and therefore HIV/AIDS should be normalised and treated like other diseases.\textsuperscript{251} De Cock,

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\item \textsuperscript{242}Burr 1997 \textit{The Atlantic} online.
\item \textsuperscript{243}De Cock and Johnson 1998 \textit{BMJ} 290. See also Jewkes 2006 \textit{The Lancet}, who at 431 concludes by pointing out that South Africa has entered a phase of the epidemic that is marked by divergence in social response and increasing normalisation of HIV/AIDS. Normalisation has started as a bottom-up response, emerging from poor African families and communities. The process presents substantial opportunities for rolling back the remaining discrimination against people with HIV/AIDS, but at the same time profoundly challenges much of our thinking about HIV/AIDS and responses to the epidemic.
\item \textsuperscript{244}See Spencer 2006 \textit{The Southern African Journal of HIV Medicine} 51.
\item \textsuperscript{245}See Bayer and Fairchild 2006 \textit{N Engl J Med} 648.
\item \textsuperscript{246}Bayer and Fairchild 2006 \textit{N Engl J Med} 647.
\item \textsuperscript{247}Bayer and Fairchild 2006 \textit{N Engl J Med} 647 and April 2010 \textit{Bull World Health Organ} 706.
\item \textsuperscript{248}Bayer and Fairchild 2006 \textit{N Engl J Med} 648. See also \textsuperscript{248} Whiteside HEARD 7, and Smith and Whiteside 2010 \textit{Journal of the International AIDS Society} 47 who point out that by 2000, AIDS exceptionalism, as it had originally been conceived, was over.
\item \textsuperscript{249}Bayer \textit{N Engl J Med} 1991 1503.
\item \textsuperscript{251}Bayer 1991 \textit{N Engl J Med}, at 1503-4, however warns out that, that the difference between the public health response to the HIV epidemic and the response to other conditions has been eroding does not mean that public health traditionalists will inevitably win out over those who have argued for a new public health practice. Were the end of HIV exceptionalism to mean a reflexive return to the practices of the past, it would represent the loss of a great opportunity to
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Mbori-Ngacha and Marum, further argue that although human rights instruments and legal interdictions can protect HIV-infected people against discrimination, such as in relation to housing, education or employment, they cannot protect against stigma, which is social rather than structural.\footnote{De Cock, Mbori-Ngacha and Marum 2002 \textit{The Lancet} 69.}

Stigma emerged universally and early on as a powerful, pernicious force that is an important barrier to prevention efforts. Paradoxically, treating HIV/AIDS as being different from other infectious diseases probably enhances stigma rather than reduces it.\footnote{De Cock, Mbori-Ngacha and Marum 2002 \textit{The Lancet} 69.} This may be said to be one of the strong points of the advocates for change, as treating HIV/AIDS so differently from other diseases may instead of eliminating the stigma against people living with this disease instead also serve to perpetuate it. However, in places or countries where there is still a high level of ignorance about HIV/AIDS, treating HIV/AIDS differently and preserving the confidentiality of people living with HIV/AIDS may still be highly necessary.\footnote{See April MD 2010 \textit{Bull World Health Organ} 704, who warns out that there may be undesirable consequences resulting from expanded HIV testing due to the repercussions accompanying a positive diagnosis. These repercussions may range from denied job opportunities or commercial services to verbal abuse and physical abuse. Although there are no comprehensive data available on the frequency of confidentiality violations that result in stigmatisation, HIV-related stigma remains a serious concern. Therefore, any decision to implement expanded HIV testing in sub-Saharan Africa must weigh the desired biomedical outcomes of testing against the possibility of discrimination. See Alcorn http://www.aidsmap.com/print/AIDS-exceptionalism-a-defensible-concept-says-Stephen-Le... (visited 8 March 2011).} However, for the proponents of HIV/AIDS exceptionalism, like Lewis, AIDS exceptionalism is a defensible concept.\footnote{Alcorn at http://www.aidsmap.com/print/AIDS-exceptionalism-a-defensible-concept-says-Stephen-Le... (visited 8 March 2011) cites Stephen Lewis, the former UN Special Envoy on AIDS in Africa as having told the opening session of the Fifth International AIDS Society Conference on HIV Pathogenesis, Treatment and Prevention.}

Lewis is reported as having said that the idea that AIDS is an exceptional response is a perfectly defensible concept and accused critics of the levels of AIDS funding of acting from base motives of resentment and professional envy.\footnote{Alcorn at http://www.aidsmap.com/print/AIDS-exceptionalism-a-defensible-concept-says-Stephen-Le... (visited 8 March 2011) cites Stephen Lewis, the former UN Special Envoy on AIDS in Africa as having told the opening session of the Fifth International AIDS Society Conference on HIV Pathogenesis, Treatment and Prevention.} Lewis further stresses the view that if AIDS in Africa was not viewed as the most exceptional communicable disease of the twentieth century, the word “exceptional” needs to be redefined. It is exactly the consequence of that exceptionality and the tremendous campaigning of grassroots advocates, that AIDS received generous funding.\footnote{Smith and Whiteside 2010 \textit{Journal of the International AIDS Society} 47.} Smith and Whiteside also argue that the shift in policy and international priorities do not change the reality of an epidemic that, after decades, is still unfolding.\footnote{Smith and Whiteside 2010 \textit{Journal of the International AIDS Society} 47.
The argument that the AIDS epidemic is not as big as expected is fallacious and should be treated as such.\textsuperscript{259} In Southern Africa, the demographic effects of the generalised epidemic will shape societies for generations. In other parts of the world, HIV/AIDS continues to mark inequalities: one in 40 blacks, one in 10 men who have sex with men, and one in eight injection drug users in New York City are HIV positive.\textsuperscript{260} So, therefore both the human rights approach, originally adopted by the HIV/AIDS response, and the recent demands for universal access to treatment, remain relevant to the 33 million\textsuperscript{261} people living with HIV/AIDS and to their communities. These issues should also remain pertinent within global health policy.\textsuperscript{262} New challenges are developing, not the least of which is the need to successfully integrate the HIV/AIDS response within the broader public health responses to the benefit of all. As how to best approach such challenge is debated, however, sight must not be lost of the approximate 2 million AIDS-related deaths that occur each year and defining these deaths as either exceptional or unexceptional seems both callous and arbitrary.\textsuperscript{263}

Whiteside sums the debate on whether AIDS should be treated as exceptional or not up by answering this question from both sides.\textsuperscript{264} In some settings it must be treated as exceptional, whereas in others not and there are three factors, according to Whiteside, that should determine this AIDS exceptionality.\textsuperscript{265} These are: (1) the level of prevalence; (2) the demographic dynamics of the country and (3) availability and domestic affordability of treatments.\textsuperscript{266} Whiteside, however, concludes by pointing out that the debate between normalisation and exceptionalism is sterile.\textsuperscript{267} AIDS is exceptional and needs to be treated as such. The idea that exceptionalism is somehow wrong is an oversimplification of an issue. Globally UNAIDS has a role in advocating for people everywhere. It needs to ensure global surveillance, especially to monitor the situation in low prevalence countries.\textsuperscript{268} It can be concluded, therefore, by observing that although HIV/AIDS may be normalised in the developed countries, it remains an exceptional disease on the continent of Africa and should be treated as such.\textsuperscript{269}

\begin{itemize}
\item \textsuperscript{259} Whiteside HEARD 10.
\item \textsuperscript{260} Smith and Whiteside 2010 Journal of the International AIDS Society 47.
\item \textsuperscript{261} Whiteside HEARD 10.
\item \textsuperscript{262} Smith and Whiteside 2010 Journal of the International AIDS Society 47.
\item \textsuperscript{263} Smith and Whiteside 2010 Journal of the International AIDS Society 47 and Whiteside HEARD 18.
\item \textsuperscript{264} Whiteside HEARD 12.
\item \textsuperscript{265} Whiteside HEARD 12.
\item \textsuperscript{266} Whiteside HEARD 12.
\item \textsuperscript{267} Whiteside HEARD 18.
\item \textsuperscript{268} Whiteside HEARD 19.
\item \textsuperscript{269} Whiteside HEARD 18.
\end{itemize}
In Africa, it will take time to have AIDS treated as a normal disease like other diseases, as there is still a high death rate due to AIDS. Cameron aptly explains that AIDS will not be ‘normal’ until no one feels inhibited from seeking treatment and support.270

2.4 VICTIMISATION

The stigma against people living with HIV may sometimes lead to them being victimised even to the extent that they are killed by their societies when they disclose their HIV-positive status. One such example is that of the fate of Gugu Dlamini who was a Durban National Association of People Living with AIDS (NAPWA) activist who was beaten to death by a group of local people, including some of her neighbours, shortly after disclosing, on World AIDS Day, that she was HIV positive.271 This murder was nationally and internationally decried. Former South African president, Thabo Mbeki himself said: “It is a terrible story. We have to treat people who have HIV with care and support, and not as if they have an illness that is evil”.272 This form of victimisation by killing an HIV-positive person was undoubtedly fuelled by stigma, prejudice and ignorance about how the disease is transmitted.273 Although it is generally accepted that this extreme form of victimisation no longer occurs in South Africa, other forms of victimisation and violence, such as dismissal of HIV-positive persons by employers274 are still frequent. Victimisation in any form, whether it is murder or dismissal of an HIV-positive person, should end.

272 Squire 33.
274 The Hoffman and The Bootes cases, discussed above, are some of the examples of victimisation of employees living with HIV/AIDS. Also, the story of Lydia Majola, which is reported in the Move of 6 February 2008 at 18, is one of such examples. (The Magazine depicted this as “Fired for having HIV”). Lydia Majola was fired without notice after she disclosed her HIV status to the head of the school where she was teaching. She, thereafter, expressed regret for disclosing her status. The story of the gentleman who was suffering guilt reported by Sunday Sun of 6 July 2008, at 1, is another example. (The paper depicted this as “My deadly secret”). The paper reported about an HIV-positive man who was suffering heavy guilt, because HIV has cost him his job, and because he had not told his wife about his HIV-status. He was reported as having said that “After the test, my life became a living hell at work. They called me names and I was unfairly dismissed.” He
2.5 CONCLUSION

Stigmatisation, discrimination and victimisation of persons living with HIV/AIDS together contribute to perpetuate the spreading of HIV. Those who suspect that they may be HIV-positive will be reluctant to have themselves tested for fear that they may be stigmatised, discriminated against or victimised. These factors may in turn enhance silence and concealment in that those who may get tested and subsequently test positive, may in fear of the shame that goes with having HIV, prefer to keep their status secret.\footnote{See Cameron 2006 Stell LR 37, who in this lecture, witnesses to this by stating that: “I experienced that shame myself, when I was diagnosed with HIV in the dark days before it could be treated, and during the years when I kept my infection a deathly secret. Even though I was an openly and proudly gay man when diagnosed, I thought that my shame related to my homosexual exposure. That was wrong. The shame is no less amongst heterosexually transmitted HIV in Africa. I witness it in too many people around me who are too ashamed, to claim help and treatment even where it is offered. The fact that AIDS can now be medically managed holds promise of diminishing the effects, since it deals with its one source (death and debilitation); but not of eliminating it, since its other source (sexual transmission) remains. There a considerable struggle remains. AIDS will not be ‘normal’ until no one feels inhibited from seeking treatment and support.”} Interventions addressing discrimination and stigmatisation have traditionally been reactive in nature, eg after discrimination has taken place, instead of proactive.
CHAPTER 3

THE RIGHT TO PRIVACY AND CONFIDENTIALITY

3.1 INTRODUCTION

The right to confidentiality derives from the right to privacy which in turn is associated with the right to dignity and autonomy.1 Cameron points out that from the Anglophone legal tradition, the right to confidentiality is most persuasively described as deriving from a right to privacy.2 Privacy has been defined as relating to the right to be left alone3 or not be bothered by other people,4 which includes respecting other people’s secrets which they would not want to become further known without their consent.5

The rights to privacy and confidentiality are very important rights to persons living with HIV/AIDS. Due to the protection afforded by these rights, people living with HIV/AIDS are able to control their personal information by deciding on their own whether to disclose or not to disclose their HIV status. Furthermore, if they decide to disclose their HIV status, they themselves may decide to whom they want to disclose their status (or not disclose).

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1 Cameron E Confidentiality in Lawyers Collective HIV/AIDS Unit: Judges’ Workshop Mumbai 7-8 1998 page 2, Cheadle MH, Davis DM and Haysom NRL South African Constitutional Law: The Bill of Rights (2002, Durban: Butterworths) 183, Govindjee A “The Right to Privacy” in Govindjee A and Vrancken P (eds) et al Introduction to Human Rights Law (2009, Durban: LexisNexis) 101 and Bernstein and others v Bester NO and others 1996 (4) BCLR 449 paragraph [68] (herafter referred to as the Bernstein v Bester case). See also Currie I & De Waal J The Bill of Rights Handbook 5th ed (2005, Cape Town: Juta & Company Ltd) 316, who point out that the common law acknowledges the right to privacy as an independent personality right that the courts consider to be part of the concept ‘dignitas’. See the case of Jansen van Vuuren and Another v Kruger 1993 (4) SA 842F-G (AD) (herafter referred to as the Van Vuuren case), where the court observed that the actio iniuriarum protects a person’s dignitas and dignitas embraces privacy.
2 Cameron 2. See also Sperling D Law, Medicine and Ethics, Posthumous Interests, Legal and Ethical Perspectives (2008, Cambridge: Cambridge University Press) 187 who points out that confidentiality is a branch or subset of informational privacy.
3 See NM and Others v Smith and Others 2007 JDR 0231 (CC) (herafter referred to as the NM v Smith case), where at paragraph [32], Madala J pointed out that it appears common cause in many jurisdictions that the nature and the scope of the right envisaged a concept of the right to be left alone.
5 Ouzounakis P and Chalkias T “The confidentiality of ‘medical secrets’ of patients by nursing staff” 2010 (3;1) International Journal of Caring Sciences 1-2, 1 and Sperling 187.
The right to privacy and confidentiality also protects persons living with HIV/AIDS against stigmatisation, discrimination and victimisation, as discussed above in chapter 2. In addition, one finds medical confidentiality or professional secrecy, which is the relationship between the doctor and the patient. It is often said that the origin of this is the oath formulated by Hippocrates in ancient Greece some 2400 years ago.

Medical confidentiality is also important to persons living with HIV/AIDS because it ensures that medical practitioners and healthcare workers do not disclose the HIV status of their patients without their patients’ consent. However, protecting confidentiality in the context of HIV/AIDS, on the other hand, is problematical in the sense that whilst it provides protection for persons who are HIV positive, it is relied upon by those who are HIV positive and refuse to disclose their status.

Examples are those persons, who as sexual partners, continue to sleep with their partners without informing them of their HIV positive status, as well as those who rape others while knowing that they are HIV positive. Husbands, also, in traditional African polygynous marriages may infect all their wives if they continue to sleep with them whilst they are HIV positive. Practices such as these may facilitate the spread of HIV and AIDS even further in South Africa.

This chapter, therefore, will look at some of the factors that impact on the rights to


8 See the Van Vuuren case at 856D-G, where the court found that the doctor of Van Vuuren had no right to disclose his HIV positive status without his consent.

9 See Sunday Times of 15 April 2007 page 1. (The paper depicted this as “HIV-positive councillor in hot water”). It reported about a North West councillor who faced an attempted murder charge for allegedly deliberately infecting his lover with HIV. See Sunday Sun of 6 July 2008 page 1. (The paper depicted this as “My Deadly Secret”). This paper carried the report of a man, who four years ago tested for HIV, but never told his wife. He continued having sex with her whilst he knew that he was HIV positive.

10 See, Daily Sun, of Thursday 7 December 2006 page 1. (The paper depicted this as “Deadly Dad!”). It reported about an HIV man who raped and infected his own daughter. See, also, Daily Dispatch, of Wednesday 2 September 2009 page 1. (The report was entitled, “Teacher held for pupil’s rape”). It reported the story of the teacher who raped his pupil. The girl, thereafter, committed suicide when she found out that the teacher was HIV-positive.

11 The story of the councillor, reported in the Sunday Times of 15 April 2007 page 1, is one example of how secrecy and non-disclosure of HIV-positive status may facilitate the spread of HIV/AIDS further in South Africa. The paper reported that the woman, who was allegedly deliberately infected by her lover with HIV, said she went to the police to stop him from spreading the virus, after he allegedly told her that he would infect other women because it was a woman who had infected him. She said she received confirmation of his HIV status in June last year, after stumbling upon a document that showed his test results. She claimed that when she confronted him, he initially told her he had withheld this information out of fear that she would leave him.
privacy, confidentiality (and medical confidentiality) in the context of HIV/AIDS. The discussion will first turn to a contextual historical background of privacy, confidentiality and medical confidentiality in paragraph 3.1.1, in order to provide a perspective on where these rights come from. Privacy and confidentiality will also be defined in paragraph 3.1.1.2 below.

3.1.1 Contextual background to the rights to privacy, confidentiality and medical confidentiality

3.1.1.1 Historical background

The right to privacy has broad historical roots which are traced in sociological and anthropological discussions about how extensively it is treasured and preserved in various cultures.\textsuperscript{12} It also has historical origins in well-known philosophical discussion, most notably Aristotle’s differentiation between the public sphere of politics and political activity, the \textit{polis}, and the private or domestic sphere of family, the \textit{oikos}, as two separate spheres of life, the latter a classic reference to a private domain.\textsuperscript{13}

Privacy in the early treaties appeared with the development of privacy protection in American law from the 1890’s onward, and was acceptable mainly on moral grounds.\textsuperscript{14} Privacy, early on, seems to have been divided into two components, namely informational privacy and a constitutional right to privacy.\textsuperscript{15} Informational privacy is considered to include the right to be left alone and to be protected against intrusion upon a person’s seclusion or into his private facts, public disclosure of embarrassing private facts, publicity placing one in a false light in the public, appropriation of one’s likeness for the disadvantage of another, unwarranted searches, eavesdropping, surveillance, and appropriation and misuses of one’s communications.\textsuperscript{16}

The constitutional right to privacy was recognised by the United States Supreme Court (US Supreme Court) in 1965 in the case \textit{Griswold v Connecticut}.\textsuperscript{17} In this case the appellants, the Executive Director of the Planned Parenthood League of Connecticut, and its medical director, a licensed physician, were convicted as accessories for providing married persons with information and medical advice on how to prevent conception and, following examination, prescribing a contraceptive device or material for the wife’s use. A Connecticut

\begin{itemize}
\item \textsuperscript{12} DeCew J \textit{Privacy} \url{http://plato.stanford.edu/privacy/} (visited 5 August 2011).
\item \textsuperscript{13} DeCew \url{http://plato.stanford.edu/privacy/} (visited 5 August 2011).
\item \textsuperscript{14} DeCew \url{http://plato.stanford.edu/privacy/} (visited 5 August 2011).
\item \textsuperscript{15} See DeCew \url{http://plato.stanford.edu/privacy/} (visited 5 August 2011), who also observed that one way of understanding the growing literature on privacy was to view it as being divided into two main categories, which may be called \textit{reductionism} and \textit{coheren}tism. Reductionists are generally critical of privacy, coherentists defend the coherent fundamental value of privacy interests.
\item \textsuperscript{16} DeCew \url{http://plato.stanford.edu/privacy/} (visited 5 August 2011).
\item \textsuperscript{17} \textit{Griswold v Connecticut} 381 US 479 (1965) (hereafter referred to as the \textit{Griswold case}). See also \textit{Eisenstadt v Baird} 405 US 438 (1972).
\end{itemize}
statute made it a crime for any person to use any drug or article to prevent conception. The statute whose constitutionality was involved in the appeal was sections 53-32 and sections 54-196 of the General Statutes of Connecticut (1958 rev.). Sections 53-32 provided that: “Any person who uses any drug, medicinal article or instrument for the purpose of preventing conception shall be fined not less than fifty dollars or imprisoned not less than sixty days nor more than one year or be both fined and imprisoned,” whilst sections 54-196 provided that “[a]ny person who assists, abets, counsels, causes, hires or commands another to commit any offence may be prosecuted and punished as if he were the principal offender.”

The appellants claimed that the accessory statute, as applied, violated the Fourteenth Amendment. However, despite this claim the appellants were found guilty as accessories and fined $100 each. Both the Appellate Division of the Circuit Court and the Supreme Court of Errors affirmed this decision. In reversing the convictions of the appellants, however, the US Supreme Court held that the right to privacy in the marital relation is fundamental and basic personal right ‘retained by the people’ within the meaning of the Ninth Amendment. Connecticut cannot constitutionally abridge this fundamental right, which is protected by the Fourteenth Amendment, from infringement by the States. Justice Douglas described the constitutional right to privacy as safeguarding a zone of privacy created by several fundamental constitutional guarantees and that the Connecticut statutes involved in this case dealt with a particular important and sensitive area of privacy, namely that of the marital relation and the marital home. The entire fabric of the Constitution and the purposes that clearly underlie its specific guarantees, demonstrate that the rights to marital privacy and to the right to marry and raise a family are of similar order and magnitude as the fundamental rights specifically protected.

This constitutional right to privacy was later on cited and applied to protect abortion rights in the case of Roe v Wade. In this case, Justice Blackmun observed that the right of privacy, whether founded in the Fourteenth Amendment’s concept of personal liberty and restrictions upon state action or in the Ninth Amendment’s

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18 The Griswold case [paragraph 2].
19 The Griswold case [paragraph 2].
20 See Roe v Wade 410 U.S. 113 (1973) [paragraph VIII] (hereafter referred to as the Roe case). In this case the Texas statutes Articles 1191-1194 of the State’s Penal Code made it a crime to ‘procure an abortion’ as there in [p118] defined, or to attempt to do one, except with respect to ‘an abortion procured or attempted by medical advice for the purpose of saving the life of the mother.’ Similar statutes were in existence in most of the states. Jane Roe a single woman who was residing in Dallas County, Texas, instituted a federal legal action in March 1970 against the District Attorney of the county. She sought a declaratory judgment that the Texas criminal abortion statutes were unconstitutional on their face, and an injunction restraining the defendant from enforcing the statutes. The Supreme Court held that a state criminal abortion statute of the current Texas type, that excepts from criminality only a lifesaving procedure on behalf of the mother without regard to pregnancy stage and without recognition of the other interests involved, is violative of the Due Process Clause of the Fourteenth Amendment. It therefore concluded that the fact that Article 1196 was unconstitutional meant that the Texas abortion statutes, as a unit, must fall.
reservation of the rights to the people, is broad enough to encompass a woman’s decision whether or not to terminate her pregnancy.\textsuperscript{21} There was, however, criticism of this constitutional right to privacy in the standard press.\textsuperscript{22} Then in 1986, in the case of \textit{Bowers v Hardwick},\textsuperscript{23} the Georgia statute which criminalised consensual sodomy was held by the United States Supreme court to be constitutional. This decision was seen by many as evidence that the constitutional right to privacy was on the demise.\textsuperscript{24}

However, recently, in 2003, the \textit{Bowers} decision was overruled by the very same United States Supreme Court, in the case of \textit{Lawrence v Texas}.\textsuperscript{25} In this case, the Houston police entered the petitioner’s apartment and saw him and another adult man engaging in a private, consensual sexual act. They were arrested and convicted of deviate sexual intercourse in violation of a Texas statute forbidding two persons of the same sex to engage in certain intimate sexual conduct. The Supreme Court held that the Texas statute that criminalises the act of two persons of the same sex engaging in certain intimate sexual conduct, violated the Due Process Clause, in that the Texas statute advanced no legitimate state interest which could justify its invasion into the individual’s personal and private life.\textsuperscript{26} This \textit{Lawrence} case, therefore, restored the constitutional right to privacy and silenced its critics. On the other hand, it is interesting to note that legal philosophers have always been and still are not always in agreement when it comes to the an interpretation of the right of privacy. As DeCew points out, the historical use of this term is not uniform, and there remains a lot of misunderstanding over the meaning, value and scope of the notion of privacy.\textsuperscript{27} Some authors, for instance, argue that there is no right to privacy and that there is nothing special about it, because any interest protected as private can be equally well explained and protected by other interests or rights, most notably rights to property and bodily security.\textsuperscript{28} Others argue that privacy interests are not distinctive, as the personal interests they protect are economically inefficient, whereas some feminist critiques argue that granting special status to privacy is detrimental to women and others, because it is used as a shield to dominate and control women, silence them and cover up abuse. However, there are those scholars who argue that there is a right to privacy and that it is a meaningful and a valuable notion.\textsuperscript{29} Some defend privacy as focusing on control over information about oneself, whilst others defend it as a broader concept which is required for human dignity or crucial for intimacy. Other proponents of

\begin{itemize}
\item[\textsuperscript{21}] The \textit{Roe} case [paragraph VIII].
\item[\textsuperscript{22}] DeCew J http://plato.stanford.edu/privacy/ (visited 5 August 2011).
\item[\textsuperscript{23}] \textit{Bowers v Hardwick} 478 US 186 (1986).
\item[\textsuperscript{24}] DeCew J http://plato.stanford.edu/privacy/ (visited 5 August 2011).
\item[\textsuperscript{25}] \textit{Lawrence et. al. v Texas} 539 US 558 (2003) (hereafter referred to as the \textit{Lawrence} case).
\item[\textsuperscript{26}] The \textit{Lawrence} case.
\item[\textsuperscript{27}] DeCew J http://plato.stanford.edu/privacy/ (visited 5 August 2011).
\item[\textsuperscript{28}] DeCew J http://plato.stanford.edu/privacy/ (visited 5 August 2011).
\item[\textsuperscript{29}] DeCew J http://plato.stanford.edu/privacy/ (visited 5 August 2011).
\end{itemize}
privacy defend it as necessary for the development of varied and meaningful interpersonal relationships, or as the value that accords people the ability to control the access of others to them, or as a set of norms which are necessary to enhance personal expression and choice, or some combinations of these.30

Discussion of this concept is complicated by the fact that privacy seems to be something that is treasured to provide a sphere within which people can be free from interference by others, and yet, it also seems to function negatively, as the cloak under which domination, degradation, or physical harm to women and others may be hidden.31 Indeed, in agreement with the proponents of the right to privacy, privacy is a valuable and important right to the people who live with HIV/AIDS, as it gives them freedom of choice whether to disclose or not disclose their HIV status and to whom to disclose or not disclose. If the right to privacy did not exist, it would not have been possible, for example, to protect persons from the violation and infringement of their personal information.

In South Africa, the right to privacy is protected in terms of section 14.32 It is however important to note that the right to privacy may be limited by section 36 of the constitution, which will be fully discussed in chapter 4 below. In the medical context, confidentiality is often said to find its most ancient reflection in the Oath of Hippocrates (to be discussed in full below, under 3.4.2) which was formulated in ancient Greece some 2400 years ago.33 This requires doctors to treat information attained from a patient in a professional relationship as ‘sacred secrets,’ about which they must ‘keep silence.’ However, there is evidence that the concept was formulated even earlier, in the Indian sub-continent, nearly 500 years before Hippocrates.34

3.1.1.2 The right to privacy in international human rights instruments

The right to privacy, like many other human rights, is also contained in the international human rights instruments and other documents such as the United Nations Universal Declaration of Human Rights (Universal Declaration of Human Rights),35 The International Covenant on Civil and Political Rights (ICCPR)36 and The
International Guidelines on HIV/AIDS and Human Rights. As Dugard points out, the Universal Declaration of Human Rights, which was adopted by the United Nations (UN) in 1948 to give substance to the Charter of the United Nations, proclaims both first generation rights (civil and political rights) and second generation rights (economic, social, and cultural rights) in the language of aspiration. However, the Universal Declaration of Human Rights is not a treaty but a recommendatory resolution of the General Assembly and is therefore not legally binding on its member states. Although not binding, the Universal Declaration of Human Rights has undoubtedly guided the political organs of the United Nations in their interpretation and application of the human rights clauses in the Charter, and its influence on the development of human rights has been enormous. It has been a source of inspiration to many international instruments such as the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, and several regional human rights conventions; it has served as a model for national Bills of Rights; it has been used by the organs of the United Nations as a standard by which to measure the conduct of states; and it was invoked by the 1975 Final Act of the Conference on Security and Co-operation in Europe. Subsequently, it is argued that the Universal Declaration of Human Rights now forms part of customary international law.

The South African Bill of Rights, also, derives its inspiration from the Universal Declaration of Human Rights and today South African courts may turn to it for the interpretation of the Bill of Rights. Article 12 of the Universal Declaration of Human Rights declares that “no one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, nor to attacks upon his honour and reputation. Everyone has the right to the protection against such interference or attacks.” It is clear, therefore, that the right to privacy is guaranteed by the Universal Declaration of Human Rights, and as said above, many bills, including the South African Bill of Rights.


40 Dugard 240 and Mubangizi 13.
41 Dugard 240 and Mubangizi 13.
42 Dugard 240-241.
43 Dugard 241 and Mubangizi 13.
44 See section 39 of the Constitution, as well as Dugard 242.
Rights,\textsuperscript{45} have adopted this right. The International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR),\textsuperscript{46} which are two covenants both adopted by the United Nations General Assembly in 1966, unlike the Universal Declaration of Human Rights, contained binding obligations.\textsuperscript{47} They have been ratified by more than 100 states.\textsuperscript{48} The ICCPR and ICESCR, together with the Universal Declaration of Human Rights, are usually regarded and described as the ‘international bill of rights.’\textsuperscript{49} Article 17 of the International Covenant on Civil and Political Rights (ICCPR), echoes the same sentiments as article 12 of the Universal Declaration of Human Rights and also guarantees protection of privacy\textsuperscript{50} against any unlawful interferences and attacks.\textsuperscript{51}

The International Guidelines on HIV/AIDS and Human Rights (The Guidelines),\textsuperscript{52} articles 119-124, also deal with the right to privacy. Article 119 of the Guidelines provides that the right to privacy encompasses obligations to respect physical privacy, including the obligation to seek informed consent to HIV testing and privacy of information, including the need to respect confidentiality of all information relating to a person’s HIV status. This article 119 of the Guidelines seems indeed to be all encompassing, dealing with the right to privacy, also ensuring that informed consent is part of privacy and deals with confidentiality and medical confidentiality. The right to privacy, therefore is protected and provided for by international human rights instruments, and they on their own have inspired regional human rights instruments\textsuperscript{53} and many bills of rights of many countries, including South Africa, to entrench this right.

\textbf{3.1.1.3 Definition of privacy, confidentiality and medical confidentiality}

It has often been remarked that the concept of privacy is problematic to define because it is vague and ephemeral, or shapeless and elusive, often meaning different things to different people.\textsuperscript{54} Indeed, as if agreeing

\textsuperscript{45} See section 14 of Constitution of South Africa of 1996 (hereafter referred to as the Constitution of 1996).
\textsuperscript{46} International Covenant on Economic, Social and Cultural Rights of 1966 (hereafter referred to as the ICESCR).
\textsuperscript{47} Mubangizi 13.
\textsuperscript{48} Mubangizi 14.
\textsuperscript{49} Mubangizi 14.
\textsuperscript{50} Dugard 243.
\textsuperscript{51} Article 17 of the ICCPR declares that: 1. No one shall be subjected to arbitrary or unlawful interferences with his privacy, family, home or correspondence, nor to unlawful attacks on his honour or reputation. 2. Everyone has the right to the protection of the law against such interference or attacks.
\textsuperscript{53} Such as The African Charter on Human and Peoples’ Rights of 1981, though it is interesting to note that the African Charter, though it contains certain rights which are related to privacy such as article 6 that deals with the right to liberty and the security of the person and article 18 that deals with the family, seems to be silent on the right to privacy.
\textsuperscript{54} Neethling J “The concept of privacy in South African Law” 2005 (122) SALJ 1-957, 18, the \textit{Bernstein v Bester}
with this statement, different authors and judges have provided different definitions of privacy and in some circumstances, scholars offer conflicting interpretations on the meaning of privacy.\textsuperscript{55} Privacy, therefore, has been defined as a secrecy or a state of being shielded or away from others, alone and undisturbed.\textsuperscript{56} It has, also, been described as meaning an individual’s claim to control the situations in which personal health information is collected, used, kept and transmitted.\textsuperscript{57} Privacy has also been further described as a condition of human life characterised by seclusion from the public and publicity.\textsuperscript{58}

Confidentiality, on the other hand, is a branch or division of informational privacy which inhibits re-disclosure of information that was originally divulged within a confidential relationship, such as doctor-patient, lawyer-client or priest-parishioner relationship.\textsuperscript{59} The word “confidentiality” originates from two Latin roots: con - completeness, and fidere - to trust.\textsuperscript{60} To confide is to trust wholly, to impart knowledge with reliance on secrecy. A confidence is a secret communication.\textsuperscript{61} Confidentiality, therefore, has been defined as meaning to be kept in secret or given in confidence.\textsuperscript{62} It has also been defined to mean a situation when information revealing that harmful acts have been or possibly will be performed, is consciously or voluntarily passed from one rationally competent person (confider) to another (confidant), in the understanding that this information shall not be further disclosed without the confider’s explicit consent.\textsuperscript{63} The harm alluded to may be physical, but moral damage alone may also be the subject matter of a confidential exchange. When this sort of communication happens in a medical setting, it constitutes medical confidentiality.\textsuperscript{64} Medical confidentiality, therefore, can described as the relationship between the doctor and the patient wherein the patient gives the confidential health information to the doctor with the understanding that the information will not be disclosed to other people without clear consent from the patient.

\textsuperscript{55} The Bernstein v Bester case, paragraph [65]. See also the definition by Parent WA “Privacy, morality and public affairs” 1983 (12;4) Philosophy & Public Affairs 269-288, 269, who defines privacy as ‘the condition of not having undocumented personal knowledge about one possessed by others. A person’s privacy is diminished exactly to the degree that others possess this kind of knowledge about him.’

\textsuperscript{56} Hornby 663 and Govindjee 101. See also Warwick SJ “A vote of no confidence” 1989 (15) Journal of Medical Ethics 183-185, 184, who points out that the right of an individual to have secrets is concerned with the notion of privacy. It derives from the ‘right to be left alone’.

\textsuperscript{57} Sperling 186.

\textsuperscript{58} Neethling 2005 SALJ 19.

\textsuperscript{59} Sperling 187.

\textsuperscript{60} Warwick 1989 Journal of Medical Ethics 184.

\textsuperscript{61} Warwick 1989 Journal of Medical Ethics 184.

\textsuperscript{62} Hornby, Cowie and Gimson 177.

\textsuperscript{63} Kottow MH “Medical confidentiality: an intransigent and absolute obligation” 1986 (12) Journal of Medical Ethics 117-122, 117.

\textsuperscript{64} Kottow 1986 Journal of Medical Ethics 117.
It follows therefore that confidentiality comes into operation once the information has been given by one person and attained by another person or by an agency within a confidential relationship.\textsuperscript{65} Such a person, therefore, who attains that confidential information, is not allowed by law to disclose that information further to other people, without the permission of the owner of that information, hence, doctors, lawyers or priests are not supposed to disclose confidential information of their patients, clients or parishioners without their permission. Failure by doctors, lawyers or priests to keep that confidential information may lead to legal action taken against them.\textsuperscript{66} Confidentiality, by definition is voluntary.\textsuperscript{67} However, the patient may waive his or her to confidentiality and allow the doctor or hospital to pass on the health information to a third party and in such a case there would be no violation of privacy or confidentiality which would arise.\textsuperscript{68} Also, in circumstances, that will be discussed below at 3.4, where the doctor will be forced by law to disclose such confidential information, there will also be no breach of any confidentiality by the doctor.\textsuperscript{69}

3.2 CONSTITUTIONAL PROVISIONS

The South African Constitution,\textsuperscript{70} in section 14, provides that everyone has the right to privacy,\textsuperscript{71} which includes the right not to have-(a) their person or home searched; (b) their property searched; (c) their possessions seized; or (d) the privacy of their communications infringed. The right to privacy is now entrenched as a fundamental right by section 14 of the Constitution\textsuperscript{72} and is structured into two parts which are, firstly, the general right to privacy and secondly, the protection against specific violations of the privacy of communications.\textsuperscript{73} The fact that the right to privacy includes the right not to have one’s person or home searched means that physical examination of a person conducted by a healthcare worker, such as the doctor or

\begin{itemize}
  \item \textsuperscript{65} Sperling 187.
  \item \textsuperscript{66} See the Van Vuuren case at 848A, where the doctor of Van Vuuren was sued by his patient for having disclosed his HIV positive status without his consent.
  \item \textsuperscript{67} Sperling 187.
  \item \textsuperscript{68} Sperling 187. See also the case of \textit{C v C} (1946) 1 ALL ER 562 (herafter referred to as the \textit{C v C} case).
  \item \textsuperscript{69} \textit{Parkes v Parkes} 1916 CPD 702 (herafter referred to as the \textit{Parkes} case) and Strauss 104.
  \item \textsuperscript{70} The Constitution of 1996.
  \item \textsuperscript{71} See Madiba TE and Vawda YA “Compulsory testing of alleged sexual offenders-implications for human rights and access to treatment” 2010 (3;1) \textit{SAJBL} 28-32, 28, who point out that “according to the South Africa Constitution, everyone has a right to freedom and security of the person and privacy.”
  \item \textsuperscript{72} Neethling J “The right to privacy, HIV/AIDS and media defendants” 2008 (124) \textit{SALJ} 1-208, 36.
  \item \textsuperscript{73} Currie & De Waal 315, Cheadle, Davis and Haysom 183, Du Plessis L \textit{An Introduction to Law} 3\textsuperscript{rd} ed (1999, Cape Town: Juta & Co, Ltd) 190 and Govindjee 101.
\end{itemize}
nurse, in health care context, is a violation of his or her privacy.\textsuperscript{74} Such an examination can only be lawfully done if that person waives his or her right to privacy for the purpose of examination.\textsuperscript{75} Testing a person for HIV, for instance, without his or her consent, would be a violation of his or her privacy.\textsuperscript{76} Similarly, information concerning a person’s health status, such as HIV or cancer, is also intricately affected by issues of privacy.\textsuperscript{77} The right to privacy, therefore, may be infringed by disclosure of personal facts, especially without the person’s consent.\textsuperscript{78} The South African Constitution therefore guarantees its citizens, including people living with HIV/AIDS, a constitutional right to privacy.\textsuperscript{79} Privacy is also protected in terms of the common law, as will be clear from the discussion below.

3.3 NATIONAL HEALTH ACT PROVISIONS

The National Health Act,\textsuperscript{80} unlike the Constitution\textsuperscript{81} which deals with the right to privacy, entrenches the right to confidentiality.\textsuperscript{82} Its section 14 provides that: (1) all information concerning a user, including information relating to his or her health status, treatment or stay in a health establishment is confidential. (2) Subject to section 15, no person may disclose any information contemplated in subsection (1) unless - (a) the user consents to that disclosure in writing; (b) a court order or any law requires that disclosure; or (c) non-disclosure of the information represents a serious threat to public health. The right to confidentiality of health information is guaranteed by

\textsuperscript{75} Carstens and Pearnain 32.
\textsuperscript{76} Even common law agrees with this view. See for instance the case of \textit{Seetal v Pravitha and Another NO} 1983 (3) SA 827 at 828D-H and 830C(D & CLD)(herafter referred as the \textit{Seetal} case), which is a case that was decided on common law principles as it was instituted before the Constitution of 1996. This case involved a dispute over paternity. The applicant, who was the husband, was suing the wife for divorce as he was alleging that she had committed adultery. He wanted blood samples to be taken from the wife, who was the first respondent, the child and himself, and to be tested in order to establish whether he could possibly be the child’s father. The wife refused point blank to let any sample of blood to be taken from either herself or the child, who was in her custody. Didcott J, observed at 861C, that a blood test on somebody without his consent is unquestionably an invasion of his privacy and the invasion is no less such because on just about every occasion the test is otherwise innocuous. The court dismissed, with costs, the application for the blood test to be conducted on the child, holding that it would not benefit him and therefore was not in his best interests.
\textsuperscript{77} Carstens and Pearnain 32.
\textsuperscript{78} Carstens and Pearnain 32.
\textsuperscript{79} Which is entrenched, as above mentioned, by section 14 of the 1996 Constitution.
\textsuperscript{80} The National Health Act 61 of 2003 (herafter referred to as The Health Act 2003).
\textsuperscript{81} The Constitution of 1996.
\textsuperscript{82} Madiba and Vawda 2010 \textit{SAJBL} 28. See also The Protection of Personal Information Bill \textit{Government Gazette} No. 32495 of 2009 which also deals with the duty to confidentiality. Section 47 stipulates that a person acting on behalf or under the direction of the Regulator, must treat as confidential the personal information which comes to his or her knowledge, except if the communication of such information is required by law or in the proper performance of his or her duties.
the National Health Act\textsuperscript{83} in South Africa. This is also emphasised in the case of \textit{Tsabalala-Msimang and Another v Makhanya and Others},\textsuperscript{84} where the court observed that section 14(1) of the National Health Act\textsuperscript{85} imposes a duty of confidence in respect of information contained in a user’s health record. This is simply because information in a health record is information that is private. Section 14(1) of the National Health Act\textsuperscript{86} deems it imperative and mandatory to afford the information recorded on the health record protection against unauthorised disclosure. Here, the right to the user’s privacy is paramount. In the National Health Act,\textsuperscript{87} the legislature considered the confidentiality of the information important enough to impose certain criminal sanctions in the event of the breach of the confidentiality. Furthermore, in terms of the Constitution,\textsuperscript{88} as well as the National Health Act,\textsuperscript{89} the private information contained in the health records of a user relating to the health status, treatment or stay in a health establishment of that user is worth protecting as an aspect of autonomy and dignity.\textsuperscript{90} Confidential medical information contained in the medical records of a patient is guaranteed and protected by both the National Health Act\textsuperscript{91} and the Constitution\textsuperscript{92} of South Africa, so much so, that people who illegally disclose such confidential information may be penalised by law.

### 3.4 SOUTH AFRICAN CASE LAW ON MEDICAL CONFIDENTIALITY AND PRIVACY

Medical confidentiality which is regarded to be the relationship between the doctor and the patient is often said to be originating from the Hippocratic Oath\textsuperscript{93} which will be discussed in detail below at 3.4.2 Medical confidentiality as a notion is said to be almost as old as medicine itself.\textsuperscript{94} In applying the oath about keeping the secrets of sick people, doctors, nurses, pharmacists, other clinical staff, administrative workers, students of medicine and other people qualified to be informed about patients’ secrets are obliged not to disclose them,

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\textsuperscript{83} The Health Act 2003.
\textsuperscript{84} \textit{Tsabalala-Msimang and Another v Makhanya and Others} (18656/07) [2007] ZAGPHC 161 (WLD) (hereafter referred to as the \textit{Tsabalala-Msimang case}) paragraph [27].
\textsuperscript{85} The Health Act 2003.
\textsuperscript{86} The Health Act 2003.
\textsuperscript{87} The Health Act 2003.
\textsuperscript{88} The Constitution of 1996.
\textsuperscript{89} The Health Act 2003.
\textsuperscript{90} The \textit{Tsabalala-Msimang} case, paragraph [27].
\textsuperscript{91} The Health Act 2003.
\textsuperscript{92} The Constitution of 1996.
\textsuperscript{93} Cameron 3 and Ouzounakis and Chalkias 2010 \textit{International Journal of Caring Sciences} 1.
\textsuperscript{94} Mason JK and McCall Smith RA \textit{Law and Medical Ethics} (1983, London: Butterworths) 95.
especially without their patients’ consent. This ethical rule is echoed in the guidelines of the Health Professions Council of South Africa (HPCSA), which are discussed below.

There are, however, some exceptions to this rule which occur in cases requiring prevention from criminal actions or protection of public health and these will be dealt with in detail in chapter 4. Medical confidentiality requires doctors and other healthcare workers not to disclose their patients’ confidential information or secrets which they have acquired during their professional duties without their patients’ consent except only under certain circumstances which are often enforced by the law, such as when the medical practitioner is ordered by the court to reply to the questions put to him. If medical practitioners and healthcare workers fail to abide by the requirement of professional secrecy and unlawfully divulge patients’ secrets in breach of medical confidentiality, they may be sued by their patients for breach of medical confidentiality. In South Africa and other countries, courts have dealt with cases of breach of medical confidentiality and privacy. Following next will be a discussion of cases that dealt with medical confidentiality and privacy in South Africa and other countries.

The case of Jansen van Vuuren and Another v Kruger, though not dealing with privacy from a constitutional perspective, was decided on the principles of common law. In this case, the plaintiff lived in a homosexual relationship with one Van Vuuren in Brakpan. It appeared that they were fairly well-known residents of that town and that the nature of their relationship was either generally known or surmised. During the beginning of 1990 they began a business venture in Brakpan and then moved to Nylstroom. They had, however, retained some links with Brakpan. During that period the plaintiff applied for life insurance cover from Liberty Life Insurance Company. The company required a medical report on the plaintiff’s HIV status. The first defendant had been the plaintiff’s general medical practitioner since 1983 and the plaintiff nominated him to prepare the medical report. For purposes of an HIV blood test, a sample was drawn on 27 March 1990 at the second defendant’s laboratory. The result was positive and the second defendant informed the first defendant accordingly. The first defendant in consequence arranged an appointment with the plaintiff in order to consult with him on the outcome. That took place on 10 April 1990. The plaintiff was extremely upset and distressed. He was also concerned about a possible leak and raised the issue with the first defendant who promised to respect his wish to keep it confidential.

97 Strauss 103.
98 The Van Vuuren case at 848A.
99 The Van Vuuren case at 847C-D.
100 The Van Vuuren case at 847E-F.
The following day, during the course of a game of golf with Dr Van Heerden, also a general medical practitioner, and Dr Vos, a dentist, the first defendant disclosed the plaintiff’s condition to them. The plaintiff and these three doctors moved in same circle in Brakpan; the plaintiff was engaged in a business venture with van Heerden’s wife; Vos had in the past been the plaintiff’s dentist; and the first defendant’s ex-wife and her parents were on friendly terms with Van Vuuren. Van Heerden, in due course, informed his wife. Whether Vos informed his wife was not established in evidence but all assumed that he had.\footnote{The Van Vuuren case at 847G-H.} The news spread and the plaintiff became aware of this fact. He was annoyed and tried to establish the source of the breach of confidence. He telephoned Mrs Vos. Her denial was vehement. His call to Mrs Adriana Kruger (the first defendant’s ex-wife) elicited that she had heard the story and that she had been told that the second defendant was the source. He then telephonically spoke to the first defendant who denied that he had disclosed the information to anyone; he stated that only the second defendant could have leaked the informed; he expressed the opinion that Mrs Vos would probably have spread the rumour; and he advised the plaintiff to let the matter to rest. The plaintiff did not accept this advice and instituted proceedings against the two defendants in October 1990. However, the action was withdrawn against the second defendant.\footnote{The Van Vuuren case at 848A.} The plaintiff’s case against the first defendant was pleaded in the following terms: the first defendant had been his general medical practitioner; in the consequence he owed him a duty of confidentiality regarding any knowledge of the plaintiff’s medical and physical conditions which might have had come to his notice; he became aware of the plaintiff’s HIV status; it was a term of the agreement which established the doctor-patient relationship that the first defendant and his staff would treat this information in a professional and confidential manner; in breach of the agreement and in breach of his professional duties the first defendant ‘wrongfully and unlawfully’ disclosed test results to third parties; in consequence the plaintiff had suffered an invasion of, and had been injured in his rights of personality and his right to privacy.\footnote{The Van Vuuren case at 848B-C.}

Sentimental (i.e. non-pecuniary) damages of R50 000 were initially claimed, but the amount was increased to R250 000 during the course of the trial. The first defendant in his plea admitted the existence of the professional relationship, his legal duty to respect the plaintiff’s confidence and the term of the agreement as alleged. However, he disputed the making of any disclosures and the resultant damages. That remained his case until Dr Van Heerden testified on behalf of the plaintiff.\footnote{The Van Vuuren case at 848E.} The first defendant then applied and was granted an amendment of his plea in terms of which, in the alternative to denial, the absence of wrongfulness was raised on three alternative bases: (a) the communication had been made during a privileged occasion, (b) it was the truth
and was made in the public interest, and (c) it was objectively reasonable in the public interest in the light of the *boni mores*. The plaintiff's claim for damages for the alleged breach of his right to privacy was dismissed by Levy AJ in the Witwatersrand Local Division. The appellants, who were the executors of the estate of the plaintiff, Mr McGeary, who died during the course of the trial of an AIDS-related disease, appealed to the Appellate Division, against the respondent, the general medical practitioner of Brakpan, who was the first defendant. The trial Judge granted the necessary leave to appeal.105

In the Appellate Division, Harms AJA observed that as far as the public disclosure of private medical facts is concerned, the Hippocratic Oath, formulated by the father of medical science more than 2370 years ago, is still in use. It requires of the medical practitioner ‘to keep silence’ about the information acquired in his professional capacity relating to a patient, ‘counting such things to be as sacred secrets’. He further observed that according to the rules of the South African Medical and Dental Council, it amounts to unprofessional conduct to reveal ‘any information which ought not to be divulged regarding the ailments of a patient except with the express consent of the patient’. The reason for this rule is twofold: On the one hand it protects the privacy of the patient. On the other it performs a public interest function.106 The duty of a physician to respect the confidentiality of his patient is not merely ethical but is also a legal duty recognised by the common law and as far as the present-day law is concerned, the legal nature of the duty is accepted as axiomatic. However, the court also observed that the right of the patient and the duty of the doctor are not absolute but relative. One is, as always, weighing up conflicting interests and a doctor may be justified in disclosing his knowledge ‘where his obligations to society would be of greater weight than his obligations to the individual’ because ‘[t]he action of injury is one which pro publica utilete exercetur’.107

The court then concluded by observing that in determining whether the respondent had a social or moral duty to make the disclosure and whether Van Heerden and Vos had a reciprocal social or moral right to receive it, the standard of a reasonable man applied.108 The court was of the view that the respondent had no such duty to transfer, nor did Van Heerden and Vos had the right to receive the information. The court further observed that AIDS is a dangerous condition. That on its own does not detract from the right of privacy of the afflicted person, especially if that right is founded in the doctor-patient relationship.109 A patient has the right to expect due compliance by the practitioner with his professional ethical standards: in this case the expectation was even

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105 The Van Vuuren case at 847B.
106 The Van Vuuren case at 850B.
107 The Van Vuuren case at 850F-G.
108 The Van Vuuren case at 856D-E.
109 The Van Vuuren case at 856E.
more pronounced because of the express undertaking by the respondent. Vos and Van Heerden had not, objectively speaking, been at risk and there was no reason to assume that they had to fear a prospective exposure. In the consequence the court concluded that the communication to Vos and Van Heerden was unreasonable and therefore unjustified and wrongful.\textsuperscript{110}

In awarding damages to the respondent, Harms AJA observed that the right to privacy is a valuable right and the award must reflect that. Aggravating factors included the fact that a professional relationship was abused, notwithstanding an express undertaking to the contrary. So, too, the breach created the risk of further dissemination by others. The evidence also established that the publication of person’s HIV condition increases mental stress and that the plaintiff was seriously distressed by the disclosure.\textsuperscript{111} And stress hastens the onset of AIDS, something which may have occurred in this instance. On the other hand, the disclosure was limited to two medical men who, it was reasonable to assume, would have dealt with the information with some circumspection. The nature of the plaintiff’s condition was that his status would inevitably have become known at some stage during the progression of the virus. He had, to an extent, already severed his links with Brakpan. There is no evidence that his friends ostracised or avoided him; it was rather a case of his chosen to withdraw from society, something he would probably in any event have done. In the light of all the circumstances, the court felt that R5 000 would be a just award. The appeal, therefore, was upheld and the order of the Court \textit{a quo} was amended to read ‘Judgment for the plaintiff in the sum of R5 000 with costs on the Supreme Court scale’.\textsuperscript{112}

This was a correct judgment by Harms AJA and a vindication for both medical confidentiality and the right to privacy of people living with HIV/AIDS. The court was correct in holding that medical practitioners, in keeping their oath in accordance with the Hippocratic Oath and their professional ethics, are obliged to keep silent about the confidential information which is given to them by their patients during their consultations. That has to be case, unless as the court correctly observed, medical practitioners are either given express consent by their patients to disclose their confidential information or are obliged by a moral duty or legal duty to divulge such confidential information. In this case of Van Vuuren, it was clear to the court that the doctor of Mr McGeary had no such duty to disclose the confidential information to the other two medical practitioners. The doctor disclosed the information whilst he was just socialising with his counterparts. If doctors were to be allowed to just disclose their patients’ confidential information in social gatherings, this would threaten trust in the medical profession, as

\begin{flushright}
\textsuperscript{110} The Van Vuuren case at 856G.  \\
\textsuperscript{111} The Van Vuuren case at 858A-B.  \\
\textsuperscript{112} The Van Vuuren case at 858B-C.  
\end{flushright}
patients would be reluctant to consult their doctors for treatment. This would, in turn, also indirectly contribute to the spreading of HIV/AIDS, as people would not know whether they are positive or not. Furthermore, as the court also observed, it might have been the case that the plaintiff's death, which occurred during the course of the trial, might have been hastened by the stress caused by the wrongful disclosure of his HIV/AIDS status.

However, a medical practitioner who is ordered by a court of law to reply to the questions put to him is obliged to answer such questions, even if it means that he has to disclose his or her patient's medical confidential information given to him during consultation.\textsuperscript{113} In such an instance the medical practitioner normally protests against divulging their patients' confidential information by claiming privilege. Such medical practitioners, who in accordance with their ethical duty protest to the presiding judge for having to testify in breach of their professional secrecy, are normally accorded sympathetic treatment by judges. They are nevertheless ordered by courts to testify, despite their patients' confidentiality, if their testimony is relevant to the case.\textsuperscript{114}

In the case of \textit{Parkes v Parkes},\textsuperscript{115} the action was for divorce on the grounds of adultery. The plaintiff, in evidence, said she was married to the defendant at Naauwpoort, Cape Province, in June, 1906. Three children were born during the marriage. The defendant had suffered from a venereal disease, which he did not contract from her. A medical practitioner, who had been subpoenaed to give evidence but had refused to make a statement, was called. He said he knew the parties. He was asked by the plaintiff's counsel if he examined the defendant in 1911. The doctor claimed privilege, since the defendant was his patient. Gardiner J ruled that the question, whether witness had treated defendant for a venereal disease, had to be answered. The doctor was bound to answer the question put to him by the counsel.\textsuperscript{116} The doctor then said he remembered treating the defendant for a venereal disease. Gardner J then observed that he regretted very much that the law compelled him to elicit these facts from a medical man when in the witness box; and that the doctor had done all that he possibly could do to observe the professional confidence reposed in him, and that he did not think that any other man could have done more to avoid the breach of that professional confidence. The Court granted a decree of divorce, with costs, plaintiff to have the custody of the children, defendant ordered to pay plaintiff £1 per month for the maintenance of each child until he or she attained the age of 16 years.\textsuperscript{117}

\begin{itemize}
\item \textsuperscript{114} Strauss 104 and Rautenbach 2004 The Southern African Journal of HIV Medicine 26-28, 27.
\item \textsuperscript{115} The \textit{Parkes} case.
\item \textsuperscript{116} The \textit{Parkes} case.
\item \textsuperscript{117} The \textit{Parkes} case.
\end{itemize}
A similar decision seems to have been reached also in the case of Botha v Botha.\textsuperscript{118} In this case, two doctors from Pietermaritzburg, Dr Lind, who was a psychiatrist, and Dr Roper, who was a general practitioner, have been subpoenaed to give evidence for the defendant. After entering the witness-box and being sworn in, and after having thereafter given evidence with respect to their qualifications, they had both refused to give evidence of what the plaintiff and the defendant revealed to them during consultations which they had with the parties. They claimed that their ethical rules prevented them from disclosing confidential information which they have been given by the plaintiff and the defendant in their capacities as medical advisers to the parties. They said that if they were to reveal such information, they would be in breach of their Hippocratic Oath which they as doctors are bound to observe.\textsuperscript{119} Leon J observed that it was clear that the evidence which was sought to be led was relevant to one of the main issues in this case, namely whether the custody of the minor child, Jacobus, should be awarded to the father or to the mother. The evidence of the doctors would have a bearing on the issue as to the fitness or otherwise of the parties to be awarded custody of that child. Leon J accordingly held that the doctors were obliged to answer all relevant questions put to them by counsel.\textsuperscript{120} In the above cases, medical practitioners had done all in their powers to protect the confidential information of their patients and only disclosed such confidential information when they were ordered to do so by the courts of law.

However, courts have felt and held that the medical practitioners who are asked by their patients to disclose confidential information between the doctor and the patient to any named person or persons are not justified to refuse to do so; and a doctor who discloses the confidential information of his or her patient asked for in those circumstances is not guilty of any breach of confidence. This was the view that was held in the British case of C v C.\textsuperscript{121} In this case, in the course of the hearing of a petition for a decree of nullity on the grounds set out in the Matrimonial Causes Act, 1937, s 7(1)(c), a question arose upon which the parties requested the court to give a direction in order that in the similar cases in the future the difficulties, trouble and expense which they had incurred could be avoided. The circumstances which gave rise to that application were as follows: The respondent, a short time after marriage, exhibited symptoms which caused her to go to a venereal disease clinic where, on February 28, 1945, it was found she was suffering from a venereal disease in a communicable state. On this being discovered the petitioner went to the clinic and was examined, observed and treated by the same doctor who examined and was treating the respondent. After some time it was found that there was no evidence that the petitioner was suffering from this disease in any form. The respondent was not told that the

\textsuperscript{118} Botha v Botha 1972 (2) SA 559 (N) (hereafter referred to as the Botha case).
\textsuperscript{119} The Botha case.
\textsuperscript{120} The Botha case.
\textsuperscript{121} The C v C case.
disease from which she was in fact suffering was in a communicable form or, if it was, on February 28, in a communicable form, how long it had been in that form. On August 3, 1946, a questionnaire consisting of six questions was sent to the doctor, signed personally by the petitioner and the respondent, with the approval of the lawyers for both parties, asking for information for the purpose of the proposed presentation or their respective cases. If those questions had been answered in one way, the petitioner would have failed in proving what was necessary to prove, if he was to succeed, and the respondent would have been able successfully defend the case. To put it in another way, the petitioner would have been unable to prove his case and the success of the respondent would have been a foregone conclusion. The doctor refused to give the information, stating that he would, if subpoenaed, give his evidence in court. He appeared in court and gave evidence and answered all questions put to him, and no sort of suggestion was made or could be made as to his good faith.

The question which arose out of those circumstances was: Is a doctor, when asked by his patient to give him or her particulars of his or her condition and illness to be used in a court of law, when those particulars are vital to the success or failure of the case, entitled to refuse? In the present case, the patient asked the doctor to give her the information and asked him also to give the petitioner that same information, with the object of their being placed in a position which would enable them to know whether or not the petitioner had a case against the respondent; in other words, to assist the course of justice.

Lewis J observed that it is, of course, of the greatest importance from every point of view that proper secrecy should be observed in connection with venereal disease clinics, and that nothing should be done to diminish their efficiency or to infringe the confidential relationship existing between doctor and patient. However, in his opinion, the judge felt that those considerations do not justify a doctor in refusing to divulge confidential information to a patient or to any named person or persons when asked by the patient so to do. In the circumstances of this case the information should have been given, and in all cases where the circumstances are similar the doctor is not guilty of any breach any confidence in giving the information asked for. This view, by Lewis J, in C v C, seems to be the correct view in that there seems to be no justification for a doctor to refuse to disclose confidential patient's information when asked by that patient to do so. The doctor, according to Lewis J, therefore, does not need to be first ordered by the court in order for him or her to divulge the confidential patient's information, he or she may disclose such information to the patient or any other person

122 The C v C case.
123 The C v C case.
124 The C v C case.
125 The C v C case.
mentioned by the patient provided that the patient has given his or her informed consent to the doctor. And if the doctor gives such confidential information with the patient’s consent, he or she will not be guilty of the breach of any confidence. This is a correct view, indeed, because the requirement of medical confidentiality, as mentioned above, is that medical practitioners and health workers must not disclose their patients’ confidential information, especially without their patients’ clear consent.\textsuperscript{126}

The case that involved a conflict of rights between privacy, medical confidentiality in the form of medical records and press freedom is the case of \textit{Tshabalala-Msimang and Another v Makhanya and Others}.\textsuperscript{127} In this case the first applicant was a member of the cabinet and the minister of health of the Government of the Republic of South Africa. The second applicant was a private hospital group and one of the private hospitals that it owned was operated in the Cape Town Medi Clinic Centre. The respondents were the editor, journalists and the owner and the publisher of ‘The Sunday Times’ newspaper respectively.\textsuperscript{128} During 2005 the first applicant was hospitalised and treated as an in-patient at the Cape Town Medi Clinic on two occasions. The dispute arose when on Sunday, 12 August 2007, the Sunday Times published an article, apparently written by the second and third respondents, that was entitled: ‘Manto’s hospital Booze Binge.’ The article, also amongst others, alleged that the Sunday Times was also in possession of documents related to Tshabalala-Msimang’s two hospital stays in 2005. Doctors who were given files to assess for the Sunday Times said they were shocked at the excessive use of painkillers and sleeping tablets and said the patient should not have been allowed to consume alcohol while one them.\textsuperscript{129} In this matter, therefore, the applicants sought to secure the delivery by the respondents of copies of the first applicant’s medical records regarding her stay at the second applicant’s Cape Town hospital and an interdict to restrain the respondents from further publishing or commenting on these records and from gaining the hospital records or any other private or confidential information concerning the first applicant’s medical condition and/or treatment.\textsuperscript{130} The respondents argued that their access of the medical records of the first applicant was justified by the great public interest in the information published.\textsuperscript{131}

The court observed that it is clear that in terms of the National Health Act,\textsuperscript{132} the medical records of a person are private and confidential. Generally speaking where a person acquires knowledge of private facts through a wrongful act of intrusion, any disclosure of such facts by such person or by any person, in principle, constitutes

\begin{thebibliography}{9}

\bibitem{126} Ouzounakis and Chalkias 2010 \textit{International Journal of Caring Sciences} 1.
\bibitem{127} The \textit{Tshabalala-Msimang case}.
\bibitem{128} The \textit{Tshabalala-Msimang case}, paragraph [6].
\bibitem{129} The \textit{Tshabalala-Msimang case}, paragraph [7].
\bibitem{130} The \textit{Tshabalala-Msimang case}, paragraph [4].
\bibitem{131} The \textit{Tshabalala-Msimang case}, paragraph [5].
\bibitem{132} The \textit{National Health Act} 2003.
\end{thebibliography}
an infringement of the right to privacy. The reason for treating the information concerning a user, including information relating to his/her health status, treatment or stay in a health establishment as confidential is not difficult to understand because the confidential medical information invariably contains sensitive and personal information about the user. This personal and intimate information concerning the individual’s health reflects sensitive decisions and the choices that relate to issues pertaining to bodily and psychological integrity. This personal and intimate private health information which is contained in health records, according to the court, was worth of protecting as an aspect of human autonomy and dignity by both the Constitution and National Health Act.

On the defence of public interest by the respondents, Jajbhay J, observed that it must be noted that public interest is a mysterious concept, like a battered piece of string charged with elasticity, impossible to measure or weigh. The concept changes with the dawn of each day, tempered by the facts of each case. Public interest will naturally depend on the nature of the information conveyed and on the situation of the parties involved. Public interest is central to policy debates, politics and democracy. While it is generally acclaimed that promoting the common well-being or general welfare is constructive, there is little, if any, consensus on what exactly constitutes the public interest. The public has the right to be informed of current news and events concerning the lives of public persons as politicians and officials. This right has been given express recognition in section 16(1)(a) and section 16(2) of the Constitution which protect the freedom of the press and other media and the freedom to receive and impart information and ideas. The public has the right to be informed not only on matters which have a direct effect on life, such as legislative enactments, and financial policy. This right may in appropriate circumstances extend to information about public figures. The court then concluded by acknowledging the fact that the overwhelming public interest pointed in the direction of informing the public about the contents incorporated in the medical records in relation to the first applicant, albeit that the medical records may have been unlawfully obtained. The court, however, held that the document relating to the health records in relation to the treatment or stay of the first applicant in the Cape Town Medi Clinic had to be returned to the second applicant. The respondents were further ordered to delete all copies of these medical records that may be stored on their personal computers or laptops. The personal notes made by the respondents were not affected by the order as the court felt that it would be difficult to unscramble the

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133 The Tshabalala-Msimang case, paragraph [26].
134 The Tshabalala-Msimang case, paragraph [27].
135 The Tshabalala-Msimang case, paragraph [37].
137 The Tshabalala-Msimang case, paragraph [38].
138 The Tshabalala-Msimang case, paragraph [50].
The decision of this case seems to been one of the difficult decisions that the court had to make, as the judge himself acknowledged that the decision had not been concluded easily and that the difficulty was compounded when the two competing constitutional rights come into conflict, as one must suffer. It also seems to have been a judgment where the court tried all possible means to satisfy the two sides. The most difficult part, of course, was the one on public interest. The court was correct in fact in holding the view that there is little consensus, if any, on what constitutes public interest. It, however, may seem to some that the court erred in holding the view that the overwhelming public interest pointed in the direction of informing the public about the contents incorporated in the medical records in relation to the first applicant, albeit that the medical records may have been unlawfully obtained.

Whilst it might have been in the public interest of other people that confidential information in medical records be published, it could still be in public interest of other people that such information should not be published, despite the fact that the first applicant was a public figure. It is in the public interest that confidential medical information in the medical records remains confidential as the public has to trust medical practitioners and healthcare centres in order for them to come for treatment. The concept of the public interest, therefore, is a controversial matter which can mean different things to different people. What may be comforting, however, is that ultimately the public interest can only be determined by the courts of law.

In *Bernstein and others v Bester NO and others*, there was a dispute, between Mr Bernstein and other partners and the employees of Kessel Feinstein, a partnership of chartered accountants (“the applicants”) and Mr Bester and other liquidators of Tollgate Holdings Limited (“the respondents”), as to whether the respondents were precluded by the Constitution from continuing with the examination of the applicants in terms of sections 417 and 418 of the Companies Act (as amended). In their attack of sections 417 and 418 of the Companies Act, the applicants submitted that ‘a witness’s privacy is clearly invaded when he is forced to disclose his books and documents that he wants to keep confidential and to reveal information that he wants to keep to himself.’ In

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139 The *Tshabalala-Msimang* case, paragraph [51] and [61].
140 The *Tshabalala-Msimang* case, paragraph [56].
141 The *Tshabalala-Msimang* case, paragraph [37].
142 The *Tshabalala-Msimang* case, paragraph [50].
143 See for instance article 120 of The International Guidelines on HIV/AIDS and Human Rights 2006, which stipulates that the community has an interest in maintaining privacy so that people will feel safe and comfortable in using public health measures, such as HIV prevention and care services.
145 The *Bernstein v Bester* case paragraph [1].
addition the applicants contended that the ‘compulsory production of documents under section 417(3) constituted a ‘seizure’ within the meaning of the right not to be subject to the ‘seizure of private possessions’ in terms section 13 of the Constitution.”

Ackermann J of the Constitutional Court observed that a distinction must be drawn between the compulsion to respond to subpoena and the compulsion to answer particular questions at a section 417 enquiry in consequence of responding to the subpoena. The mere compulsion to be physically present at a particular place at a particular time cannot in itself be regarded as an intrusion on a person’s privacy, however widely that concept is defined. It could be examined in relation to concepts such as freedom or perhaps even dignity, but it cannot notionally be categorised as interfering with one’s privacy. It may of course be that, in particular circumstances, the disclosure of the person’s identity might constitute a breach of the right of privacy, but that does not arise in this case. It is the compulsion to respond to particular questions about oneself and one’s activities for example, which could lead to an infringement of one’s right to personal privacy. Before this stage is reached a person’s privacy is not compromised.

On the scope of the right to privacy, the Constitutional Court also indicated that the concept of privacy is an amorphous and elusive one which has been subject of much scholarly debate. 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’. The Court further cited Forst who acknowledges that the communal bonds are not to be substituted with abstract relations, but argues beyond this for a multi-levelled recognition of identity. Besides the concrete and abstract realms, this thirdly also pertains to societal membership and fourthly to the community of humanity itself. The relevance of such an integrated approach to the interpretation of the right to privacy is that this process of creating context cannot be confined to any one sphere, and specifically not to an abstract individualistic approach. The truism that no right is to be considered absolute, implies that from the outset of interpretation each right is always already limited by every other right accruing to another citizen. In the context of privacy this would mean that it is only the inner sanctum of a person, such as his/her family life, sexual

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148 The Bernstein v Bester case, paragraph [56]. The court observed at paragraph [57] that section 13 of the Interim Constitution of 1993, entrenched the right to privacy as follows: Every person shall have the right to his or her privacy, which shall include the right not to be subject to searches of his or her person, home or property, the seizure of private possessions or the violation of private communication.

149 The Bernstein v Bester case, paragraph [58].

150 The Bernstein v Bester case, paragraph [65].


152 The Bernstein v Bester case, paragraph [66].
preference and home and environment, which is shielded from erosion by conflicting rights of the community. This implies that community rights and the rights of the fellow members place corresponding obligation on a citizen, thereby shaping the abstract notion of individualism towards identifying a concrete member of the civil society. Privacy is acknowledged in the truly personal realm, but as a person moves into communal relations and activities such as business and social interaction, the scope of personal space shrinks accordingly.\footnote{153 The Bernstein v Bester case, paragraph [67].}

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 \textit{dignitas}. ‘Privacy is an individual condition of life characterised by seclusion from the public and publicity, which implies ‘an absence of acquaintance with the individual or his personal affairs in this state.’\footnote{154 The Bernstein v Bester case, paragraph [68].} Examples of wrongful intrusion and disclosure which have been acknowledged at common law are entry into the private residence, the reading of private documents, listening in to private conversations, the shadowing of a person, the disclosure of private facts which have been acquired by a wrongful act of intrusion, and the disclosure of private facts contrary to the existence of a confidential relationship. These examples were all clearly related to either the private sphere, or relations of legal privilege and confidentiality. There was no indication that they may be extended to include the carrying on of business activities.\footnote{155 The Bernstein v Bester case, paragraph [69].} The Court, however, cautioned about attempting to project common law principles onto the interpretation of fundamental rights and their limitations, observing that it is important to keep in mind that at common law the determination of whether an invasion of privacy has taken place constitutes a single enquiry, including an assessment of its unlawfulness. As in the case of \textit{iniuriae}, the presence of a ground of justification excludes the wrongfulness of an invasion of privacy.

In constitutional adjudication under the Constitution, by contrast, a two-stage approach must be employed in deciding constitutionality of a statute.\footnote{156 The Bernstein v Bester case, paragraph [71].} The Constitutional Court, therefore, in the present case came to the conclusion that the facts applicable concerned neither the invasion of private living space, nor any specific protected relationship.\footnote{157 The Bernstein v Bester case, paragraph [80].} The Court, therefore also, concluded that sections 417 and 418 of the Companies Act were accordingly not inconsistent with any of the section 13 rights.\footnote{158 The Bernstein v Bester case, paragraph [92].} This case, therefore, was concerned with
the right to privacy and it seems that the Constitutional Court was correct in its decision that the two sections were not inconsistent with the right to privacy as was encapsulated by section 13 of the Interim Constitution.\footnote{The Interim Constitution of 1993.}

As it appears from the facts of this case, it seems that the applicants wanted to use the right to privacy, which is meant to protect private individuals and relationships, to protect their business activities and interests. The court also made important findings about the right to privacy, in the that, like all other rights, privacy is also not absolute, however, it is limited by the rights of other citizens. Furthermore, that the right to privacy of an individual may remain truly private in his or her own space or place, but as such individual mingles with other community members in social relations and business activities, his or her right to privacy shrinks accordingly to those relations and activities. The right to privacy, therefore, is not absolutely inviolable;\footnote{See Seetal case at 861D, which is a common law and not a constitutional case as it was instituted before the Constitution of 1996, where the court pointed out that it must be admitted, on the other hand, that the privacy of the individual is not in law absolutely inviolable.} instead it can be limited, provided that such limitation is justifiable and complies with the requirements of section 36 of the constitution.\footnote{The Constitution of 1996.}

In \textit{National Coalition for Gay and Lesbian Equality and Another v Minister of Justice and Others}\footnote{\textit{National Coalition for Gay and Lesbian Equality and Another v Minister of Justice and Others} 1998 (12) BCLR 1517; 1999 (1) SA 6 (CC) (hereafter referred to as the \textit{National Coalition for Gay case}).} the matter concerned the confirmation of a declaration of constitutional invalidity of – (a) section 20A of the Sexual Offences Act;\footnote{The Sexual Offences Act 23 of 1957 (hereafter referred to as the Sexual Offences Act).} (b) the inclusion of sodomy as an item in Schedule 1 of the Criminal Procedure Act;\footnote{The Criminal Procedure Act 23 of 1957 (hereafter referred to as the Sexual Offences Act).} and (c) the inclusion of sodomy as an item in the schedule to the Security Officers Act,\footnote{The Security Officers Act 1987.} made by Heher J in the Witwatersrand High Court on 8 May 1998.\footnote{The \textit{National Coalition for Gay case}, paragraph [1].} The Constitutional Court found the offence of sodomy to be unconstitutional because it breached the rights of equality, dignity and privacy.\footnote{The \textit{National Coalition for Gay case}, paragraph [30].} In making this finding, the court further, observed that privacy recognises that we all have a right to a sphere of private intimacy and autonomy which allows us to establish and nurture human relationships without interference from the outside community. The way in which we give expression to our sexuality is at the core of this area of private intimacy. If, in expressing our sexuality, we act consensually and without harming one another, invasion of that precinct will be a breach of our privacy. Our society has a poor record of seeking to regulate the sexual expressions of South Africans. In some cases, as in this one, the reason for the regulation was discriminatory; our law, for
example, outlawed sexual relationships among people of different races. The fact that a law prohibiting forms of sexual conduct if discriminatory does not, however, prevent it at the same time being an improper invasion of the intimate sphere of human life to which protection is given by the Constitution in section 14.

We should not deny the importance of a right to privacy in our new constitutional order, even while we acknowledge the importance of equality. In fact, emphasising the breach of both of these rights in the present case highlights just how egregious the invasion of the constitutional rights of gay persons has been. The offence which lies at the heart of the discrimination in this case constitutes at the same time and independently a breach of the rights of privacy and dignity, without doubt, strengthens the conclusion that the discrimination is unfair. The court accordingly held that the common law offence of sodomy to be inconsistent with the Constitution and invalid. This is one of the cases that emphasised the importance of the right to privacy especially in intimate private life. However, this case is also significant in that it also emphasised the relationship of the right to privacy with other rights such as the right to dignity and equality.

In the case of Jordan and Others v State, the appellants were the owner of a brothel, a salaried brothel employee and a prostitute. They were convicted in the magistrates’ court of contravening the Sexual Offences Act. Section 20(1)(aA) of the Act penalised sex for reward and sections 2, 3(b) and 3(c) criminalised brothel-keeping. They appealed to the Constitutional Court against the refusal of the High Court to set aside their convictions under the brothel provisions. The Constitutional Court concluded that section 20(1)(aA) was not inconsistent with section 8(2) of the interim Constitution. Having come to this conclusion, Ngcobo J, expressed grave doubts as to whether the prohibition contained in section 20(1)(aA) implicated the right to privacy, as this case was different from National Coalition for Gay and Lesbian Equality v Minister of Justice case. The court was of the view that the case of the National Coalition for Gay and Lesbian Equality was concerned with the unfair discrimination against gay people and their right to dignity. The infringement,
according to the court, intruded into the private sphere which allows people to establish and nurture human relations without interference from the outside community and in so affected the sexuality of gay people ‘at the core of private intimacy’, of which none of those considerations were present in this Jordan’s case.180

This case was concerned with the commercial exploitation of sex, which in the view of the court neither involved a violation of dignity nor unfair discrimination.181 However, according to the court, even if the right to privacy was implicated, it lied at the periphery and not at its inner core. What lied at the heart of the prostitutes’ complaint was that they were prohibited from selling their sexual services. After all, they were in the industry solely for money. The prohibition was directed solely at the sale of sexual activity. Otherwise the prostitutes were entitled to engage in sex, to use their bodies in any manner whatsoever and to engage in any trade as long as that did not involve the sale of sex and breaking a law validly made.182 What the law limited were the commercial interests of the prostitute. But that limitation was not absolute. They may pursue their commercial interests but not in the manner that involves the sale of sex. The court, having regard to the legitimate state interest in proscribing prostitution and brothel-keeping, considering also the scope of the limitation on the right of the prostitute and brothel-keeper to earn a living, concluded that if there be a limitation of the right to privacy, the limitation was justified. The challenge, therefore, based on the right to privacy was dismissed.183 This was a correct decision, in that the Sexual Offences Act184 only criminalised the sale of sex and keeping of brothels. The Act did not prevent prostitutes from engaging in any sexual activities or interfere with their sexual practices which were done privately, as long they were not selling sex. The law, therefore, did not infringe the right of prostitutes of having sex, but only the commercialisation of sex. It follows, therefore, that the right to privacy under these circumstances was not violated or if alleged to be violated, as the court correctly held that would be a justifiable limitation. Prostitution, therefore, still remains criminalised in South Africa.

In NM and Others v Smith and Others,185 a biography of Ms Patricia de Lille entitled ‘Patricia de Lille’ and authored by Ms Charlene Smith, was published by New Africa Books (Pty) Ltd, in March 2002. The names of three women who were HIV positive were disclosed. They alleged that their names had been published in the book without their prior consent having been obtained. These women claimed that their rights to privacy, dignity

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180 The Jordan case, paragraph [27].
181 The Jordan case, paragraph [28].
182 The Jordan case, paragraph [29].
183 The Jordan case, paragraph [29].
184 The Sexual Offences Act.
185 The NM v Smith case, paragraph [1].
and psychological integrity had been violated. A sequel to that publication was an action for damages in the Johannesburg High Court. The High Court dismissed with costs the action against Ms Smith and Ms de Lille.\textsuperscript{186} It, however, ordered the third defendant, New Africa Books (Pty) Ltd, to pay each of the plaintiffs an amount of R15 000 and to delete from all copies of the ‘Patricia de Lille’ in its possession, the reference at page 170 and 171 to the plaintiffs’ names. Further, that until such deletion was made, the third defendant should not sell any further copies of the book.\textsuperscript{187} The three women, NM, SM and LH, then appealed to the Constitutional Court, after both their appeals to the High Court and Supreme Court of Appeal, were unsuccessful. They appealed only against the decisions for the first respondent, Charlene Smith and second respondent, Patricia de Lille, and not against the third respondent, New Africa Books (Pty) Ltd, decision.\textsuperscript{188} Madala J, on the right to privacy observed that the academic literature on privacy demonstrates the considerable controversy over the definitional nature and the scope of the right. However, it appears common cause in many jurisdictions that the nature of the right envisages a concept of the right to be left alone.\textsuperscript{189} Privacy encompasses the right of a person to live his or her life as he or she pleases.\textsuperscript{190} Private facts have been defined as those matters the disclosure of which will cause mental distress and injury to anyone possessed of ordinary feelings and intelligence in the same circumstances and in respect of which there is a will to keep them private.\textsuperscript{191} The applicants contended that as a result of the disclosure of their names and HIV status to the public the respondents had wrongfully and intentionally or negligently violated their rights of personality, more particularly their right to privacy, dignity and psychological integrity and therefore, they claimed that they had suffered damages.\textsuperscript{192} In denying liability, the respondents relied on the fact that the applicants’ names had previously been disclosed in the Strauss Report which was not marked ‘confidential’. They therefore argued that the applicants had made public their names and HIV status. The respondents also relied on the fact that the applicants had appeared before the various commissions of enquiry including the Strauss enquiry and had brought an application in their own names in the High Court seeking interdict against the inclusion of their names in the book.\textsuperscript{193} The Constitutional Court was of the view that, when the applicants made their application for the interdict in their names, they were not thereby saying their names should be published in the book having a wide circulation throughout South Africa, which would be the position since the second respondent was a

\textsuperscript{186} The NM v Smith case, paragraph [1].

\textsuperscript{187} The NM v Smith case, paragraph [2].

\textsuperscript{188} The NM v Smith case, paragraphs [2]-[5] and [20].

\textsuperscript{189} The NM v Smith case, paragraph [32].

\textsuperscript{190} The NM v Smith case, paragraph [33].

\textsuperscript{191} The NM v Smith case, paragraph [34].

\textsuperscript{192} The NM v Smith case, paragraph [35].

\textsuperscript{193} The NM v Smith case, paragraphs [36] and [38].
national figure. Similarly, by attending the various inquiries they were not giving blanket consent to the publication of their status. On medical confidentiality, Madala J pointed out that private and confidential medical information contains highly sensitive and personal information about individuals. The personal and intimate nature of an individual’s health information, unlike other forms of documentation, reflects delicate decisions and choices relating to issues pertaining to bodily and psychological integrity and personal autonomy. Individuals value the privacy of confidential medical information because of the vast number of people who could have access to the information and the potential harmful effects that may result from disclosure. The lack of respect for private medical information and its subsequent disclosure may result in fear, jeopardising an individual’s right to make certain fundamental choices that he or she has a right to make. There is therefore a strong privacy interest in maintaining confidentiality. The disclosure of an individual’s HIV status, particularly within the South African context, deserves protection against indiscriminate disclosure due to the nature and negative social context the disease has, as well as the potential intolerance and discrimination that result from its disclosure.

The affirmation of secure privacy rights in the Constitution may encourage individuals to seek treatment and divulge information, encouraging disclosure of HIV which has previously been hindered by fear of ostracism and stigmatisation. The need for recognised autonomy and respect for private medical information may also result in the improvement of public health policies on HIV/AIDS. As a result, it is imperative that all private and confidential information should receive protection against unauthorised disclosures. The involved parties should weigh the need for access against the privacy interest in every instance and not only when there is an implication of another fundamental right, in this case the right to freedom of expression.

The Court further pointed out that the assumption that others are allowed access to private medical information once it has left the hands of authorised physicians and other personnel involved in the facilitation of medical care, is fundamentally flawed. It fails to take into account an individual’s desire to control information about him or herself and to keep it confidential from others. It does not follow that an individual automatically consents to or expects the release of information to others outside the administration of health care. As appears from what has gone on before, there was nothing on the record to suggest that the applicants’ HIV status had become a

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194 The NM v Smith case, paragraph [39].
195 The NM v Smith case, paragraph [40] and the Tshabalala-Msimang case, paragraph [27].
196 The NM v Smith case, paragraph [41] and the Tshabalala-Msimang case, paragraph [27].
197 The NM v Smith case, paragraph [42].
198 The NM v Smith case, paragraph [43].
matter of public knowledge. The court also emphasised that there are in the case of HIV/AIDS special circumstances which justify the protection of confidentiality, bearing in mind that the disclosure of the condition has serious personal and social consequences for the sufferer. For example, such a person stands to be isolated and even rejected by others. In the present case, each of the applicants testified as to the several setbacks which occurred in their lives following the disclosure of their status. The first applicant had her shack burned down by her boyfriend who has since left her and broken off that relationship. The second applicant has withdrawn from the society for fear of being ostracised by her family. The third applicant has shied away and has not told members of her family about her condition which depresses her.

The protection of privacy, therefore in the view of the court, increased in every individual an expectation that he or she will not be interfered with. Indeed there must be a pressing social need for that expectation to be violated and in the person’s right to privacy interfered with. There was no such compelling public interest in this case. The Constitutional Court therefore came to the conclusion that, in disagreement with the decision of the High Court, the publication by respondents of the HIV status of the applicants’ names constituted a wrongful publication of a private fact and so the applicants’ right to privacy was breached by the respondents. Further, that the need for access to medical information must also serve a compelling public interest. The court finally concluded that, in the present case, highly personal and confidential material had been placed in the book and without the respondents having obtained the express informed consent of the applicants. The consent which the applicants had given earlier in the Strauss Report had the consumption of the facts in a book. This consent was limited to medical records and if any other publication was envisaged, the requisite consent had to be obtained for that particular publication.

The respondents clearly violated the dignity and privacy enjoyed by the applicants and were therefore liable to compensate the applicants in damages. The Constitutional Court then ordered the respondents to pay each applicant the sum of R35 000 each, and that the names of the applicants be deleted from all unsold copies of the book ‘Patricia de Lille’ by Charlene Smith and that in court each party should pay its own cost, including the costs in High Court.

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199 The NM v Smith case, paragraph [44].
200 The NM v Smith case, paragraph [63].
201 The NM v Smith case, paragraph [45].
202 The NM v Smith case, paragraph [47].
203 The NM v Smith case, paragraphs [80]-[82].
204 The NM v Smith case, paragraph [90].
This decision by the Constitutional Court was a victory for protection of the right to privacy and medical confidentiality of persons living with HIV/AIDS. The Court was correct in observing that when the applicants made the original application, they were not giving blanket consent that their names be published in a book which would in turn be distributed in all the bookshops of South Africa. This decision, therefore, has an implication for researchers and writers who are involved with persons living with HIV/AIDS that before they can publish the names of such persons in their articles or books, they must first ensure that they obtain clear written and informed consent allowing them to do so. If they fail to get such consent, they may expose themselves to legal action. The Court was also correct in holding that private and confidential medical information contains highly sensitive and personal information about individuals. It was further also correct in pointing out that the assumption that other people are allowed access to private medical information once it has left the hands of authorised medical practitioners and other personnel involved in the facilitation of medical care, is fundamentally flawed. This means that private medical information remains confidential even outside the healthcare context. This also means that even members of support groups, for instance, and other people, also need to be educated that if one of their members discloses his or her HIV status in their meeting, that does mean that they are given a blanket permission to inform other people outside such support group without an express permission from such a member for them to do so. Finally, it also seems that the Constitutional Court held the view that the right to privacy may be limited by a compelling public interest. However, the court found that in that specific case, such public interest did not exist.

Although the disclosure of private information in the public interest may be justified, it is sometimes difficult to know what is in the public interest. Furthermore, Rautenbach points out that the disclosure of information in the public’s interest is arguably the situation that creates the most anxiety among health care professionals and it is also the most difficult for which to provide practical guidelines. Disclosure of confidential information without consent may be justified where failure to do so may expose the patient or others to risk of death or serious harm, that is, where third parties are exposed to risks so serious that they may outweigh the

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205 As Jajbhay J, pointed out, in the case of Tshabalala-Msimang and Another v Makhanya and Others, that public interest it must be noted is a mysterious concept. Like a battered piece of string charged with elasticity, impossible to measure or weigh. The concept changes with the dawn of each day, tempered by the facts of each case. Public interest will naturally depend on the nature of the information conveyed and on the situation of the parties involved. Public interest is central to policy debates, politics and democracy. While it is generally acclaimed that promoting the common well-being or general welfare is constructive, there is little, if any, consensus on what exactly constitutes the public interest. Rautenbach 2004 The Southern African Journal of HIV Medicine 27.
patient’s right to privacy. There are, therefore, circumstances where the right to privacy may be limited by public interest, however, as indicated above, it is normally the courts which decide whether disclosure in the public interest is justifiable or not. Disclosure in the public interest will be discussed fully, below in chapter 4.

3.5 ETHICAL GUIDELINES OF THE MEDICAL PROFESSION AND THE OATH OF HIPPOCRATES

3.5.1 Ethical guidelines of the medical profession

Medical practitioners in South Africa are registered with the relevant professional body known as the Health Professions of South Africa (HPCSA) and are also bound to follow the ethical guidelines of this body. According to the Spirit of Professional Guidelines of the HPCSA: “Practice as a health care professional is based upon a relationship of mutual trust between patients and health care practitioners.”

Section 5 of the HPCSA Ethical Guidelines for Good Practice with Regard to HIV deals with confidentiality. Section 5 provides that:

5.1 Ethics, the South African Constitution and the law recognise the importance of maintaining the confidentiality of the HIV status of a patient.

5.2 The test results of HIV positive patients should be treated with the highest possible level of confidentiality.

5.3 Confidentiality regarding a patient's HIV status extends to other health care practitioners. Other health care professionals may not be informed of a patient’s HIV status without that patient’s consent unless the disclosure is clinically indicated. For treatment and care to be in the best interests of the patient, the need for disclosure of clinical data, (including HIV and related test results), to health care practitioners directly involved in the care of the patient, should be discussed with the patient.

5.4 The decision to divulge information relating to the HIV status of a patient must always be done in consultation with the patient.

5.5 The report of the HIV test results by a laboratory, as is the case with all laboratory test results, should be considered confidential information. A breach of confidentiality is more likely to occur in the ward, hospital or health care practitioner’s reception area than in the laboratory. It is, therefore, essential that health care practitioners protect the confidentiality of the report and any information subsequently derived from it.

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210 HPCSA Guidelines for Good Practice Booklet 12.
institutions, pathologists and health care practitioners formulate a clear policy as to how such laboratory results will be communicated and how confidentiality of the results will be maintained.

It is, therefore clear according to the Ethical Guidelines that doctors, nurses, other health care workers and staff that work in the hospital or healthcare practitioner’s workplace, such as a receptionist, are all bound by the duty of maintaining the confidentiality of the HIV status of a patient. It seems also to be clear that should there be a need to disclose the HIV status of the patient, this should always be done with the permission of the patient. Failure to do that may lead to a patient instituting legal action against the medical practitioner, unless as mentioned above, the doctor would disclose such HIV status in cases requiring prevention from criminal actions or for the protection of public health. Otherwise, the general rule is that the medical practitioners must treat and keep the confidentiality of their HIV positive patients with highest possible level of confidentiality. This duty of the medical practitioners to maintain the confidentiality of their patients of course derives from the Oath of Hippocrates.

3.5.2 The Oath of Hippocrates

Medical law authors and judges in common law seem to agree that the duty of medical confidentiality of the medical practitioners originated from the Oath of Hippocrates. In the Van Vuuren case, Harms AJA observed that as far as the public disclosure of private medical facts is concerned, the Hippocratic Oath, formulated by the father of medical science more than 2370 years ago, is still in use. It requires of the medical practitioner ‘to keep silence’ about information acquired in his professional capacity relating to a patient, ‘counting such things to be as sacred secrets.’ However, it is believed that the original oath was undoubtedly not written by Hippocrates, but the work was traditionally included in the Corpus Hippocratum, which is a collection of medical

212 See the Van Vuuren case at 848A, where the patient sued his doctor for breach of medical confidentiality.
214 Cameron 3 and Ouzounakis and Chalkias 2010 International Journal of Caring Sciences 1, Mason and McCall Smith 95 and the Van Vuuren case at 849H.
216 The Van Vuuren case at 849H.
writings credited to Hippocrates, written between the fifth and the fourth century, BC. In fact there seems to be evidence that this idea was firstly formally preserved in the Indian sub-continent, nearly 500 years before Hippocrates, and that the Hippocratic Oath has antecedents in other civilisations. However, the original oath is rarely read or recited nowadays, and the oaths taken these days are much altered and barely recognisable when compared to it. The original Oath read as follows:

I swear by Apollo Physician and Asclepius and Health and Panacea and all gods and goddesses, making them witnesses, that I will make complete this oath and this written covenant according to my ability and discernment:

- To regard my teacher of this art as equal to my parents and to share my livelihood (with him), and to make a contribution to him when he is in need of a debt, and to judge his offspring as equal to my brothers in manhood, and to teach this art – if they want to learn it – without wage and written covenant (to them) to make an imparting of the set of rules and lecture and all the rest of instruction to my sons and those of my teacher, and to those pupils who have been indentured and who have taken an oath according to the medical law, but to no one else.

- I will use diets for the assistance of the sick according to my ability and discernment; but also to keep away injury of health and injustice.

- I will neither give any deadly drug, having been asked for it, nor will I guide the same advice. Similarly, I will not give an abortifacient pessary to a woman. In purity and in holiness I will maintain my life and my art.

- I will not use the knife, not even on those suffering from the stone, but I will give way to those who are practitioners of this work.

- And as many houses as I may go into, I will go in for as assistance of the sick, being free from all voluntary injustice and mischief and the rest, even abstaining from sexual pleasures of both female and male persons, both free and slave.

- That which I may see or hear during treatment, or even outside of treatment concerning the life of men, which must not in any way be divulged outside, I will not speak, regarding such things to be unutterable.

And so may it be to me making complete my oath and not making it of no effect that I enjoy the benefits of my life and art and be honoured by all men for time eternal; but may it be opposite of this to me transgressing and swearing falsely.

The original Oath clearly prohibited many practices which are now either allowed or omitted in the present day oaths, practices such as abortions, euthanasia and surgeries. Herrell points out that the early version of the

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218. Cameron 3. See also the Van Vuuren case at 849-I, where Harms AJA cited Oosthuizen, Shapiro and Strauss Professional Secrecy in South Africa (1983) at 98 as stating that: 'In a work written in Sanskrit presumed to be about 800 BC Brahmin priests were advised to carry out their medical practices by concentrating only on the treatment of a patient when they entered a house and not divulging information about the sick person to anyone else. In ancient Egypt also the priestly medical men were under strict oaths to retain the secrets given to them in confidence. They worshipped in the temples of Isis and Serapis, a healer of the sick, and also of their son, Horus, who was usually called Harpocrates by the Greeks and pictured with his finger held to the mouth. The name for medicine, ars muta (dumb art), is used in Roman poetry by Virgil in Aeneid XII. The Pythagorean school in Greece, to which medical men especially belonged, considered silence as one of the most important virtues.'
Oath is seldom used today for several reasons of which some are that: (i) Few medical students today would take swearing by Apollo and Asclepius seriously; (ii) also, prohibitions of abortions and surgeries, as well as the unique financial arrangements and indenturements to the teacher and teacher’s family are far removed from modern medical ethics and the practical process of medical ethics and practical process of medical education.\textsuperscript{221} However, the Oath that is alleged to be bearing the name of Hippocrates seems to be different from the above mentioned original Oath and the modern versions that followed after are similar to it, albeit with some few differences.\textsuperscript{222} This Oath that ‘Bears the Name of Hippocrates’ reads as follows:

\begin{quote}
I do solemnly swear, by whatever each of us holds most sacred
That I will be loyal to the Profession of Medicine and just and generous to its members
That I will lead my life and practice my art in uprightness and honour
That into whatsoever house I will enter: it shall be for the good of the sick to the utmost of my power, my holding myself far aloof from wrong, from corruption, from the tempting of others to vice
That I will exercise my art solely for the cure of my patients, and will give no drug, perform no operation for a criminal purpose, even if solicited; far less suggest it
That whatsoever I shall see or hear of the lives of my patients which is not fitting to be spoken, I will keep inviolable secret
These things do I swear. Let each of us bow the head in sign of acquiescence
And now, if I will be true to this oath, may good repute ever be mine; the opposite, if I should prove myself forsworn.\textsuperscript{223}
\end{quote}

This Oath that is alleged to be bearing the name of Hippocrates is different from the original one in that it omits swearing using Apollo or Asclepius and also omits prohibition of abortions. As mentioned above, the modern version of the oath seemed to follow this Hippocrates Oath instead of the original version and an example of the modern version of the Hippocratic Oath is the one by the South African Medico-Legal Society\textsuperscript{224} which stipulates that:

\begin{quote}
In the name of God, Most compassionate, Most high, I do solemnly swear, by whatever I hold most sacred, that I will exercise the art of medicine solely for the cure of my patients, and will give no drug, perform no operation for a criminal purpose, even if solicited, far less suggest it; in like manner I will not give to a woman any kind of strange material to produce abortion, and I will maintain respect for human life from the moment of its conception.
That whatsoever I shall see or hear of the lives of men or women which is not fitting to be spoken, I will keep inviolable secret. I will not carry out moral judgment of any patient, but will deal with its diseases to the maximum of my capacity
\end{quote}

\textsuperscript{221} Herrell http://www.utilis.net/hippo.htm (visited 20 July 2011).
\textsuperscript{222} http://www.aapsonline.org/ethics/oaths.htm (visited 03 August 2011).
\textsuperscript{223} http://www.aapsonline.org/ethics/oaths.htm (visited 03 August 2011).
\textsuperscript{224} The South African Medico Legal Society The Hippocratic Oath http://new.saml.s.co.za/node/149 (visited 26 July 2011)
without concerning the circumstances. Knowing my own limitations and those of medicine in general, I will make an effort to
cure when possible and always comfort. I will only request studies if I believe that they have reasonable probability to
produce better results for my patients, and I will not carry out studies neither procedures nor surgery only for monetary gain.
I will freely refer my patients to other doctors if I am convinced that they are more enabled than I to treat a certain problem.

I will care for my patients and their families as I would have them care for me and my family. Into whatever houses I enter, I
will go into them for the benefit of the sick and will abstain from every voluntary act of mischief and or corruption; and, further
from the seduction of females or males. I will not experiment with patients unless they grant their consent after informing
them truthfully, and I will continue being a student all my professional life.

I will try to work like an expert for all my patients to be able to take care of them more indeed and to be able to apply the
lessons they provide to me in the care of other patients. I will offer care to all the patients who ask for it. No matter the sex,
race, colour, creed or economic status. I will voluntarily offer part of my time for the care of the poor and undeserved ones.
While I continue to keep this oath inviolated, may it be granted to me to enjoy the practice of the art of medicine, respected
by all men, at all times! But should I trespass or violate this oath, that God and society demand these violations against me.

It can be clearly observed that the South African Medico-Legal Society Oath, like the one that is alleged to bear
the name of Hippocrates, differs from the original version in that there is no longer swearing by the names of
Apollo, Asclepius or other gods or goddesses that were referred to in the past, but instead the oath refers to
God, the Almighty. However, there are some similarities that were kept from the original Oath, such as
prohibition of abortion and the keeping of confidentiality of the secrets that the doctor has heard from his or her
patients. The South African modern Oath and other modern versions have also followed the Hippocratic Oath of
the Declaration of Geneva of the World Medical Associations.\textsuperscript{225} What is strikingly common among these Oaths,
starting with the original version to the modern versions, is that they all agree that the secrets of the patients
which are not fitting to be spoken, must be kept secret. With the Declaration of Geneva Hippocratic Oath
stipulating that such secrets confided to the medical practitioners must be kept even after the patient has
died,\textsuperscript{226} This shows how important the Hippocratic Oath values the confidentiality of the medical information that
the patient confides to the doctor. This is the reason why ethically doctors are still required to maintain medical
confidentiality of their patients even today.\textsuperscript{227} And also, it is the reason why if medical practitioners violate this
ethical obligation with no justification, this may point to a breach of medical confidentiality.\textsuperscript{228}

\begin{itemize}
\item \textsuperscript{225} \url{http://www.aapsoline.org/ethics/oaths.htm} (visited 03 August 2011), this Declaration of Geneva Hippocratic Oath
reads as follows: I solemnly pledge myself to consecrate my life to the service of humanity; I will give my teachers the
respect and gratitude which is their due; I will practice my profession with conscience and dignity; The health of my patient
will be my first consideration; I will respect the secrets which are confided in me, even after the patient has died; I will
maintain by all the means in my power, the honour and the noble traditions of the medical profession; My colleagues will be
my brothers; I will not permit considerations of religion, nationality, race, party politics or social standing to intervene between
my duty and my patient; I will maintain the utmost respect for human life from its beginning even under threat and I will not
use my medical knowledge contrary to the laws of humanity; I make these promises solemnly, freely and upon my honour.
\item \textsuperscript{226} \url{http://www.aapsoline.org/ethics/oaths.htm} (visited 03 August 2011).
\item \textsuperscript{227} Cameron 3 and Ouzounakis and Chalkias 2010 \textit{International Journal of Caring Sciences} 1.
\item \textsuperscript{228} See the Van Vuuren case at 856G.
\end{itemize}
There is agreement from almost all the international and regional documents, codes and instruments around the world that the obligation of the medical practitioners to keep confidentiality of their patients’ health information continues even when such patients have died.\textsuperscript{229} The World Medical Association (WMA) Declaration of Geneva, for instance, stipulates that the physician must state that: “I will respect the secrets which are confided in me, even after the patient has died”\textsuperscript{230} and the Health Professions Council of South Africa (HPCSA) Guidelines for Good Practice, provides that health care practitioners still have an obligation to keep personal information confidential after a patient dies.\textsuperscript{231}

This doctor’s duty to maintain confidentiality even after the patient is dead is based on respecting the privacy of the patient, fidelity to the best interests of the patient, and maintaining public trust in medicine in generally.\textsuperscript{232} Unauthorised revealing of the HIV status or other medical information after death may affect the perceptions of others about the deceased patient or cause speculation, suspicion, or judgments regarding his or her character. Such illegal disclosure by the doctor would infringe the patient’s privacy and best interests.\textsuperscript{233} This therefore means that the duty of a doctor to keep confidential personal health information of his or her patients does not end when the patient dies, but it continues to exist even after such a patient has died.\textsuperscript{234}

Sperling points out that the question of whether there exists a privacy interest in one’s personal health information after death is not only theoretical, but also has important practical implications and also legal implications.\textsuperscript{235} The fact is that the personal health information of dead patients is normally required for various

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\textsuperscript{230} WMA \textit{Declaration of Geneva} 1983.

\textsuperscript{231} HPCSA \textit{Guidelines for Good Practice} Booklet 11, Section 9.5 (9.5.1).

\textsuperscript{232} The CEJA Report 1992.

\textsuperscript{233} The CEJA Report 1992.


\textsuperscript{235} Sperling 187.
\end{flushright}
purposes. Some of such uses are those for therapeutic purposes, for instance, providing treatment for relatives of the deceased or other parties in need; for research purposes, such as determining the cause of death or disease from which death resulted; as well as evidentiary and succession purposes. In the latter instance, medical information of a decedent who died testate may be sought by parties who would like to show that such decedent was of unsound mind when he or she made his or her last will and testament and it may also be required by insurers in relation to death benefits.

There seems to be no dispute, therefore, that the doctor-patient medical confidentiality does not die with the patient, but continues even after the death of such patient. What is interesting and controversial, however, is the contradiction that seems to exist between two international codes of the same international body, that is, the World Medical Association (WMA) which are International Code of Medical Ethics and the Declaration of Geneva, as to the extent such confidentiality of the patients should be kept by the doctors. The International Code of Medical Ethics, for instance, provides that: “A physician shall preserve absolute confidentiality on all he knows about his patient even after the patient has died.” The Declaration of Geneva, on the other hand, however, stipulates that the physician must state that: “I will respect the secrets which are confided in me, even after the patient has died.” As James and Leadbeatter point out, the International Code of Medical Ethics rejects any circumstance in which disclosure may be justified, which is an absolutist approach, whilst the Declaration of Geneva recognises that there are circumstances where disclosure may be justified. It is amazing that there seems to be this contradiction as these two codes are published under the auspices of the World Medical Association, however, these opposing opinions may be an indication of differing views within the medical profession and national practices.

There seems to be two schools of thought, at the one extreme, some argue strongly for absolute confidentiality, an argument that result, as in France, in a criminal offence if such confidentiality is violated. On the other extreme, some argue for the complete rejection of the duty of confidentiality. For the absolutists,

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236 Sperling 187.
237 Sperling 187.
238 WMA International Code of Medical Ethics 1983.
241 WMA International Code of Medical Ethics 1983.
244 Led by Kottow 1986 Journal of Medical Ethics 117-122.
Kottow argues and defends confidentiality as an exceptionless or absolute commitment on the part of the
doctors. Emson, however, refutes Kottow’s arguments of confidentiality being exceptionless or absolute. Whilst Emson agrees with Kottow that in its original form, as a medical value, confidentiality may have been absolute, he argues that this concept has become eroded by patient consent, legal actions and change in the climate of public opinion. According to him, the confidentiality of the doctor-patient relationship in societies deriving their law from English origins has been greatly modified by requirements arising out of legal statutes and common law judgments.

Despite this, however, he further argues that confidentiality remains a value that a physician must strive to preserve, although he cannot do this without considering its effect upon possible innocent third parties. According to Emson, confidentiality is no longer absolute, as Kottow claims, but whilst it is still important, it has now being modified by other circumstances, such as patient consent, legal actions and public opinion. Emson’s view seems to be the correct one which, as will be discussed below, are mirrored in many international documents and national ethical codes. A more radical approach against that of the absolutists is the view espoused by Warwick. Warwick argues that doctors need not accept any information in confidence. He argues that if no confidence is expected, the patient can decide whether or not his illness would merit a loss of privacy. He believes that acceptance of the principle of non-confidentiality of information revealed to medical practitioners would increase personal privacy and personal autonomy. This view of no confidentiality between the doctor-patient, however, does not seem to be possible as there are very important considerations in favour of the continuance of medical confidentiality, e.g. the interest of public health. Few patients would be willing in

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248 Kottow 1986 Journal of Medical Ethics 117, he further argues at 118 that, “In the case where a physician believes the patients exorbitant threats and alerts the police, a morally questionable principle becomes involved. The patient has sought the clinical encounter and proffered information on the understanding that this is necessary for an efficient therapy and also that the relationship with the physician is protected by a mantle of confidentiality. Confidence is offered and accepted in the medical profession, and known to be an indispensable component of the encounter, thus enticing the patient to deliver unbiased, unfiltered, uncensored and sincerely presented information. Consequently, it appears contradictory and perverse to offer confidentiality as an enticement to sincerity, only subsequently breach it because it cannot remain unpublicised. Confidence is understood as an unconditional offer, otherwise it would not be accepted, and it appears profoundly unfair to disown the initial conditions once the act of confiding has occurred.”


250 Emson 1988 Journal of Medical Ethics 87.

251 Emson 1988 Journal of Medical Ethics 87.


253 Warwick 1989 Journal of Medical Ethics 183.


255 Warwick 1989 Journal of Medical Ethics 185.
the present circumstances to consult doctors if they do not trust that their medical information will be kept confidential. Further, confidentiality is no longer absolute, as Emson correctly submits. This is not only the position in South Africa, but also in England, Wales and others.

In fact, as Yang points out, not every code around the world follows the absolutist approach that is advocated by the International Code of Medical Ethics. Many international codes and documents seem to follow the view held by the Declaration of Geneva which recognises that confidentiality of the dead patient is not absolute and that there are circumstances where disclosure may be justified. The Australian Medical Association (AMA) Code of Ethics, for instance, provides that the doctors must maintain their patients confidentiality, but that exceptions to this must be taken very seriously which may include where there is a serious risk to the patient or another person; where required by law; where part of approved research, or where there are overwhelming societal interests.

The Health Professions Council of South Africa (HPCSA), also, stipulates that the extent to which confidential information may be disclosed after a patient’s death depends upon the circumstances, which include the nature of the information, whether that information is already public knowledge or can be anonymised, and the intended use to which the information will be put. Health care practitioners are required to consider whether the disclosure of the information may cause distress to, or be of benefit to, the patient’s partner or family. It is therefore clear that the medical practitioner’s obligation to keep confidentiality of his or her patients’ health information continues even when such patients have died. However, such obligation to keep confidentiality is not absolute and may, depending on the circumstances, be disclosed.

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256 Emson 1988 Journal of Medical Ethics 87.
261 HPCSA Guidelines for Good Practice Booklet 11, Section 9.5. (9.5.1). Subsection 9.5.2 stipulates the circumstances under which health care practitioners may be asked to disclose or wish to use, information about their patients who have died such as: To assist with in connection with an inquest, as part of a clinical audit or for education research with approval of research ethics committee, on death certificates, to obtain information relating to public health surveillance and for insurance purpose or for the administration of the deceased estates’ purposes. See also General Medical Council Confidentiality: Protecting and Providing Information Section 30.


3.7 HOW DO THESE ETHICAL GUIDELINES IMPACT ON THE SPREAD OF HIV/AIDS IN CONSENSUAL SEXUAL RELATIONS IN CIVIL AND AFRICAN CUSTOMARY MARRIAGES?

The Recognition of Customary Marriages Act\textsuperscript{262} defines customary law as meaning the customs and usages traditionally observed among the indigenous African peoples of South Africa and which form part of the culture of those peoples.\textsuperscript{263} A customary marriage, therefore, is defined as meaning a marriage concluded in accordance with customary law.\textsuperscript{264} A customary marriage is recognised to be valid by section 3(1) of the Recognition of Customary Marriages Act, if it meets the following requirements: (a) the prospective spouses-(i) must both be above the age of 18 years; and (ii) must both consent to be married to each other under customary law; and (b) the marriage must be negotiated and entered into or celebrated in accordance with customary law.\textsuperscript{265} Customary marriages have also been characterised by the payment of \textit{lobolo} by the family of the husband to the family of the wife. \textit{Lobolo} is defined by the Recognition of Customary Marriages Act as the property in cash or in kind, whether known as \textit{lobolo}, \textit{bogadi}, \textit{lumalo}, \textit{thaka}, \textit{ikhazi}, \textit{magadi}, \textit{emabheka} or by other name, which a prospective husband or head of his family undertakes to give to the head of the prospective wife’s family in consideration of a customary marriage.\textsuperscript{266}

Customary marriage, therefore, has also been defined as an agreement between two families, with bridewealth as its object.\textsuperscript{267} However the Recognition of Customary Marriages Act, although it gives the definition of \textit{lobolo}, does not mention that it is requirement for a valid marriage.\textsuperscript{268} The implication created by this situation, therefore, would be that a customary marriage would be recognised to be a marriage if it complies with the requirements stated above, even if \textit{lobolo} is not paid. There had been a debate about the function and desirability of \textit{lobolo} which has continued into the twenty-first century, that \textit{lobolo} leads to the subordination of

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\item \textsuperscript{262} Recognition of Customary Marriages Act 120 of 1998 (hereafter referred to as Recognition of Customary Marriages Act 1998), Section 1.
\item \textsuperscript{263} See Herbst M and Du Plessis W “Customary law v Common law marriages: A hybrid approach in South Africa” 2008 (12;1) \textit{Electronic Journal of Comparative Law} 1-15, 3, who point out that African customary law in the modern sense of word denotes all those legal systems originating from African societies as part of the culture of particular tribes or groups that have been maintained, amended and or superseded in part by: (a) changing community views and demands of the changing world; (b) contact with societies with other legal systems; (c) contact with and influence of other legal systems; (d) the direct and indirect influence of foreign (non-indigenous) government structures.
\item \textsuperscript{264} Section 1 of the Recognition of Customary Marriages Act 1998.
\item \textsuperscript{265} Recognition of Customary Marriages Act 1998.
\item \textsuperscript{266} Section 1 of the Recognition of Customary Marriages Act 1998.
\item \textsuperscript{267} Bennet TW \textit{Customary Law in South Africa} (2004, Cape Town: Juta and Company Ltd) 220. See also Herbst and Du Plessis 2008 \textit{Electronic Journal of comparative Law} 7, who state that the validity of a customary marriage is based on the agreement to pay lobolo.
\item \textsuperscript{268} Herbst and Du Plessis 2008 \textit{Electronic Journal of comparative Law} 8.
\end{itemize}

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women. However, despite such debates many people still practise and support lobolo and very few people would be prepared to support its abolishment. Its symbolic functions remain a powerful force and lobolo has been and is still regarded as the rock on which the customary marriage is founded. In fact, in many African cultures where this custom is practised, lobolo has always been regarded as the link that builds and strengthens the relationship between the two families, that of the husband and wife.

Customary law, unlike civil or Christian marriages which are strictly monogamous, allows polygyny. This means that in customary marriages, men are allowed to marry as many wives as they wish and can afford. With each new marriage, the wife and her children establish a separate house. All the valid customary marriages which were entered into by a spouse in more than one customary marriage, before or after the commencement of the Recognition of Customary Marriages Act are recognised to be marriages, provided they comply with the provisions of the Act. The problem of polygyny when it comes to the issue of HIV/AIDS, is that it creates an environment where if one partner in a polygynous union is infected, the male partner would distribute the disease to all the partners he sleeps with in the marriage. This would lead to a spread of HIV/AIDS. Polygyny, therefore, is a risky social or cultural practice as far as vulnerability to HIV infection is concerned, though however, there is no evidence that it leads to a higher rate of infection than monogamy which is practised by couples in civil marriages. Polygyny is feasible in the context of the HIV/AIDS pandemic if all the partners in the marriage are faithful. This would mean, therefore, that in order to fight the spread of HIV/AIDS, whether in a monogamous civil marriage or in polygynous customary marriage, couples must always be encouraged to be faithful to one another.

Bennet 224. See also Izama CMM The HIV/AIDS Problem and Customary Marriages among the Baganda in Uganda: A Discussion of Some Aspects of Customs, lived reality and HIV/AIDS (unpublished Master's Degree in Women’s Law long essay) 7, who points out that bride wealth confers a subordinate status on women and leaves them vulnerable to a legal system that does not recognise their status as wives when bride wealth has not been paid. Bennet 224.

Bennet 221.


Izama 8.

Izama 8.

Izama 8.
Customary marriages are also characterised by patriarchy, which denotes the authority and the range of special rights and privileges enjoyed by senior males.\textsuperscript{279} By implication, this means that all women are subordinate and according to tradition, the husband, as the head a conjugal unit, may expect his wife to be meek and obedient.\textsuperscript{280} However over time, as a wife proved her worth, her status improved and finally in old age, the significance of gender differences was quietly forgotten.\textsuperscript{281} Nowadays, it could be argued that the status of women has significantly improved by virtue of section 9 of the Constitution\textsuperscript{282} which elevated all women to be equal to their husbands. This, however, does not mean that all women in South Africa in practical terms are equal to their husbands. In some parts of the country patriarchy and unequal gender relationships still exist.

As Izama points out in terms of women’s control of their sexuality in marriage, customary norms weigh heavily against them and controlling their own sexual life in marriage.\textsuperscript{283} Women are normally socialised by older women to indulge their husbands whenever they want sex, as failure to do so would drive the husband into other women’s arms. Women normally do not initiate sex and so cannot insist on condom use in marriage as a strategy for the prevention of infection against diseases, including HIV.\textsuperscript{284} Neither are they able to abstain for long periods from sex, except when they are separated from their husbands and usually sex is regarded as a hidden or private thing and discussions about it is taboo. When husbands migrate to towns or mine for work and come back after a long period of time, wives are still powerless to insist on protected sex.\textsuperscript{285} All these factors may assist in the spreading of HIV/AIDS. To compound this situation, this position is exacerbated by the strong emphasis on health care practitioners maintaining confidentiality of a patient’s HIV status. As discussed above, these guidelines emphasise the importance of the maintenance of confidentiality of the HIV status of the patient. Section 5(5.1) of the Health Professions of South Africa (HPCSA)\textsuperscript{286} provides that “[e]thics, the South African Constitution and the law recognise the importance of maintaining the confidentiality of the HIV status of a patient.” The application of the ethical guidelines, although not legally binding and although protecting a patient from unwarranted disclosure of his or her HIV status, may, however, by emphasising confidentiality and patient autonomy at almost all costs, have the unintended and inadvertent consequence of exposing the sexual partner

\textsuperscript{279} Benet 248.
\textsuperscript{280} Benet 243.
\textsuperscript{281} Benet 249.
\textsuperscript{282} Section 9 of the Constitution of the Republic of South Africa Act 108 of 1996.
\textsuperscript{283} Izama 5.
\textsuperscript{284} Izama 5.
\textsuperscript{285} Izama 5.
\textsuperscript{286} HPCSA Guidelines for Good Practice Booklet 12.
of the infected person to the virus, whether they are in a relationship, civil or customary union or not. The duty to disclose one’s HIV status is clearly that of the HIV-positive person himself or herself.

This thesis seeks to illustrate that a more nuanced approach to medical confidentiality is necessary; one that will recognise the unique context in which HIV in South Africa is transmitted and the factors that contribute to or assist in the spreading of the virus. Interventions, such as partner-notification, which will be discussed and submitted under chapter 4, below, become important in such situations in order to protect the ignorant uninfected partners and to curb the spread of HIV/AIDS. It will also be for the same reason that chapter four will discuss that although medical confidentiality may be limited in exceptional circumstances, as argued above, HIV-infection poses novel challenges that requires a different approach. How such an approach should be framed, will be discussed in the chapters that follow.287

3.8 CONCLUSION

The rights to privacy, confidentiality and also medical confidentiality have been shown to be one of the most important rights to persons living with HIV/AIDS, especially considering that despite constitutional protection, stigmatisation and discrimination against persons living with HIV/AIDS remain. These rights enable persons living with HIV/AIDS to control their health information and determine to whom they can disclose their HIV positive status and if they want to disclose such status. All these rights, however, are not absolute and they can be modified by circumstances such as the patient consent, legal actions, statutes and the protection of public health. Medical practitioners who have an obligation to keep confidential their patients personal health information are also governed by ethical guidelines of their professional bodies. The ethical guidelines emphasise the importance of maintaining confidentiality of patients’ information.

Despite the importance of maintaining the confidentiality of patient information, this chapter has argued that the context of HIV requires a different approach that will strike a balance between protecting the patient from unwarranted disclosure of his or her HIV status, yet also protect the ignorant sexual partners of these persons in

287 See Sunday Sun of 6 July 2008 page 1. (The paper depicted this as “My Deadly Secret”). This paper reported about a guy who four years ago tested for HIV, but never told his wife. And he still continued to have sex with her whilst he knew that he was HIV positive.
instances where the infected person decides not to disclose his or her HIV status to these partners. Such an approach should take cognisance of varied social and cultural factors that influence perceptions and attitudes relating to the disclosure of a person’s HIV status.
CHAPTER 4

THE LIMITATION OF THE RIGHTS TO PRIVACY, CONFIDENTIALITY AND MEDICAL CONFIDENTIALITY

4.1 INTRODUCTION

The rights contained in the Bill of Rights of the South African Constitution\(^1\) are not absolute.\(^2\) All the rights and liberties in the Bill of Rights are limited by the limitation clause, section 36.\(^3\) It is generally accepted in international law, the domestic law of most states, and according to international and other human rights instruments, that only a very few number of rights, if any, are absolute.\(^4\) These rights include freedom from torture, the abuse and exploitation of children and possibly freedom from servitude, freedom of conscience, belief, thought and opinion.\(^5\) The majority of human rights and liberties, therefore, are of necessity restricted by the inherent duty, which should be perceived as the inextricable counterpart of a corresponding right, to respect the rights of others.\(^6\) In South Africa, however, as Mureinik points out,\(^7\) there are no rights in the Bill of Rights which are absolute, not even the rights to freedom from torture and servitude.\(^8\) In fact, in the case of *S v Williams*,\(^9\) the question of whether there are indeed any rights, which despite the apparent universality of the limitation clause could not be limited, was left open by the Constitutional Court.\(^10\) It must, however, be noted

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5. Devenish 179.
6. Currie & De Waal 163 and Devenish at 179, who points out that, the classical example in this regard is that freedom of speech does not allow one person to defame another nor would it sanction a person shouting ‘fire’ in a full theatre when there is no fire.
7. See Devenish 179, who points out that Mureinik gave no explanation why there are no rights which are absolute.
10. Devenish 179. In this *Williams* case, paragraphs [55-56], the Constitutional court observed that applicants had
that section 36 only limits the rights contained in Bill of Rights and does not limit other rights which are directly or indirectly granted elsewhere in the Constitution. The right to privacy (and hence also confidentiality and medical confidentiality), is therefore limited by section 36 of the Constitution. This chapter will examine the limitation of the rights to privacy, confidentiality and medical confidentiality by the limitation clause, section 36 of the Constitution.

4.1.1 Meaning of limitation

Currie and De Waal describe a ‘limitation’ as a synonym for ‘infringement’ or possibly a justifiable infringement. A law that limits a right violates that right. Such violation, however, will not be unconstitutional if it takes place for the reason that is accepted as a justification for infringing rights in an open and democratic society based on human dignity, equality and freedom. It follows, therefore, that not all violations of fundamental rights are unconstitutional, for instance, where a violation can be justified in accordance with the criteria in section 36, it will be held to be constitutionally valid.

\[\text{Currie & De Waal 163. See also the case of Van Rooyen and Others v S and Others (General Council of the Bar of South Africa Intervening) 2002 (5) SA 246 (CC) paragraph [35], where the constitutional court observed that institutional independence itself is a constitutional principle and norm that goes beyond and lies outside the Bill of Rights. The provisions of section 36 of the constitution dealing with the limitation to rights entrenched in the Bill of Rights are accordingly not applicable to it. Judicial independence is not subject to limitation. This observation by the constitutional court in this case seems to be the correct view in that section 36(1) stipulates that the rights in the Bill of Rights may be limited and does not talk about other rights. However, this observation by the court is controversial in the sense that it gives the implication that other rights that are granted elsewhere in the constitution and not in the Bill of rights, may, therefore be regarded as absolute rights. This is so because, there seems to be no other limitation in the constitution except the limitation clause which is section 36. It follows, therefore, that if these rights are not subject to section 36, the conclusion that may be drawn would be that they are absolute rights. However, these rights may still be limited through the courts as is the case with the United States constitution which, as Cheadle, Davis and Haysom point out at 695, that though it does not have limitation clause and the rights are stated in absolute terms, nevertheless the courts have always balanced the constitutional rights and social interests using the scope of the right and the threshold levels of scrutiny to manage the conflict. See also S v Makwanyane 1995 (3) SA 391 (CC) (hereafter referred to as the Makwanyane case) paragraph [100]. The Constitution of 1996 and The Bernstein v Bester case, paragraph [67].}

\[\text{Currie & De Waal 164.}
\[\text{Currie & De Waal 164.}
\[\text{Currie & De Waal 164.}
4.2 THE LIMITATION CLAUSE

Section 36 of the Constitution provides that:

(1) The rights in the Bill of Rights may be limited only in terms of the 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 the extent of the limitation;
(d) The relation between the limitation and its purpose; and
(e) Less restrictive means to achieve the purpose.

(2) Except as provided in subsection (1) or in any other provision of the constitution, no law may limit any right entrenched in the Bill of Rights.

The main function of the limitation clause has been said to be the clear recognition that the constitutional rights are not absolute and that they may be limited by law giving effect to social interests, as expressed by a democratically elected legislature. The other function of a limitation clause is to provide a basis by which a majority in a democracy can have its political will, but only within the framework which demands that the exercise of all political power is subject, at the very least, to rational justification. By doing that, the limitation clause provides a template not only for the courts but, also for the legislature and it provides a common platform for dialogue between the courts and the legislature. Finally, the limitation clause also determines what and who can limit the rights. It is, however, important to note that the fact that there is a general limitation clause of the rights in the Bill of Rights does not mean that the rights can just be limited for any reason whatsoever. The reason needs to be exceptionally strong and serve a compelling purpose. Furthermore, in order for the limitation to be justifiable, there must be a good reason for thinking that it would achieve the purpose it is designed to achieve, and that there is no other realistically available manner in which the purpose can be

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17 The Constitution of 1996.
19 Cheadle, Davis and Haysom 695, Mureinik 1994 SAJHR 35 and Currie & De Waal 163.
20 Cheadle, Davis and Haysom 695.
21 Cheadle, Davis and Haysom 695.
22 Cheadle, Davis and Haysom 695.
23 Currie & De Waal 164.
24 Currie & De Waal 164.
achieved without limiting the rights.\textsuperscript{25} This was emphasised in the case of \textit{S v Manamela},\textsuperscript{26} where the Constitutional court pointed out that as a general rule, the more serious the impact of measure on the right, the more persuasive or compelling the justification must be. Ultimately the question is one of degree to be assessed in the concrete legislative and social setting of the measure, paying due regard to the means which are realistically available in the country at this stage, but without losing sight of the ultimate values to be protected.\textsuperscript{27} Also, in the case of \textit{S v Williams},\textsuperscript{28} in finding the provisions which infringed the rights in issue to be unconstitutional, the Constitutional court held that although the provision concerned is a law of general application, the limitation it imposes on the rights in question is, in the light of all the circumstances, not reasonable, not justifiable and it is furthermore not necessary.\textsuperscript{29} This means that the limitation clause puts a very stringent test for limiting the rights, in that not just any reason may be used to limit the rights in the Bill of Rights, but a very important and a convincing reason is required.

The limitation clause is general in that it applies to all the rights in the Bill of Rights and stipulates that all the rights may be limited in accordance with the same set of criteria.\textsuperscript{30} This general limitation clause differentiates the South African Constitution from other Bills of Rights and international rights documents, such as the United States Constitution, which does not have a limitation clause\textsuperscript{31} and the German Basic Law which does not have a general limitation clause, but which attaches specific limitation provisions to many of the fundamental rights.\textsuperscript{32} The South African Bill of Rights adopted the general limitation clause from its principal model, the Canadian Charter of Rights and Freedoms, which has a list of rights and a general limitation clause governing the limitation of those rights.\textsuperscript{33} The inclusion of this general limitation clause in the Bill of Rights also means that the process of limitation must be differentiated from the process of interpretation of the rights, and in this manner, the Bill of Rights involves a two-stage approach: The first is to determine whether the right in question is violated by a law or conduct of the respondent; and secondly (which normally depends on an affirmative answer

\begin{itemize}
  \item \textsuperscript{25} Currie & De Waal 164.
  \item \textsuperscript{26} \textit{S v Manamela} 2000 (3) SA 1 (CC) (hereafter referred to as \textit{The Manamela case}).
  \item \textsuperscript{27} \textit{The Manamela} case, paragraph [32].
  \item \textsuperscript{28} \textit{The Williams} case.
  \item \textsuperscript{29} \textit{The Williams} case, paragraph [92].
  \item \textsuperscript{30} Currie & De Waal 165.
  \item \textsuperscript{31} See \textit{The Makwanyane} case, paragraph [100], where the constitutional court observed that the South African Constitution differs from the constitution of the United States, which does not contain a limitation clause, as a result of which the courts in that country have been obliged to find limits to constitutional rights through a narrow interpretation of the rights themselves. See also Cheadle, Davis and Haysom 695.
  \item \textsuperscript{32} Currie & De Waal 165.
  \item \textsuperscript{33} Cheadle, Davis and Haysom 695, Currie & De Waal 165 and \textit{S v Zuma and others} 1995 (2) SA 642 (CC) (hereafter referred to as \textit{The Zuma case}), paragraph [21].
\end{itemize}
of the first question), to determine whether the violation can be justified as a permissible limitation of the right.\textsuperscript{34} The second stage concerns the justification for the limitation, the application of section 36(1).\textsuperscript{35}

This two-stage approach was adopted and emphasised by the Constitutional court in the case of \textit{S v Zuma and Others},\textsuperscript{36} where the court pointed out that the Canadian cases on reverse onus provisions seem to be particularly helpful, not only because of their persuasive reasoning, but because section 1 of the Charter has a limitation clause analogous to section 33 of the South African interim Constitution and this called for a ‘two-stage’ approach.\textsuperscript{37} First, has there been a contravention of a guaranteed right? If so, is it justified under the limitation clause? The single stage approach (as in the United States constitution or Hong Kong Bill of Rights) may call for a more flexible approach to the construction of the fundamental right, whereas the two-stage approach may call for a broader interpretation of the fundamental right, qualified only at the second stage.\textsuperscript{38} The two-stage approach will next be discussed.

\subsection*{4.2.1 Two-staged approach}

\subsubsection*{4.2.1.1 Whether the right in question is infringed by a law or conduct of the respondent}

The first stage of the enquiry is to determine whether a law or conduct of the respondent has infringed a right of the applicant.\textsuperscript{39} The court must determine the scope of the rights by the process of interpretation and there are two approaches to the task.\textsuperscript{40} The first is that the rights be given the broadest possible scope within the bounds

\begin{thebibliography}{99}
\bibitem{35} Section 36(1) of the Constitution of 1996.
\bibitem{36} See \textit{The Zuma} case, paragraph [21] and \textit{Ferreira v Levin NO and others} and \textit{Vryhenhoek v Powell NO and others} 1996 (1) SA 984 (CC) (hereafter referred to as \textit{The Ferreira and Vryhenhoek} case), paragraph [44]. Note that the \textit{Zuma} case, seems to have followed and adopted the ruling of the Canadian case of \textit{R v Oakes} [1986] 1 S.C.R. 103, paragraphs [9] and [14], where the court expressed the view that to determine whether a particular reverse onus provision is legitimate, Martin J.A. outlined a two-pronged enquiry. Two specific questions are raised: (1) does s. 8 of the Narcotic Act violate s. 11 of the Charter; and, (2) if it does, is s. 8 a reasonable limit prescribed by law as can be demonstrably justified in a free and democratic society for the purposes of s. 1 of the Charter?
\bibitem{37} \textit{The Zuma} case, paragraph [21].
\bibitem{38} \textit{The Zuma} case, paragraph [21].
\bibitem{39} Currie & De Waal 166, Devenish 183, Cheadle, Davis and Haysom 696, \textit{The Zuma} case, paragraph [21] and \textit{The Ferreira and Vryhenhoek} case, paragraph [44]. See also the case of \textit{Hoffmann v South African Airways} 2000 (11) BCLR 1235 (CC) (hereafter referred to as \textit{The Hoffmann} case), paragraph [41], where the constitutional court held that the refusal by \textit{SAA} to employ the appellant as a cabin attendant because he was HIV-positive violated his right to equality guaranteed by section 9 of the Constitution.
\bibitem{40} Cheadle, Davis and Haysom 698 and Currie & De Waal 166.
\end{thebibliography}
of the text.\(^{41}\) This approach argues that any limitation of the application of the right should be reserved for the limitations enquiry under section 36. If the text is wide and general enough to encompass the full range of interests, the scope of the right will accordingly be wide.\(^{42}\) Under this approach, for instance, freedom of speech includes all speech, whether insulting or defamatory or hate speech, (subject of course to the narrowing of the scope of hate speech in section 16(2)).\(^{43}\)

The alternative approach is to define the constitutionally protected interest advanced by the right. That interest may be narrower than a literal interpretation of the text and may be determined by hermeneutic exercise based on the text, the context and the foundational values.\(^{44}\) This approach has been endorsed by the Constitutional court.\(^{45}\) This approach entails an analysis of the text in its context, namely the historical background to both the Constitution and the right, the reason for the inclusion as a constitutional right, the concepts enshrined in the right and their legal elaboration under both South African law and comparative law, the other provisions of the Constitution, in particular the other constitutional rights, and the foundational values.\(^{46}\) Under this approach, for instance, the right to freedom of expression may be held not to include hate speech, or the right to freedom of association not to include terrorist organisations or crime syndicates.\(^{47}\) However, Cheadle, Davis and Haysom\(^{48}\) argue that the courts should engage in rights analysis on the understanding that there is no need to shape the contours of the right in order to accommodate pressing social needs and that the rights analysis should not be a proxy for the limiting of rights. The first stage, therefore, of inquiry is for the court to determine whether the right in question was violated or not. If the court finds that the right in question was not violated, then the case ends there. However, if the court finds that a law infringed a constitutional right, then, the second stage is triggered. This means that the onus will now shift to the defendant to prove to the court that though the law had infringed a constitutional right, however, such infringement is justified under section 36 of the Constitution.

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\(^{41}\) Cheadle, Davis and Haysom 698.  *The Zuma* case, paragraph [18], seems to have adopted this approach.

\(^{42}\) Cheadle, Davis and Haysom 698.

\(^{43}\) Cheadle, Davis and Haysom 698.

\(^{44}\) Cheadle, Davis and Haysom 698.

\(^{45}\) Cheadle, Davis and Haysom 698.  See also *The Ferreira and Vryenhoek* case, paragraph 46, where the constitutional court, pointed out that this court has given its approval to an interpretive approach ‘which, whilst paying due regard to the language that has been used, is generous and purposive and gives expression to the underlying values of the constitution.’

\(^{46}\) Cheadle, Davis and Haysom 698.

\(^{47}\) Cheadle, Davis and Haysom 698.

\(^{48}\) Cheadle, Davis and Haysom 699.
4.2.1.2 Whether the violation can be justified as a permissible limitation of the right

The law that limits the rights in the Bill of Rights will be justifiable, according to section 36(1) of the Constitution, only if it is a law of general application which is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom.\textsuperscript{49} This justification will now be discussed in detail below.

4.2.1.2.1 Law of general application

Rights may only be validly limited by a law of general application.\textsuperscript{50} A limitation of a right must have its source in a law of general application and it cannot be located in an executive act or policy, unless an authorising law permits such limitation.\textsuperscript{51} A limitation must be authorised by a law, and the law must be of general application.\textsuperscript{52} The law of general application requirement is the expression of a basic principle of liberal political philosophy and of constitutional law known as the rule of law and there are two components to this principle.\textsuperscript{53} The first is that the power of the government derives from the law. The government must have lawful authority for all its actions otherwise it will not be a lawful government.\textsuperscript{54} It should be noted, however, that the fact that a law does not apply to all persons does not mean that it is not a law of general application.\textsuperscript{55} It may be limited to an area, category of persons, or subject matter. Provided that its application is not arbitrary or personal, the law will be a law of general application, which includes legislation, subordinate legislation, the common law and customary law.\textsuperscript{56} This requirement of the law of general application was clearly illustrated in the case of \textit{August v Electoral Commission},\textsuperscript{57} where the issue before the Constitutional court concerned the voting rights of prisoners. The appeal in this case arose out of the fact that the High court had held that the Electoral Commission (The Commission) had no obligation to ensure that awaiting trial and sentenced prisoners may register and vote in the general elections which had been announced on 2 June 1999.\textsuperscript{58} The 1996 Constitution, according to the Court, provided that one of the values on which the one, sovereign and democratic state of the Republic of South Africa was founded, was ‘[u]niversal and adult suffrage’ and ‘a national common voters’ roll.’ It continued

\textsuperscript{49} The Constitution of 1996.
\textsuperscript{50} Currie & De Waal 168, Cheadle, Davis and Haysom 702 and Devenish 180.
\textsuperscript{51} Cheadle, Davis and Haysom 702 and Devenish 180.
\textsuperscript{52} Currie & De Waal 168 and Devenish 180. See also The Hoffmann case, paragraph [41], where the constitutional court held that the refusal by SAA to employ the appellant as a cabin attendant because he was HIV-positive violated his right to equality guaranteed by section 9 of the Constitution. Further, that the third enquiry, namely whether this violation was justified, did not arise as the court was not dealing with a law of general application.
\textsuperscript{53} Currie & De Waal 168, Cheadle, Davis and Haysom 702 and Devenish 180.
\textsuperscript{54} Currie & De Waal 168.
\textsuperscript{55} Cheadle, Davis and Haysom 702.
\textsuperscript{56} Cheadle, Davis and Haysom 702 and Currie & De Waal 169.
\textsuperscript{57} \textit{August v Electoral Commission} 1999 (3) SA 1 (CC) (hereafter referred to as The August case).
\textsuperscript{58} \textit{The August} case, paragraph [1].
to state that 'every adult citizen had the right to vote in elections for the legislative body established in terms of the Constitution, and to do so in secret'. Further that, unlike the interim Constitution, however, the above sections contained no provision allowing for disqualifications from voting to be prescribed by law. Accordingly, if parliament sought to limit the unqualified right of adult suffrage entrenched in the Constitution, it would be obliged to do so in terms of a law of general application which met the requirements of reasonableness and justifiability as set out in section 36. Parliament, according to the Court, had not sought to limit the right of prisoners to vote through the Electoral Act, as prisoners were not included in the list of disqualified persons.

The Constitutional court held that in the absence of a disqualifying legislative provision, it was not possible for the respondents to seek to justify the threatened infringement of prisoners' rights in terms of section 36 of the Constitution, as there was no law of general application upon which they could rely to do so. The court then ordered the Electoral Commission, amongst others, to make all reasonable arrangements necessary to enable the applicants and other prisoners to vote in those general elections. The Constitutional court was correct in this view, because denying the prisoners their constitutional right to vote by the Commission, without any law of general application authorising it to do so, was tantamount to undermining the rule of law. The second aspect of the rule of law relates to the character or quality of the law which authorises a particular action. The law must be general in its application and this means that the law must be sufficiently clear, accessible and precise that those who are affected by it can ascertain the extent of their rights and obligations. On a substantive level, it means that, at a minimum, the law must apply impersonally, it must apply equally to all and it must not be arbitrary in its application. The law of general application requirement in section 36 therefore prevents laws that have personal, unequal or arbitrary application from qualifying as legitimate limitations of rights. This was emphasised in the case of S v Makwanyane, where the Constitutional court pointed out that South Africa had moved from the past, characterised by much which was arbitrary and unequal in the operation of the law, to a present and a future in a constitutional state where the state action must be such that it is capable of being

59 The August case, paragraph [3].
60 The August case, paragraph [3].
61 Electoral Act 73 of 1998 (hereafter referred to as the Electoral Act).
62 The August case, paragraph [4].
63 The August case, paragraph [23].
64 The August case, paragraph [42].
65 Currie & De Waal 168.
66 Currie & De Waal 169 and Cheadle, Davis and Haysom 703.
67 Currie & De Waal 168.
68 The Makwanyane case, paragraph [156].
analysed and justified rationally.\textsuperscript{69}

The idea of the constitutional state presupposes a system whose operation can be rationally tested against or in terms of the law. Arbitrariness, by its very nature, is dissonant with these core concepts of the new constitutional order. Neither arbitrary action nor laws or rules which are inherently arbitrary or must lead to arbitrary application can, in any real sense, be tested against the precepts or principles of the Constitution.\textsuperscript{70} Arbitrariness must also inevitably, by its very nature, lead to the unequal treatment of persons. Arbitrary action or decision-making is incapable of providing a rational explanation as to why similarly placed persons are treated in a substantially different way. Without such a rational justifying mechanism, unequal treatment must follow.\textsuperscript{71} The law that limits a right must be a law of general application, apply to all people equally and be not arbitrary, in order for it to qualify as a justifiable limitation.

4.2.1.2.2 Approach generally

The limitation clause requires any infringing law to be reasonable and justifiable in terms of section 36(1).\textsuperscript{72} The determination of reasonableness and justifiability must be conducted in a context, in an open and democratic society based on human dignity, equality and freedom and in the light of all relevant factors.\textsuperscript{73} The limitation of fundamental rights, therefore, as sanctioned by section 36, involves a judicious weighing up of competing societal and ethical values, using an assessment based on proportionality.\textsuperscript{74} This view was emphasised in the case of \textit{S v Makwanyane},\textsuperscript{75} where the court observed that the limitation of rights for a purpose that is reasonable and necessary in a democratic society involves the weighing up of competing values, and ultimately an assessment based on proportionality.\textsuperscript{76} Different rights have different implications for democracy, and therefore, also for our body politic, premised as it is on “an open and democratic, society based on freedom and equality, with the result that “there is no absolute standard which can be laid down for determining reasonableness and necessity”.\textsuperscript{77} Principles must therefore be established and articulated, but the application of these to particular circumstances can be assessed on a case by case basis. It, therefore, follows that reasonableness and

\begin{footnotesize}
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\item[\textsuperscript{69}] The \textit{Makwanyane} case, paragraph [156].
\item[\textsuperscript{70}] The \textit{Makwanyane} case, paragraph [156].
\item[\textsuperscript{71}] The \textit{Makwanyane} case, paragraph [156].
\item[\textsuperscript{72}] See \textit{Prince v President of the Law Society, Cape of Good Hope and Others} 1998 (8) BCLR 976 (C), where the court held that for all the reasons, including the strong body of foreign judicial decisions, the inroads made by section 4(b) of the Drugs Act into the exercise by the applicant of his religious observations, is in the judgment of the court justified by section 36(1) of the constitution.
\item[\textsuperscript{73}] Cheadle, Davis and Haysom 703 and Currie & De Waal 176.
\item[\textsuperscript{74}] Cheadle, Davis and Haysom 703 and Currie & De Waal 176.
\item[\textsuperscript{75}] The \textit{Makwanyane} case, paragraph [104].
\item[\textsuperscript{76}] The \textit{Makwanyane} case, paragraph [104].
\item[\textsuperscript{77}] The \textit{Makwanyane} case, paragraph [104].
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justification of the limitation of rights will be determined by the courts having weighed and balanced all the facts of the case and determined which right weighs heavier than the other. In terms of section 36, therefore, all rights in the Bill of Rights may be limited provided that the law limiting the rights will be reasonable and justifiable in an open and democratic society and such law must be a law which applies to all people.

4.3 NATIONAL HEALTH ACT ON THE LIMITATION OF RIGHTS TO PRIVACY AND CONFIDENTIALITY

The National Health Act, section 14, deals with the right to confidentiality and section 15 deals with access to health records. Section 14 provides that:

- (1) All information concerning a user, including information relating to his or her health status, treatment or stay in a health establishment is confidential.
- (2) Subject to section 15, no person may disclose any information contemplated in subsection (1) unless-
  - (a) the user consents to that disclosure in writing;
  - (b) a court order or any law requires that disclosure; or
  - (c) non-disclosure of the information represents a serious threat to public health.

Section 15, on the other hand, provides that:

- (1) A health worker or any health care provider that has access to the health records of a user may disclose such personal information to any other person, health care provider or health establishment as is necessary for any legitimate purpose within the ordinary course and scope of his duties or her duties where such access or disclosure is in the interests of the user.

Section 14(2) (b) and section 14(2)(c) therefore limit the rights to privacy and confidentiality of a patient. It is clear according to sections 14(2)(b) and 14(2)(c) that a patient’s health information may not be disclosed unless a court order requires the disclosure or that non-disclosure of the information would cause a serious threat to public health. It follows, therefore, that in circumstances where a court requires a disclosure of a patient’s health information, his or her right to privacy will be limited by the health care worker’s disclosure of such health information to the court. Furthermore, where a healthcare worker is of the opinion that non-disclosure of health information of a patient would pose a serious threat to the public, he or she can limit the rights to privacy and confidentiality of such a patient by disclosing his or her health status. Section 15(1) also allows health care workers to disclose personal health information of a patient to any other person, health care provider or health

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78 The National Health Act 61 of 2003 (hereafter referred to as The Health Act 2003).
establishment, if such a disclosure is in the interest of such a patient and by so doing such health care workers would be limiting the rights to privacy and confidentiality.

4.3.1 Regulations made in terms of the National Health Act on notifiable communicable diseases

The National Health Act, Regulations Regarding Communicable Diseases,\(^\text{80}\) regulation 12, stipulates that:

The Minister may, after consultation with the National Health Council, declare by Notice in the Government Gazette any disease to be a notifiable communicable disease if in his or her opinion such a disease:

(a) poses a serious threat to an entire or part of a population of a particular province or the Republic;

(b) may require immediate, appropriate and specific action to be taken by the national department, one or more provincial departments and/or one or more municipalities;

(c) may be regarded as a public health emergency of international concern or a public health risk;

and may determine that-

(i) on application of a province, any disease other than a notifiable communicable disease under (a) and (b), be declared notifiable within a province or district for a period specified in the notice or until the notice is withdrawn;

(ii) certain diseases be notifiable in certain provinces or certain municipalities;

(iii) certain diseases be notifiable by certain categories of health care workers; and

(iv) specific diagnostic or laboratory criteria apply to specific diseases for notification.

It should, however, be noted that HIV/AIDS is not listed as a notifiable communicable disease in Annexure A of the National Health Act, Regulations Regarding Communicable Diseases.\(^\text{81}\) It follows therefore that HIV/AIDS is not a notifiable disease in South Africa and may not be reported to health authorities as contemplated by regulation 13(1).\(^\text{82}\) The question of whether HIV/AIDS should be made a notifiable disease in South Africa, as some seem to suggest,\(^\text{83}\) will be discussed in detail, under 5.5 below.

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\(^{80}\) The Health Act 2003, Regulations Regarding Communicable Diseases (GG 33107 of 13 April 2010) (hereafter referred to as Regulations Regarding Communicable Diseases).

\(^{81}\) Regulation 13(1), Regulations Regarding Communicable Diseases, which stipulates that: When a health care provider diagnoses the disease referred to in Annexure A in a person or in a specimen obtained from a person, he or she must report the findings thereof to the relevant district and local authority concerned and: (a) where the disease concerned is acute and life threatening as referred to in Annexure A Table 1, immediate verbal notification based on clinical suspicion must be done and this must be followed by notification in writing within 24 hours of laboratory confirmation of the disease; (b) for diseases listed in Annexure A Table 2, notification must be done in writing within 24 hours of laboratory confirmation of the disease; and for other communicable diseases referred to in Annexure A Table 3, notification must be done in writing within seven days.

\(^{83}\) See, City Press of 4 March 2012 page 1. (The paper depicted this as “ANC wants new Constitution”). In this
4.4 CRIMINAL LAW (SEXUAL OFFENCES AND RELATED MATTERS) AMENDMENT ACT (THE CRIMINAL LAW AMENDMENT ACT), HIV TESTING OF ACCUSED PERSONS AND INFORMATION TO VICTIMS

The Criminal Law (Sexual Offences and Related Matters) Amendment Act (The Criminal Law Amendment Act) deals with the limitation of the rights to privacy and confidentiality of sexual offenders. Section 30, stipulates that:

(1) (a) Within 90 days after the alleged commission of a sexual offence, any victim or any interested person on behalf of a victim, may apply to a magistrate, in the prescribed form, for an order that-

(i) the alleged offender be tested for HIV and that the results thereof be disclosed to the victim or interested person, as the case may be, and to the alleged offender; or

(ii) the HIV test results in respect of the alleged offender, obtained on application by a police official as contemplated in section 32, be disclosed to the victim or interested person, as the case may be.

(2) (a) Every application must-

(i) state that a sexual offence was committed against the victim by the alleged offender;

(ii) confirm that the alleged offence has been reported as contemplated in section 28(2);

(iii) state that the victim may have been exposed to the risk of being infected with HIV as a result of the alleged sexual offence.

31(3) If the magistrate is satisfied that there is prima facie evidence that-

(a) a sexual offence has been committed against the victim by the alleged offender;

(b) the victim may have been exposed to the body fluids of the alleged offender;

(c) no more than 90 calendar days have lapsed from the date on which it is alleged that the offence in question took place, the magistrate must-

(i) in the case where the offender has not been tested for HIV on application by the police official as contemplated in section 32, order that the offender be tested for HIV in accordance with the

Paper, it is observed that: “The ANC is contemplating dramatic changes to the country’s Constitution, including scrapping the “sunset clauses” and changing the powers of the Reserve Bank and provinces. City Press is in possession of draft policy documents that will be distributed to the party’s branches tomorrow ahead of its policy conference in June. The documents are likely to shape the direction of government programmes if adopted at the ANC’s national conference in December. In a section on strategy and tactics titled the “The second transition?” the ANC says the Constitution of 1996 “may have been appropriate for a political transition, but it has proven inadequate and even inappropriate for a social and economic transformation phase’. Other points to be discussed include that: HIV/AIDS should be made a notifiable disease.”

84 Criminal Law (Sexual Offences and related Matters) Amendment Act 32 of 2007 (hereafter referred to as The Criminal Law Amendment Act).

85 The Criminal Law Amendment Act.
State’s prevailing norms and protocols and that the HIV test results be disclosed in the prescribed manner to the victim or interested person, as the case may be, and to the alleged offender.

The Criminal Law Amendment Act,\textsuperscript{86} therefore, limits the rights to privacy and confidentiality of the sexual offenders as it stipulates clearly that the offender may be ordered by the magistrate to be tested for HIV against his will\textsuperscript{87} and the result, thereof, of such a test be disclosed to the victim and interested persons. However, sections 36 and 37 of The Criminal Amendment Act still maintain the confidentiality of the application and the test results in that such disclosure has to be done only to the relevant persons mentioned by the Act.\textsuperscript{88} In fact, section 38(b) makes it an offence for anyone with malicious intent or who in a grossly negligent manner discloses the results of any HIV tests in contravention of section 37, and such an individual would be guilty of an offence and is liable to a fine or imprisonment for a period not exceeding three years.\textsuperscript{89} The Criminal Amendment Act, therefore, is a limitation to the right of privacy and confidentiality of sexual offenders and it may be argued that it a justified limitation as far as it benefits the victims. A victim of rape, for instance, may be anxious to know whether the offender was HIV-positive or negative when he or she was raped. Knowledge of the results may assist in deciding to be tested for HIV or use Antiretroviral drugs (ARVs) to prevent infection from the virus.

4.5 BIRTHS AND DEATHS REGISTRATION ACT

The Births and Deaths Registration Act (Births and Deaths Registration Act),\textsuperscript{90} deals with the registration of death in sections 14 to 22. Section 14 provides that:

\begin{footnotesize}
\begin{enumerate}
\item The Criminal Law Amendment Act.
\item In fact, according to section 38(2), an alleged offender who, in any manner whatsoever, fails or refuses to comply with or avoids compliance with, or deliberately frustrates an attempt to serve on himself or herself, an order of court that he or she be tested for HIV, is guilty of an offence and is liable on conviction to a fine or imprisonment for a period not exceeding three years.
\item The Criminal Law Amendment Act, section 37, for instance, stipulates that: (1) The results of the HIV tests performed on an alleged offender in terms of this chapter may, subject to subsection (2), be communicated only to (a) the victim or interested person referred to in section 30; (b) the alleged offender; and (c) the investigating officer and where applicable, to (i) a prosecutor if alleged offender is tested as contemplated in section 32; or (ii) any other person who needs to know the test results for the purposes of any civil proceedings or an order of the court.
\item Section 38(b) of the Criminal Law Amendment Act.
\item Births and Deaths Registration Act 51 of 1992 (hereafter referred to as The Births and Deaths Registration Act).
\end{enumerate}
\end{footnotesize}
In the case of a death due to natural causes any person who was present at the death, or who became aware thereof, or who has charge of the burial concerned, shall give, as soon as practicable, by means of a certificate mentioned in section 15(1) or (2), notice thereof to a person contemplated in section 4.

If the person contemplated in section 4 is satisfied on the basis of the certificate issued in terms of section 15(1) or (2) that the death was due to natural causes, he shall complete the prescribed death register and issue a prescribed burial order authorising burial.

Where a medical practitioner is satisfied that the death of any person who was attended before his death by the medical practitioner was due to natural causes, he shall issue a prescribed certificate stating the cause of death.

A medical practitioner who did not attend any person before his death but after the death of the person examined the corpse and is satisfied that the death was due to natural causes, may issue a prescribed certificate to that effect.

After a death has been registered in terms of this Act, the Director-General shall issue a prescribed death certificate.

According to Births and Registration Act, if a medical practitioner is satisfied that the death of a person whom he or she had attended to before this person died was due to natural causes, he or she has to issue a prescribed certificate stating the cause of death (section 15(1)). The death certificate has two pages. The first page is for the registration of the death with the Department of Home Affairs, so that they can issue a burial order and on this page the doctor only has to indicate if the cause of death was the result of ‘natural’ or ‘unnatural’ causes. The second page is a confidential document that is only used for data collection and it not a public record. Even if this second page shows that a person died of an AIDS-related illness, it is a confidential document. The family of the deceased person will only be given the second part of the death certificate if they are to make a legal claim; otherwise, they are normally given only the first page. Doctors, in South Africa, therefore, are not allowed to enter AIDS as a cause of death on the first page of the death certificate and as a result of this, the Health Professionals Council of South Africa (HPCSA) took a medical practitioner (Dr Wagner)

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92 It differs from section 36 of the Australian Births, Deaths and Marriages Act of 1996, which stipulate that the form consists of three sections and each section must be completed by the doctor which are: (1) The stub which is kept for the doctor’s records; (2) The central panel, the doctor’s certificate of cause of death, which is to be handed to the funeral directors and; (3) The outer panel, the notice of death, which must be sent promptly to the Births, Deaths and Marriages Registration office.

93 Barret-Grant 129.

94 Barret-Grant 129.
to a disciplinary hearing in Bloemfontein after the practitioner listed AIDS as a cause of death of a young woman on the death certificate, contrary to the HPCSA policy.  

There may be strong arguments in favour of disclosing AIDS on the death certificates, as persons would know the real cause of death and stop speculating about such things as witchcraft, for instance.

4.6 THE CHILDREN'S ACT AND PROVISIONS CONCERNING CONFIDENTIALITY OF HIV DIAGNOSIS

The Children’s Act, section 133(1) and section 133(2), deal with the confidentiality of information on the HIV/AIDS status of children. Section 133(1), stipulates that:

No person may disclose the fact that a child is HIV-positive without consent given in terms of subsection (2), except-

(a) within the scope of that person’s powers and duties in terms of this Act or any other law;

(b) when necessary for purpose of carrying out the provisions of this Act;

(c) in terms of an order of a court.

It seems clear according to section 133(1) that although the right confidentiality of HIV positive status of a child must be protected, there are circumstances where such right to confidentiality may be limited. Amongst others, one such circumstance is when a court order dictates that the HIV status of a child be disclosed. This disclosure is another example of a justified limitation of right to confidentiality of a child who is HIV-positive.

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96 The Children's Act 38 of 2005 (hereafter referred to as The Children’s Act).
97 Section 133(1) of The Children’s Act. Section 133(2), stipulates that: Consent to disclose the fact that a child is HIV-positive may be given by-(a) the child, if the child is-(i) 12 – years of age or older; or (ii) under the age of 12 years and is of sufficient maturity to understand the benefits, risks and social implications of such a disclosure; (b) the parent or caregiver, if the child is under the age of 12 years and is not of sufficient maturity to understand the benefits, risks and social implications of such a disclosure; (c) a designated child protection organisation arranging the placement of the child, if the child is under the age of 12 years and is not of sufficient maturity to understand the benefits, risks and social implications of such a disclosure; (d) the superintendent or person in charge of a hospital, if – (i) the child is under the age of 12 years and is not of sufficient maturity to understand the benefits, risks and social implications of such a disclosure; and (ii) the child has no parent or care-giver and there is no designated child protection organisation arranging the placement of the child; or (e) a children's court, if – (i) consent in terms of paragraph (a), (b), (c) or (d) is unreasonably withheld and disclosure is in the best interest of the child; or (ii) the child or the parent or care-giver of the child is incapable of giving consent.
4.7 COMMON LAW PROVISIONS

Common law has long recognised that a health care worker owes a duty of care, not only to his or her own patients, but also to other patients at large.98 A partner at risk may sue a doctor for failing to disclose information if the doctor exercised his or her discretion against disclosure and, as a result, the partner at risk becomes infected.99 In that sense the discretion is very constrained, and effectively amounts to a duty as the exercise of the discretion not to disclose may give rise to legal liability. In practice the discretion, therefore, amounts to an obligation once the health care worker has determined that someone is at a clear risk of infection from the tested person.100 The question as to what a doctor’s duty of care entails is determined with reference to the standards of reasonableness as set out in the legal convictions of the community or boni mores.101 The question to be asked by the health care worker or anyone applying his or her discretion is: will it be considered reasonable and in the community interest to disclose?102

In the case of Minister van Polisie v Ewels,103 the court expressed the view that, our law has developed to the stage wherein an omission is regarded as unlawful conduct when the circumstances of the case are of such a nature that the omission not only incites moral indignation but also that the legal convictions of the community demand that the omission ought to be regarded as unlawful and that the damage suffered ought to be made good by the person who neglected to do a positive act.104 The courts have also recognised that the right to privacy is not absolute but can be limited. In the case of Bernstein and Others v Bester NO and Others,105 the court pointed out that the truism that no right is to be considered absolute,106 implies that from the outset of interpretation each right is always already limited by every other right accruing to another citizen.107 In the context of privacy, this would mean that it is only the inner sanctum of a person, such as his/her family life,
sexual preference and home environment, which is shielded from erosion by conflicting rights of the community.\textsuperscript{108} This implies that community rights and the rights of fellow members place a corresponding obligation to the citizen, thereby shaping the abstract notion of individualism towards identifying a concrete member of civil society. Privacy is acknowledged in the truly personal realm, but as a person moves into communal relations and activities such as business and social interaction, the scope of personal space shrinks accordingly.\textsuperscript{109} This case clearly shows that no right can be regarded as unlimited.\textsuperscript{110} Rights, as the court correctly pointed out, are limited by the rights of other people. Privacy of person, as the court also emphasised, remains truly private as long as the individual remains at his or her home environment that is away from the intrusion of others. But once the person starts to mingle with other people in social interactions such as school, work, church, business, social media (such as Facebook and Twitter\textsuperscript{111}), his or her privacy becomes limited by such interactions.

4.8 DUTY TO INFORM EXPOSED THIRD PARTIES IN TERMS OF THE PROFESSIONAL ETHICAL GUIDELINES

The ethical guidelines of the Health Professions of South Africa (HPCSA)\textsuperscript{112} lay out the ethical duties under which the medical practitioners will be obliged to inform third parties, such as exposed health care workers and

\textsuperscript{108} The Bernstein v Bester case, paragraph [67].
\textsuperscript{109} The Bernstein v Bester case, paragraph [67]. The court, however, in this Bernstein case at paragraph [71], pointed out that caution must be exercised when attempting to project common law principles onto the interpretation of fundamental rights and their limitation; it is important to keep in mind that at common law the determination of whether an invasion of privacy has taken place constitutes a single enquiry, including an assessment of its unlawfulness. As the case of other iniuriae the presence of a ground of justification excludes the wrongfulness of an invasion of privacy. In constitutional adjudication under the constitution, by contrast, a two-stage approach must be employed in deciding constitutionality of a statute.

\textsuperscript{110} Currie & De Waal 163, Cheadle, Davis and Haysom 695 and Mureinik 1994 SAJHR 33 and 35.
\textsuperscript{111} See Daily Dispatch of Tuesday, May 15, 2012, page 6 (The paper depicted this as: “Warning for Facebook, Twitter users”), where this paper reported that Facebook and Twitter users should not say in private what they do not want to be made public. This was the advice from the former head of social media in President Jacob Zuma’s private office. The advice by a master’s student, Suni Gopal, comes as the American Consumer Report last week revealed that most Facebook users worldwide were sharing too much information and simply ignored privacy settings. Gopal said recent Twitter storm over the racist tweets by model Jessica Leandra dos Santos was an example of how private thoughts could easily be exposed to the wider public. She was cited by the paper as saying: ‘Many people are unaware other members of the public can easily view their comments and profile information. They are under the impression only their friends can see their thoughts, feelings and actions. However, literally thousands of others are now privy to one’s personal information, from where you are and what you are doing, to being able to view your private holiday pictures.’

\textsuperscript{112} See the Health Professions Council of South Africa (HPCSA) Guidelines for Good Practice in the Health Care
sexual partners, of a patient’s HIV-status, and as a result, limit the rights to privacy and confidentiality of the patient. These ethical duties will next be discussed.

4.8.1 Exposed health care workers

The HPCSA Guidelines for Good Practice in the Health Care Professions, Ethical Guidelines for Good Practice with regard to HIV address the responsibilities of health care practitioners to positive HIV patients in guideline 4, whereas guideline 5 deals with confidentiality. Guideline 4 provides that:

4.5 In the management of an HIV positive patient it is important that the health care practitioner gives due consideration to other health care professionals who are also involved in the management of the same patient (e.g. where necessary, and with the patient’s consent, informing them of the HIV status of the patient).

Guideline 5, provides as follows in respect of confidentiality:

5.1 Ethics, the South African Constitution and the law recognise the importance of maintaining the confidentiality of the HIV status of a patient.

5.2 The test results of HIV positive patients should be treated with the highest possible level of confidentiality.

5.3 Confidentiality regarding a patient’s HIV status extends to other health care practitioners. Other health care practitioners may not be informed of a patient’s HIV status without that patient’s consent unless the disclosure is clinically indicated. For treatment and care to be in the best interests of the patient, the need for disclosure of clinical data, (including HIV and related test results), to health care practitioners involved in the care of the patient, should be discussed with the patient.

5.4 The decision to divulge information relating to the HIV status of a patient must always be done in consultation with the patient.

The health care worker, therefore, may tell other health care workers about his or her patient’s HIV status, provided that the patient gives his or her consent to such disclosure to the other health care workers. Where the disclosure of the patient’s HIV status to other health care workers is clinically indicated, the health care worker must first discuss such disclosure with the patient, but will be ethically entitled to inform other health care workers of the patient’s HIV status, even if the patient refuses to allow him or her to do so. The reason for this would be if the information is going to be important for future medical treatment and this must be explained.

113 HPCSA Guidelines with regard to HIV.

114 See Dickens BM “The doctor’s duty of confidentiality: separating the rule from the expectations” 1999 (77;1) University of Toronto Medical Journal 40-43, 41, who points out that health care professionals may discuss personal details of an identified patient’s best clinical care with others who share clinical responsibility for the patient’s well-being, since this falls within the scope of the patient’s implied consent.
to the patient, who must give permission for the medical information to be passed on to other health care workers or health facilities.\textsuperscript{115} However, the guidelines, unlike in the case of partner disclosure, which will be discussed below, are unclear about what should happen in the case where the disclosure is not clinically indicated and the patient refuses that other health care practitioners should be informed. As the case is now, it seems that if the patient refuses that his or her HIV status information be disclosed to other health care workers, the health care worker will have to respect such a decision and not disclose such information.\textsuperscript{116}

### 4.8.2 Exposed sexual partners

The HPCSA Guidelines for Good Practice in the Health Care Professions, Ethical Guidelines for Good Practice with regard to HIV,\textsuperscript{117} provide guidance regarding partner disclosure in guideline 9. Guideline 9 stipulates that:

\begin{enumerate}
  \item Health care practitioners should try to encourage their HIV positive patients to disclose their status to their sexual partners so as to encourage them to undergo VCT and access treatment if necessary. This is consistent with good clinical practice.
  \item If the patient refuses consent, the health care practitioner should use his or her discretion when deciding whether or not to divulge the information to the patient’s sexual partner, taking into account the possible risk of HIV infection to the sexual partner and the risks to the patient (e.g. through violence) that may follow such disclosure. The decision must be made with great care, and consideration must be given to the rights of all the parties concerned.
\end{enumerate}

\textsuperscript{115} Barret-Grant 124 and Carstens and Pearmain 958.

\textsuperscript{116} Barret-Grant 124. See, however, Carstens and Pearmain 958, who cite The Medical and Dental Council ethical guidelines of 1989 which seemed to be specific on the fact that if the patient refused to have other health care workers informed, the patient had to be told that the health care worker had an ethical duty to inform other health care workers involved with the patient, failing of which if the health care worker were to be found to have committed an act or omission which would have led to the unnecessary exposure to HIV infection of another health care worker, the Council would see this in a very serious light and would consider disciplinary action against the practitioner concerned. See also the case of Jansen \textit{v} van Vuuren \textit{and Another} \textit{v} Kruger 1993 (4) SA 842 (AD) (hereafter referred to as \textit{The Van Vuuren} case) at 854C-G, where the court also cited the said Medical and Dental Council guidelines of 1989 and concluded that an important aspect was that the patient had to be informed of the doctor’s obligation to make a disclosure, which would give the patient the opportunity to say why it is in fact not necessary, something which the court felt in that case the plaintiff was denied. It is interesting to note, however, that in that case the court did not decide on the basis of whether the defendant had an ethical duty or legal duty to inform the other two health care workers about the HIV status of his patient, but decided on whether he had a social or moral duty to make such a disclosure. The court was of the view that the health care worker had no such social or moral duty to transfer, nor did the other two health workers had the right to receive, the information. In certain circumstances, however, as stipulated in HPCSA Guidelines Confidentiality: Protecting and Providing Information, guideline 7.2 provides that: where patients have consented to treatment, express consent is not usually needed before relevant personal information is shared to enable the treatment to be provided. An example in point here is that express consent is not needed before a general practitioner discloses relevant personal information to a medical secretary so that she can type a referral letter. In such circumstances, the patient will be assumed to have given implied consent to such disclosure being made to the secretary. However, according to guideline 7.3 the health care practitioner must make sure that any recipient to whom personal information about patients is disclosed, understands that it is given to them in confidence, which they must respect. Also, according to guideline 7.4 in cases of medical emergency, the health care worker should disclose the relevant information promptly to those providing the patient’s care, and explain the situation to the patient after the emergency had passed. See also Dickens 1999 \textit{University of Toronto Medical Journal} 41, who seems to concur with this by stating that patients expect, and the law requires, that relevant information will be made available to all members of a patient’s health care team. Patients’ consent to this disclosure is an element of their consent to care.

\textsuperscript{117} HPCSA Guidelines with regard to HIV.
If the health care practitioner decides to make the disclosure against the patient’s wishes, the practitioner must do so after explaining the situation to the patient and accepting full responsibility at all times. The following steps are recommended, the health care practitioner must:

9.2.1 Counsel the patient on the importance of disclosing to his or her sexual partner and on taking other measures to prevent HIV transmission.

9.2.2 Provide support to the patient to make the disclosure.

9.3.3 If the patient still refuses to disclose his or her HIV status or refuses to consider other measures to prevent infection, counsel the patient on the health care practitioner’s ethical obligation to disclose such information.

9.3.4 If the patient still refuses, disclose information on the patient’s HIV status to the sexual partner and assist them to undergo VCT and access treatment if necessary.

9.2.5 After disclosure, follow up with the patient and the patient’s partner to see if disclosure has resulted in adverse consequences or violence for the patient, and, if so, intervene to assist the patient appropriately.

9.3 Health care practitioners must recognise the major ethical dilemma when confronted with a person who is HIV positive and who refuses, despite counselling, to inform his/her partner or partners.

Health care workers have an ethical duty to inform exposed sexual partners about the HIV status of their patients, provided they have followed the recommended steps of first counselling the patient to disclose his or her HIV status himself or herself. In the case where the health care worker had counselled the patient about informing his or her sexual partner, but the patient refuses to do so, then the health care worker is ethical obliged to inform the sexual partner and thereby justifiably limiting the right to confidentiality of that patient. Disclosure by the health care worker to the exposed sexual partner, as will be discussed below, may also be done in the public interest in order to protect the sexual partner from harm by the patient. The implication created by these guidelines is that in the case of multiple sexual partners, the health care worker will have to inform all identifiable sexual partners of the patient, as it will serve no purpose to inform only one sexual partner if there are others whom the patient may still infect. This will also be discussed below.

4.8.3 Disclosure in the public interest

The ethical guidelines also deal with the disclosure of patients’ information in the public interest, which is normally a sensitive, controversial and a subject of public debate.\(^{118}\) Guideline 8 of the HPCSA Guidelines for

\(^{118}\) For instance, there is currently a public debate in South Africa about whether the disclosure of information in the public interest should not be included as a defence in the controversial Protection of State Information Bill. See Daily Dispatch of 4 May 2012 page 4. (The paper depicted this as “Information Bill a threat to Democracy”). This paper cited South African Editors’ Forum (Sanef) as having said that: “Without the insertion of a clause protecting from prosecution those who publish such secrets in the public interest...the bill is a danger not just to press freedom, but to democracy.”
Good Practice in the Health Care Professions, Confidentiality: Protecting and Providing Information deals with disclosure of information other than for treatment of individual patients.\textsuperscript{119} It stipulates that:

8.2.4 Disclosures in the public interest:

8.2.4.1 In cases where health care practitioners have considered all available means of obtaining consent, but are satisfied that it is not practicable to do so, or that the patients are not competent to give consent, or exceptionally, in cases where patients withhold consent, personal information may be disclosed in the public interest where the benefits to an individual or to society of the disclosure outweigh the public and the patient's interest in keeping the information confidential, (e.g. endangered third parties such as the spouse or partner of patient who is HIV positive, who after counselling refuses to disclose his or her status to such spouse or partner; or reporting a notifiable disease).

8.2.4.2 In all such cases the health care practitioner must weigh the possible harm (both to the patient, and the overall trust between practitioners and patients) against the benefits that are likely to arise from the release of information.

The ethical guidelines therefore require the health care practitioners to do the difficult task of weighing between the two public interests, one of which was discussed in chapter 3 above, namely that of protecting the confidentiality of the patient in order for the public to trust health care workers and to access treatment,\textsuperscript{120} and the other being that of protecting the public from harm.\textsuperscript{121} As Rautenbach points out,\textsuperscript{122} disclosing information in the public interest is arguably the situation that creates the most anxiety among health care professionals and is also the most difficult to provide practical guidelines for. This means that medical practitioners will often find themselves in a dilemma of choosing between the two public interests, that is, whether to keep the information about the patient confidential or to disclose it in order to protect the public from harm. However, difficult as it may be, the health care workers have to make the decision. What they are required to do according to the professional guidelines, therefore, is to make a decision whether the benefits of the individual or society of the disclosure outweigh the public or patient's interest to keep the information confidential.\textsuperscript{123} Disclosure of

\textsuperscript{119} HPCSA Guidelines Confidentiality: Protecting and Providing Information.
\textsuperscript{120} See the Van Vuuren case 850B-D, where the court expressed the view that according to the rules of the SA Medical and Dental Council it amounted to unprofessional conduct to reveal 'any information which ought not to be divulged regarding the ailments of a patient except with the express consent of the patient'. The reason for the rule is twofold. On the one hand it protects the privacy of the patient. On the other it performs a public interest function. See also the American case of Tarasoff v The Regents of the University of California 17 Cal. 3d 425 (1976), Supreme Court of California (hereafter referred as The Tarasoff case), where the court recognised the public interest in supporting effective treatment of mental illness and in protecting the rights of patients to privacy and the consequent public importance of safeguarding the confidential character of psychotherapeutic communication.
\textsuperscript{123} HPCSA Guidelines Confidentiality: Protecting and Providing Information, Strauss 17 and The Van Vuuren case, at 850F-I. See also Rautenbach 2004 The Southern African Journal of HIV Medicine 27, who points out that in all cases such as these the possible harm to the patient must be weighed against the benefits that are likely to arise out of the release of
confidential information without consent may be justified where failure to do so may expose the patient or others to risk of death or serious harm, that is, where third parties are exposed to risks so serious that they outweigh the patient’s right to privacy.\textsuperscript{124}

The case in issue would be the English case of \textit{W v Egdell},\textsuperscript{125} where W, a paranoid schizophrenic, was detained in a secure hospital because he had shot seven people, killing five and wounding two. Ten years later his attorneys requested Dr. Henry George Egdell, a psychiatrist, to evaluate W’s mental condition in order to prepare an application for eventual release or transfer to less secure facility. Upon receipt of Egdell’s negative report, which pointed out that W’s interest in guns and homemade bombs predated his schizophrenia, the attorneys withdrew W’s application. When Egdell learned that neither W’s hospital nor review tribunal had seen the report, in the interest of further treatment, he sent a copy to the hospital and asked the hospital to send the copy to the tribunal. W claimed Egdell had breached his duty to confidentiality.

Balancing the public interests in confidence and in disclosure, the court held in favour of the restricted disclosure of vital information about W’s dangerousness because of the grave concern for public safety. The court was correct in its decision in this case. The doctor, Egdell, was correct in disclosing the mental condition of his patient, W, to the hospital and the review tribunal, in order for them to make a correct decision if they had to decide whether to release W into the community or not. W’s right to confidentiality was correctly limited by the court in favour of public safety, as it was not absolute in any event.\textsuperscript{126} Had the doctor failed to warn the review tribunal and W happened to be released and subsequently harmed or killed other people, the doctor could have

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\textsuperscript{124} Rautenbach 2004 \textit{The Southern African Journal of HIV Medicine} 27. See \textit{The Van Vuuren} case, at 850F-I, where the court had the view it must weigh this interest against the public interest in safety from violent assault.

\textsuperscript{125} \textit{W v. Egdell} [1990] 1 All ER 835, Court of Appeal.

\textsuperscript{126} See \textit{The Van Vuuren} case, at 850F-I, where the court expressed the view that the right of the patient to confidentiality was not absolute but relative.
been sued by such people or their relatives. Health care practitioners, therefore, will be justified to disclose their patients’ confidential information if they believe that the public interest in disclosure outweighs the public interest in confidentiality. However, disputes about public interest will ultimately be determined by the courts of law.

4.9 DO MEDICAL PRACTITIONERS HAVE A LEGAL DUTY TO INFORM EXPOSED THIRD PARTIES?

In South Africa, the legal situation concerning the medical practitioner’s legal duty to inform or warn exposed third parties about the HIV status of his or her patients is still not clear. As Carstens and Pearmain point out, the legal duty to warn third parties when a patient is a potential danger to them has been canvassed fairly extensively by the American courts, but not by the South African ones. South African courts, influenced by these American decisions, however, are likely in future to hold that there is a legal duty to warn, especially because the same considerations that lead to them may be applicable in South African law due the fact that the right to privacy is not absolute; the rights in the Bill of Rights are interrelated and interconnected; and there has to be balancing of the right to privacy and the rights to life and freedom and security of the person.

The leading American case on the duty to warn which may have an impact on South African courts is the case of Tarasoff v The Regents of the University of California (the Tarasoff case). In this case, Prosenjit Poddar killed Tatiana Tarasoff. The plaintiffs, Tatiana’s parents, alleged that two months before their daughter’s death, Poddar confided his intention to kill Tatiana to Dr. Lawrence Moore, a psychologist employed by the Cowell

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127 An example of an HIV case is an Australian case which is reported at http://news.bbc.co.uk/2/hi/health/ (visited 30 April 2012), where an Australian woman successfully sued two doctors after they failed to tell her that her husband was HIV positive. The woman, known only as ‘PD’, and her then fiancé, known only as ‘FH’, underwent joint tests for sexual tests for sexually transmitted infections and HIV in November 1998. All her tests were negative but her fiancé tested positive for HIV. The couple were not told each other’s results and they subsequently married and had unprotected sex. The woman contracted the disease. The woman told the court she believed both test were negative. She said doctors Nicholas Harvey and King Weng Chen should have warned her of her husband-to-be’s condition. Judge Jerrold Cripps ruled that the two doctors should have warned the woman’s fiancé he would be breaking the law if he did not tell her that he had HIV. The court had a view that the doctors should not have assumed that the fiancé would tell her about his HIV-positive test. The court awarded the woman A$ 727,000 damages.

128 See The Tarasoff case, paragraph [442], where the court concluded that the public policy favouring protection of the confidential character of patient-psychotherapist communication in such circumstances must yield to the extent to which disclosure is essential to avert danger to others.


130 Carstens and Pearmain 1000.

131 Carstens and Pearmain 1000.

132 The Tarasoff case.
Memorial Hospital at the University of California at Berkeley. They alleged that on Moore’s request, the campus police briefly detained Poddar, but released him when he appeared rational. They further claimed that Dr. Harvey Powelson, Moore’s superior, then directed that no further action be taken to detain Poddar. No one warned the plaintiffs of Tatiana’s peril. The plaintiffs’ complaint predicated liability on two grounds, namely the defendants’ failure to warn plaintiffs of the impending danger; and their failure to bring about Poddar’s confinement. The defendants, in turn, asserted that they owed no duty of reasonable care to Tatiana and that they were immune from suit.

The court expressed the view that the defendant therapists could not escape liability merely because Tatiana herself was not their patient. When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of this duty may require the therapist to take one or more of various steps, depending upon the nature of the case. Thus it may call for him to warn the intended victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances. The court, further, expressed the view that although the plaintiffs’ pleadings asserted no special relation between Tatiana and the defendant therapists, they established the special relation between Poddar and the defendant therapists, which arises between a patient and his doctor or psychotherapist. Such a relationship may support affirmative duties for the benefit of third persons. Thus, for example, a hospital must exercise reasonable care to control the behaviour of a patient which may endanger other persons. A doctor must also warn a patient if the patient’s condition or medication renders certain conduct, such as driving a car, dangerous to others.

The court concluded that the public policy favouring protection of the confidential character of patient-psychotherapist communication must yield to the extent to which disclosure is essential to avert danger to others. The protective privilege ends where the public peril begins. The court held that the plaintiffs could amend their complaints to state a cause of action against the defendant therapists by asserting that the therapists in fact determined that Poddar presented a serious danger of violence to Tatiana, or pursuant to the standards of their profession should have so determined, but nevertheless failed to exercise reasonable care to

133 The Tarasoff case, paragraph [430].
134 The Tarasoff case, paragraph [431].
135 The Tarasoff case, paragraph [431].
136 The Tarasoff case, paragraph [436].
137 The Tarasoff case, paragraph [442].
protect her from that danger.\textsuperscript{138} This Tarasoff ruling has, for the first time, created a duty for the mental health professionals, both psychiatrists and psychologists, to protect society from dangerous patients when they learn that an individual is in danger.\textsuperscript{139} Though, as Carstens and Pearmain observe,\textsuperscript{140} this ruling was also criticised and decried by some mental health commentators as undermining the practice of psychotherapy by destroying the tenets of confidentiality, it seems that these observers were wrong in that the Tarasoff ruling was followed in other American cases thereafter.

The Tarasoff case, indeed, is an important decision regarding the legal duty of medical practitioners to warn third parties if their patients are dangerous.\textsuperscript{141} The court was correct in finding that when a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another person, he incurs an obligation to use reasonable care to protect the intended victim against such danger and that obligation may call for him to warn the intended victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances.\textsuperscript{142} However, the health care practitioner is not only obliged to warn an identifiable individual, as was the case with Tarasoff, but he or she may be required to inform other third parties even if they are not identifiable. As Dickens points out,\textsuperscript{143} the duty is sometimes expressed as a duty to warn, but giving an identified victim due warning is only one option to discharge the duty ‘to use reasonable care to protect’ foreseeable victims. When future victims are not individually identifiable, such as when a patient threatens violence against a class of persons, notice to the police will usually be appropriate.\textsuperscript{144} However, as mentioned above, the legal position concerning the legal duty to warn third parties, in South Africa, is still not clear. South African courts have long recognised the legal duty to act in certain situations and the legal convictions or boni mores of the society, as discussed above.\textsuperscript{145}

In the case of Minister van Polisie v Ewels,\textsuperscript{146} the court held that where the respondent, an ordinary citizen, had been assaulted by a sergeant of police, who was not on duty, in a police station under the control of the police and in the presence of several members of the police, who jointly, and even easily, could have prevented or

\footnotesize{\textsuperscript{138} The Tarasoff case, paragraph [448].}
\footnotesize{\textsuperscript{139} Carstens and Pearmain 1003.}
\footnotesize{\textsuperscript{140} See Carstens and Pearmain 1003, who cite cases such as McIntosh v Milano 403 A2d 500 (NJ 1979), where the court found a psychiatrist liable using the rationale of Tarasoff.}
\footnotesize{\textsuperscript{141} See Dickens 1999 University of Toronto Medical Journal 42, who points out that the duty is not limited to psychotherapists, but applies to any practitioner who according to 'the standards of his profession,' believes a patient to pose 'a serious danger of violence to another.'}
\footnotesize{\textsuperscript{142} The Tarasoff case, paragraph [431].}
\footnotesize{\textsuperscript{143} Dickens 1999 University of Toronto Medical Journal 42.}
\footnotesize{\textsuperscript{144} Dickens 1999 University of Toronto Medical Journal 42.}
\footnotesize{\textsuperscript{145} Carstens and Pearmain 1001 and Viljoen 76.}
\footnotesize{\textsuperscript{146} The Ewels case.}}
have put an end to the attack, had a legal duty to have come to the assistance of the respondent. Not assisting the respondent was a failure which happened in the course of the policemen’s duty, which meant that the appellant was liable for the damages claimed by the respondent. The court further observed that our law has developed to the stage where an omission is regarded as unlawful conduct when the circumstances of the case are of such a nature that the omission not only incites moral indignation but also that the legal convictions of the community demand that the omission ought to be regarded as unlawful and that the damage suffered ought to be made good by the person who neglected to do a positive act.

The present position is that if a South African court finds that there is duty to warn that applies to health care workers, for example, it would be either based on reasonableness in the context of the facts of the case or on the boni mores of the society.\(^\text{147}\) In the case of a failure to warn, the conduct in question would be an omission on the part of the health professional.\(^\text{148}\) The legal convictions of the society, of course, may not allow that a health care practitioner fail to warn an individual if he or she knows that his or her patient is dangerous and has threatened to kill that person in the past. However, it may not be ruled out that South African courts may follow decisions, such as Tarasoff, in the future to hold health care practitioners liable for damages if they fail to warn individuals about the dangerousness of their patients, which may include protecting persons against the potential harm of HIV/AIDS.

### 4.9.1 Exposed health care workers

In South Africa, as discussed above, there appears to be no clear legal duty on the part of a health care worker to warn other health care workers about the HIV status of their patients. Court decisions on this issue will turn to the issue of the social or moral duty to warn.\(^\text{149}\) The case that involved a disclosure of an HIV status of a patient by a health care worker to other health care workers is the case of Jansen van Vuuren v Kruger (The Van Vuuren case).\(^\text{150}\) In this case, discussed elsewhere in this thesis, the doctor of Van Vuuren, Dr Kruger, disclosed his patient’s HIV positive condition to two other medical doctors, Dr Van Heerden and Dr Vos during the course of a game of golf.\(^\text{151}\) The court observed that the duty or right to communicate and the reciprocal duty or right to receive the communication may be legal, social and moral. A legal duty to communicate would, for example, exist in respect of the duty of a medical practitioner to testify in court or to disclose a notifiable

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\(^{147}\) Carstens and Pearmain 1001.  
\(^{148}\) Carstens and Pearmain 1001.  
\(^{149}\) The Van Vuuren case at 856D-G.  
\(^{150}\) The Van Vuuren case.  
\(^{151}\) The Van Vuuren case at 847F-G.
disease. A social or moral duty was exemplified in *Hague v Williams*,\(^{152}\) where it was held that knowledge of a child's pathological heart condition was not of such confidential nature that it prevented the physician from disclosing it extracurially to an insurer to whom the parents had applied for life insurance on the child.\(^^{153}\) In determining whether Van Vuuren's doctor had a social or moral duty to make the disclosure and whether the other two doctors had a reciprocal social or moral right to receive it, the court applied the standard of a reasonable man.

The court held the view that the doctor had no such duty to transfer, nor did the other two doctors have the right to receive the information. The court then concluded that the communication to Vos and Van Heerden was unreasonable and therefore unjustified and wrongful.\(^^{154}\) This view by the court seems to be the correct view in that when the doctor made the disclosure to the two doctors about the HIV status of his patient, they were out enjoying a round of golf. As the court correctly stated, there was no threat of exposure to the two doctors which could justify the breach of doctor-patient confidentiality. So, morally, the doctor was not justified to disclose the HIV status of his patient to the other two medical practitioners. The *Van Vuuren* case decision shows that the courts may accept that there is a social or moral duty to disclose or warn other health care practitioners on the part of a health care practitioner, but that such duty should be done in a proper manner.

### 4.9.2 Exposed sexual partners

There is no legal duty in South Africa on the part of a health care worker to warn a sexual partner about the HIV status of his or her patient. It appears that courts would again base decisions in this regard on the social or moral duty to warn.\(^^{155}\) Strauss\(^^{156}\) points out that in South African law, there appears to be a qualified duty on a person to come to the rescue of another. It is unlikely that the duty would be interpreted by a court of law as requiring a doctor to take active steps to directly inform the sexual partner or partners of the patient. Decisions of this kind would depend on what is regarded as reasonable in all the circumstances of the case.\(^^{157}\) Ordinarily, a medical practitioner, who has diagnosed a patient to be HIV positive, would be regarded as having acquitted himself of his duty to society once he has informed the patient of the diagnosis and has warned him or her of the

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\(^{152}\) Cited in *The Van Vuuren case*, 851D-E, as *Hague v Williams* [1962] 181 Atlantic Reporter 2d 345, Supreme Court of New Jersey.

\(^{153}\) *The Van Vuuren case*, 851D-E.

\(^{154}\) *The Van Vuuren case*, 856D-G.

\(^{155}\) Barret-Grant 124.

\(^{156}\) Strauss 17.

\(^{157}\) Strauss 17 and *The Van Vuuren case*, 856D-G.
potential offspring, unless ‘safe sex’ is practised.\textsuperscript{158} A doctor can hardly be expected to cast himself in the role of a private investigator or information officer seeking out and warning the sexual partners of the patient. If, however, it were to come to the knowledge of a doctor, who has properly counselled a patient, that the latter refuses to practise ‘safe sex’, and the identity of a regular sexual partner, such as the patient’s husband or wife, is known to the doctor, it may conceivably be regarded as reasonable for the doctor to act by informing the sexual partner about the HIV status of his patient.\textsuperscript{159} It may, however, also be expected of the doctor in the case of a polygamous marriage to inform all the sexual partners as they also would identifiable in such a case. It does appear, however, in South Africa, that the doctor would not have a legal duty, but would have social or moral duty to inform exposed sexual partner or partners about the HIV status of his patient.

\textbf{4.10 \textsc{Does the HIV-positive individual have a legal duty to inform health care workers and sex partners?}}

There is generally no legal duty for an infected individual to disclose his or her status and one cannot be compelled to disclose one’s HIV status.\textsuperscript{160} However, that being said, where non-disclosure of one’s HIV positive status is coupled with the conduct that causes transmission of HIV to another, legal liability may follow; criminal liability from the conduct through which HIV is transmitted and civil liability from the non-disclosure.\textsuperscript{161} In fact, in many countries, around the world such as Canada, United States of America (USA), Australia,\textsuperscript{162} Germany, Switzerland, Denmark, Italy, United Kingdom and some African countries such Uganda, anyone who infects another person with HIV, commits a criminal offence and may be prosecuted under laws expressly criminalising HIV transmission or under a variety of appropriate traditional offences, such as attempted murder, murder, manslaughter, assault or poisoning.\textsuperscript{163}

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\textsuperscript{158} Strauss 17.
\textsuperscript{159} Strauss 17.
\textsuperscript{160} Verrier C and Tuson S “The transmission of HIV in martial arts” 2009 De Rebus 19-21, 19.
\end{flushright}
Transmission of HIV, therefore, in countries such as the USA is a crime in certain states, prosecuted under specific HIV statutes. In the USA, for instance, where thirty-six states have prosecuted HIV-positive individuals for criminal exposure or transmission, only twenty-eight countries criminalise HIV transmission using specific HIV public or criminal law statutes. California, Kansas, Maryland, Oklahoma, South Dakota and Washington have laws that criminalise HIV exposure with intent. A Missouri law allows for the death penalty if transmission is proved as a result of HIV exposure without disclosure and the military courts have court-marshalled more than thirty HIV-positive individuals for having unprotected sex without disclosure and almost all have been convicted. However, some states in the USA and other countries in Europe prosecute HIV transmission because it meets the definition of the more general offences of assault, attempted murder or conduct endangering life, and therefore they chose to use existing laws and not HIV specific statutes. The State of Texas, for instance, up to the end of 2009, convicted fifteen people for HIV-related criminal offences and yet it does not use HIV specific statutes but existing laws to prosecute. Similarly, European countries such as Switzerland, Denmark, Italy, Germany and United Kingdom have used existing laws and not HIV-specific legislation.

Countries such as Germany punish reckless or negligent HIV transmission. The German Criminal Code provides that whoever causes bodily harm to another through negligence shall be punished by up to three years’ imprisonment or fine. This provision is usually applied to reckless driving and medical negligence and is regarded as important in view of the increase in traffic and the use of dangerous instruments in specialised professions. It is also wide enough to apply to negligent bodily harm in the case of HIV infection. The ‘negligence’ mentioned in the German Criminal Code may take the form of an infected person knowing about his or her infection, but failing to take the steps a reasonable person would have taken to prevent infection, perhaps because he or she hopes that the virus will not be transmitted (conscious negligence). Negligence could also

Ndawula LLM dissertation 57.
Ndawula LLM dissertation 57.
Ndawula LLM dissertation 57, also points out that the Canadian approach could be viewed as a primary example of the use of existing criminal laws to prosecute HIV related crimes without recourse to stigma ridden HIV specific legislation. See also Van Wyk 2000 Codicillus 6.
Ndawula LLM dissertation 57.
Ndawula LLM dissertation 59.
Van Wyk 2000 Codicillus 9. See also Ndawula LLM dissertation 60, who points out that Germany has at least three convictions under the German Criminal Code sections 223, 224, 226 and 229. These sections are not HIV/AIDS specific. Exposing another person to HIV, in Germany, has been held to carry a sentence of up to 10 years imprisonment.
consist of an infected person not ascertaining his or her serostatus in circumstances where a reasonable person would have gone for testing. However, there had not been a case in Germany dealing with negligent bodily harm in case of HIV infection through sexual intercourse by a person who was aware of being HIV-positive. In England and Wales, as well, in addition to public health strategies, the criminal law has been utilised against persons living with HIV who recklessly transmit the disease through consensual sexual intercourse. Still, other countries’ jurisdictions punish not only actual transmission but also risky conduct that creates merely a risk of HIV-transmission, such as unprotected sex, mother-to-child transmission through breastfeeding, non-disclosure to a sex partner of HIV status and spitting on another by an infected person.

In the Southern Africa Development Corporation (SADC) region, countries do not criminalise HIV transmission, be it deliberate or reckless, instead, emphasis is placed on public health goals, such as education, information, voluntary counselling and testing, universal access to HIV prevention programmes and the provision of support systems, including treatment. The SADC region is made up of the following countries: Zimbabwe, Botswana, Zambia, Malawi, Mozambique, Tanzania, Namibia, Angola, Democratic Republic of Congo, Swaziland, Lesotho, South Africa and Mauritius.

The members of SADC subscribe to the Model Law on HIV/AIDS in Southern Africa (SADC Model Law) which, unlike its West African model, does not call for the criminalisation of HIV, but advocates a caring approach in combating the disease. The Model law calls for member states to promote public awareness on

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175 Matthieson S “Should the law deal with reckless HIV infection as a criminal offence or as a matter of public health? 2010 (21) KLJ 123-132, 123.
176 Anyangwe 415. See also Ndawula LLM dissertation 58, who cites an example of an HIV-positive man in Texas who was sentenced to 35 years in prison for harassing a public servant with a deadly weapon after spitting on a police officer.
177 Ndawula LLM dissertation 63 and Anyangwe 411.
178 Ndawula LLM dissertation 63.
180 See Ndawula LLM dissertation 60 who points out that West African parliamentarians drafted what is known as the N’djamena African Model Law of 2004 (hereafter referred to as African Model Law). This African Model Law generally requires HIV status disclosure to a spouse or regular sexual partner within six weeks of diagnosis. It permits mandatory testing of pregnant women, their spouses and rape victims where necessary. It also creates the offence of wilful transmission pertaining to those who transmit the virus through any means with full knowledge of their HIV status. It does not distinguish between those who intend to do harm and those whose behaviour can be categorised as reckless or negligent and therefore raises questions on culpability of individuals who might not be aware of their HIV positive status. The African Model Law has been the basis of at least nine West African and Central African states modifying their domestic HIV legislation.
181 Ndawula LLM dissertation 63.
nature of HIV/AIDS, its causes and modes of transmission. It also encourages schools, institutions and health care facilities to participate in awareness campaigns and governments are also urged to sensitise communities of dangerous cultural practices that have to be avoided, such as early marriage, widow inheritance and female genital mutilation.\textsuperscript{182}

Despite this SADC Model law, however, there seems to be about 50\% of SADC member states who have introduced legislation that specifically create offences for the wilful transmission of HIV and provide for harsher sentences for sexual offenders.\textsuperscript{183} Zimbabwe is one of such SADC states which have adopted HIV-specific legislation.\textsuperscript{184} South Africa, however, appears to be one of those member states that have adhered to the SADC Model law by not criminalising HIV transmission,\textsuperscript{185} but opted to use existing general criminal offences to deal with cases of transmission.\textsuperscript{186} The South African Law Commission (the Commission) had cautioned that criminal law is not the means by which the spread of HIV should be addressed, and that the AIDS epidemic is first and foremost a public health issue and it is internationally accepted that non-coercive measures are the most successful means through which public health authorities can reduce the spread of the disease.\textsuperscript{187} However, the Commission recognised the fact that it is accepted that there are individuals, who through their irresponsible behaviour, deliberately place others at risk of HIV infection and that existing public measures are in themselves insufficient as a means to deal with harmful HIV-related behaviour.\textsuperscript{188} The Commission recommended that common law crimes of murder, culpable homicide, rape and assault could be used to deal with harmful HIV-related behaviour. However, up to that time, there had never been a prosecution under common law of harmful HIV related behaviour in South Africa and therefore there was no legal clarity in the appropriateness of these crimes to deal with such behaviour.\textsuperscript{189}

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\item \textsuperscript{182} Ndawula LLM dissertation 63.
\item \textsuperscript{183} Ndawula LLM dissertation 66.
\item \textsuperscript{184} Bhamjee 2008 Obiter 325.
\item \textsuperscript{185} Bhamjee 2008 Obiter 326.
\item \textsuperscript{186} Bhamjee 2008 Obiter 326, Anyangwe 417 and Verrier and Tuson 2009 De Rebus 19.
\item \textsuperscript{187} South African Law Commission Sexual Offences: The Substantive Law, The Need for a Statutory Offence Aimed at Harmful HIV-related Behaviour Discussion Paper 85, 12 August 1999 (hereafter referred to as The Commission). See also The Cuerrier case where the court contradicted this by pointing out that where public health endeavours fail to provide adequate protection to individuals like the complainants, the criminal law can be effective. The criminal law has a role to play both in deterring those infected with HIV from putting the lives of others at risk and protecting the public from irresponsible individuals who refuse to comply with public health orders to abstain from high-risk activities. The Commission and R v Cuerrier [1998] Z S.C.R. 371 (hereafter referred to as The Cuerrier case).
\item \textsuperscript{188} The Commission. Furthermore, the Commission specifically pointed out that HIV-related offences are not easily prosecuted under the existing common law crimes. It may be difficult for instance, to prove elements such as fault (whether the accused acted negligently, or with intention of transmitting HIV) and causation (whether the accused caused or was likely to cause the transmission of HIV infection to the other person), in order for the state to secure a conviction for murder or attempted murder where a person transmits or exposes another to HIV/AIDS.
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The Commission concluded by pointing out that the possibility of creating an HIV-specific statute should be examined which would look at the four possible options. These options were: (a) criminalising the intentional infection of another with HIV; (b) criminalising the intentional exposure of another to any sexually transmitted disease (including HIV); (c) prohibiting sexual intercourse by a person with HIV with any other person, unless certain conditions exist (such as consent by the other person who knows of the accused’s HIV status; and (d) requiring a person with HIV to take all reasonable measures to prevent transmission of the disease.\textsuperscript{190} However, until to date, there seems to be no such HIV-specific statute which has been enacted by the South African legislature.\textsuperscript{191} The Commission, however, in a subsequent report, recommended that harmful HIV-related behaviour should not be criminalised, reasoning that criminalisation may harm rather than help people living with HIV, and disturb public health efforts to stop the spread of HIV.\textsuperscript{192} It would, however, be recommended that in view of the high HIV-infection rate, South Africa take the route of criminalising the intentional infection with HIV of another person by a person who knows that he or she is HIV positive. As already argued above, there seems to be absolutely no justification for a person to deliberately or intentionally infect another person with HIV. One example of a civil case that dealt with the transmission of HIV is the case of \textit{Venter v Nel}.\textsuperscript{193} In this case, the plaintiff claimed an amount of R466 031, 86, alleging that the defendant, a businessman who resided in the Durban area, infected her, with HIV. This occurred when the parties had sexual intercourse during August and September 1995. The court had no difficulties in reaching its decision as the matter was undefended. The court awarded the damages totalling R344 399, 06, taking into account past medical expenses, future medical expenses and general damages.

In the Canadian case of \textit{R v Cuerrier} (The Cuerrier case),\textsuperscript{194} the accused was charged with two counts of aggravated assault pursuant to section of the Criminal Code. Even though he had been explicitly instructed by a public health nurse to inform all prospective sexual partners that he was HIV positive and to use condoms every

\textsuperscript{190} The Commission.

\textsuperscript{191} Though an attempt of criminalising HIV transmission through rape was made by Schedule 2 of The Criminal Law Amendment Act 105 of 1997 by providing special sentences for those offenders who rape complainants while knowing that they are HIV-positive. Schedule 2 provides that: Rape as contemplated in section 3 of the Criminal Law (Sexual Offences and Related Matters) Amendment Act, 2007- (a) when committed- (iv) by a person, knowing that he has the acquired immunodeficiency virus.


\textsuperscript{193} \textit{Venter v Nel} 1997 (4) SA 1014 (D) hereafter will be known as \textit{The Nel’s case}.

\textsuperscript{194} \textit{The Cuerrier} case.
time he engaged in sexual intercourse, the accused had unprotected sexual relations with the two complainants without informing them that he was HIV positive.\textsuperscript{195} Both complainants had consented to unprotected sexual intercourse with the accused, but they testified at the trial that if they had known that he was HIV positive, they would never have engaged in unprotected intercourse. At the time of the trial, neither complainant had tested positive for the virus. The trial judge had entered a directed verdict acquitting the accused and the Court of Appeal upheld the acquittals.

In allowing the appeal and ordering a new trial, the court observed that in the context of the wording of section 265, an accused’s failure to disclose that he is HIV positive is a type of fraud which vitiates consent to sexual intercourse.\textsuperscript{196} The essential element of fraud in commercial criminal law is dishonesty, which can include non-disclosure of important facts and deprivation or risk of deprivation. The dishonest action or behaviour must be related to the obtaining of consent to engage in sexual intercourse. The accused’s actions must be assessed objectively to determine whether a reasonable person would find them to be dishonest. The dishonest act consists of either deliberate deceit respecting HIV status or non-disclosure of that status. Without disclosure of HIV status there cannot be a true consent.\textsuperscript{197} The consent cannot simply be to have sexual intercourse. Rather, it must be consent to intercourse with a partner who is HIV-positive. The extent of the duty to disclose will increase with risks attendant upon the act of intercourse. The failure to disclose HIV-positive status can lead to a devastating illness with fatal consequences and in those circumstances there exist a positive duty to disclose. The nature and extent of the duty to disclose, if any, will always have to be considered in the context of the particular facts presented.\textsuperscript{198}

To establish that the dishonesty resulted in deprivation, which may consist of actual harm or simply a risk of harm, the Crown needs to prove that the dishonest act had the effect of exposing the person consenting to a significant risk of serious bodily harm. The risk of contracting AIDS as a result of engaging in unprotected intercourse meets the test.\textsuperscript{199} Further, in situations such as this, the Crown is still required to prove beyond reasonable doubt that the complainant would have refused to engage in unprotected sex with the accused if she had been advised that he was HIV-positive. Therefore, a complainant’s consent to sexual intercourse can properly be found to be vitiated by fraud under section 265\textsuperscript{200} if the accused’s failure to disclose his HIV-positive

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\item\textsuperscript{195} The Cuerrier case.
\item\textsuperscript{196} The Cuerrier case.
\item\textsuperscript{197} The Cuerrier case.
\item\textsuperscript{198} The Cuerrier case.
\item\textsuperscript{199} The Cuerrier case.
\item\textsuperscript{200} Section 265 of The Criminal Code R.S.C, 1985, c.C-46, as cited in the Cuerrier case, provides that: (1) A person
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status is dishonest and results in deprivation by putting the complainant at a significant risk of suffering serious bodily harm.\textsuperscript{201}

Where public health endeavours fail to provide adequate protection to individuals like the complainants, the criminal law can be effective. The criminal law has a role to play both in deterring those infected with HIV from putting the lives of others at risk and protecting the public from irresponsible individuals who refuse to comply with public health orders to abstain from high-risk activities.\textsuperscript{202} The court concluded by holding that an individual who knows that he was HIV-positive and had unprotected sexual intercourse without disclosing this condition to his partner may be found guilty of contravening section 265 of the Criminal Code. It is right and proper for public health authorities to be concerned that their struggles against AIDS should not be impaired.\textsuperscript{203} This case provides a classic example of the ineffectiveness of the health scheme. The accused was advised that he was HIV positive and on three occasions he was instructed to advise his partner of this and not to have unprotected sex. Nevertheless, blithely ignored these instructions and endangered the lives of the two partners. Through deterrence, the Criminal Code will protect and serve to encourage honesty, frankness and safer sexual practices. The court stated that if the application of the Criminal Code really does impede the control of AIDS, it the Canadian parliament would have to determine whether the protection afforded by the Code should be curtailed in the interests of controlling the plague solely by the public health measure.\textsuperscript{204}

The \textit{Cuerrier} case established that there is a positive legal duty upon the infected HIV positive person to disclose his or her status, to his or her sexual partner or partners, failing of which he or she may be criminally charged. The court was correct in holding the view that without disclosure of the HIV-positive status there can be no true consent. It is true that consent should not, in the case of HIV-positive person who knows his or her status, only be for sexual intercourse. But consent should be for sexual intercourse \textit{with an HIV-positive person}. In fact, the only reason why an HIV-positive person would refuse to disclose his or her status to his or her sexual partner, impliedly, would be that he or she is afraid that the sexual partner would refuse to have sexual intercourse or unprotected sexual intercourse with him or her in this instance, which is what happened in the

\textsuperscript{201} commits an assault when (a) without the consent of another person, he applies force intentionally to that other person, directly or indirectly; (2) This section applies to all forms of assault, including sexual assault with a weapon, threats to a third party or causing bodily harm and aggravated sexual assault; (3) For the purposes of this section, no consent is obtained where the complainant submits or does not resist by reason of (a) the application of force to the complainant or to a person other than the complainant; (b) threats or fear of the application of force to the complainant or to a person other than the complainant; (c) fraud; or the exercise of authority.

\textsuperscript{202} \textit{The Cuerrier} case.

\textsuperscript{203} The \textit{Cuerrier} case.

\textsuperscript{204} The \textit{Cuerrier} case.

\textit{The Cuerrier} case.
The *Cuerrier* case. Both the complainants had testified that they would not have engaged in unprotected sex with the accused if they had known that he was HIV positive, which must have been one of the main reasons why the accused had concealed his HIV-positive status. It is clear that by not disclosing his HIV status the accused intended to have unprotected sexual intercourse with the complainants, and thereby, as the court correctly stated, infecting them with the devastating illness with fatal consequences. Surely, there is a justification for criminal law to punish such an accused and thereby serve as a deterrent to other would-be offenders who would like to have unprotected sexual intercourse with others whilst they know that they are HIV positive and thereby continue the spread of HIV in the process.

The *Cuerrier* case provides support for the criminalisation of harmful HIV transmission and non-disclosure of HIV status. The court correctly reasoned that the health care system is in certain cases ineffective and this case provided a classic example. It seems to be clear that where an HIV positive person has been told three times to inform his or her partner and not to have unprotected sex but failed to do so, the public health system of counselling the patient is ineffective in that respect. It is in such cases therefore that the criminal law can be effective.\(^{205}\)

In these instances, the criminal law can provide a much needed measure of protection in the form of deterrence and reflects society’s abhorrence of the self-centered recklessness and the callous insensitivity of actions of the respondent and those who have acted in a similar manner. In order to effectively address the spread of HIV, both the public health system and criminal law should play a role, as public education alone may not succeed in modifying the behaviour of individuals at risk of contracting AIDS, as the *Cuerrier* case illustrates.\(^{206}\) It follows that if the deterrence of criminal law is applicable it may well assist in the protection of individuals and it should be utilised.\(^{207}\) It is recommended, therefore that firstly, an HIV positive person should be counselled and advised by the healthcare worker to inform his or her partner or partners about his or her HIV status. If he or she fails to do so he can then be criminally charged and if found guilty, be sentenced and this will serve as a deterrence to others.

The Canadian case of *Cuerrier* was followed and applied by the case of *R v Williams* (*The Williams case*).\(^{208}\) In this case, the complainant and the respondent, during their sexual affair that lasted for approximately 18 months, engaged in numerous acts of vaginal intercourse and occasional fellatio. Condoms were used

\(^{205}\) *The Cuerrier* case.  
\(^{206}\) *The Cuerrier* case.  
\(^{207}\) *The Cuerrier* case.  
\(^{208}\) *R v Williams* [2003] 2 S.C.R. 134, 2003 SCC 41 (hereafter referred to as *The Williams case*).
occasionally. The complainant did not take the usual precautions against pregnancy because the respondent had told her that he had had a vasectomy.\textsuperscript{209} The relationship began in June 1991 and soon after the sexual activity began. Unknown to the complainant, the respondent attended a medical clinic for HIV testing on October 16, 1991. Seemingly, his name was on the list of former partners provided by an individual who tested HIV positive. He was told on November 15, 1991, that he was HIV-positive. He received counselling on three different occasions by two doctors and a nurse about HIV, its transmission, safer practices and his duty to disclose his HIV status to sexual partners. The respondent said he was devastated by the result of the test, but chose to follow none of the recommended safer practices in his relationship with the complainant, whom he kept in the dark about his HIV status. He provided the names of two past sexual partners to the public health authorities, but not the name of the complainant.\textsuperscript{210} The complainant took an HIV test on November 20, 1991, tested negative and informed the respondent. Their relationship continued for another year, ending for unrelated reasons in November 1992.\textsuperscript{211} The complainant, subsequently, took the second test and was informed that she was HIV-positive on April 15, 1994. When she confronted the respondent with the result of her test, he repeatedly and falsely denied that he had ever tested positive for HIV. It was accepted that the complainant would never knowingly have had sex with an HIV-positive person.\textsuperscript{212}

The respondent had conceded that he infected the complainant with HIV. Similarly, the Crown had conceded that it is quite possible that the respondent infected the complainant before learning of his HIV-positive status.\textsuperscript{213} The court expressed the view that the respondent acted with a shocking level of recklessness and selfishness. There was no doubt that he committed a criminal assault with regard to the complainant, and further that he was guilty of an attempted aggravated assault (maximum penalty of seven years) and common nuisance (maximum penalty of two years).\textsuperscript{214} However, the court dismissed the appeal for aggravated assault holding that the Crown was unable to establish the \textit{actus reus} of that particular offence.\textsuperscript{215} In dismissing the appeal, the court reasoned that there was a reasonable doubt that the assault in question was capable of causing the life-threatening consequences alleged in the indictment. The court further reasoned that medical evidence indicates that a single act of unprotected vaginal intercourse carries a significant risk of HIV transmission.\textsuperscript{216} Accordingly, at the time the respondent found out that he was HIV-positive, it was clear that he had already been a carrier of HIV for

\textsuperscript{209} The Williams case, paragraph [3].
\textsuperscript{210} The Williams case, paragraphs [4-5].
\textsuperscript{211} The Williams case, paragraph [6].
\textsuperscript{212} The Williams case, paragraphs [7-9].
\textsuperscript{213} The Williams case, paragraph [10].
\textsuperscript{214} The Williams case, paragraph [2] and [20].
\textsuperscript{215} The Williams case, paragraph [2].
\textsuperscript{216} The Williams case, paragraph [2] and [11].
a significant period of time. Equally, although the complainant tested negative for HIV shortly thereafter, she may as well have been infected with HIV but not yet had time to develop the antibodies that would disclose her condition in the test. It was therefore at least doubtful that the complainant was free of HIV infection at the time the respondent first discovered, and then concealed, his HIV status on November 15, 1991.\textsuperscript{217} In applying the 

\textit{Cuerrier’s} principle, the court observed that the most important date in this case was November 15, 1991, which was the date that the respondent learned that he was HIV-positive. The court reasoned that the critical date for the purpose of establishing fraud to vitiate consent is when the respondent had sufficient awareness of his HIV-positive status that he can be said to have acted ‘intentionally or recklessly, with the knowledge of the facts constituting the offence, or with wilful blindness towards them.’\textsuperscript{218}

Once an individual becomes aware of a risk that he or she has contracted HIV, and hence that his or her partner’s consent becomes an issue, but nevertheless persists in unprotected sex that creates a risk of further HIV transmission without disclosure to his or her partner, recklessness is established. In this case, therefore, the court had the view that November 15, 1991 was the date that the respondent clearly knew that he was HIV-positive and, moreover, had been warned by the doctors that sexual intercourse with an unprotected partner could have potentially lethal consequences for her, but nevertheless persisted.\textsuperscript{219} However, the court had the view that although the respondent, in this case, was deceitful after November 15, 1991, the Crown conceded that it could not show that sexual activity after that date harmed the complainant or even exposed her to a significant risk of harm, because at that point she was possibly, and perhaps likely, already infected with HIV.

Furthermore, the court observed that to constitute a crime, the \textit{actus reus} and the \textit{mens rea} or intent must, at some point, coincide. Here, however, before November 15, 1991, there was an endangerment but no intent; after November 15, 1991, there was an intent but at the very least a reasonable doubt about the existence of any endangerment and therein laid the Crown’s problem in this case.\textsuperscript{220}

The absence of consent was an essential element of any assault and there was no doubt, according to the court, that the complainant did not subjectively consent to unprotected sex with an HIV-positive partner, as she so testified. Following 15, November, 1991, the respondent knew, but the complainant did not, that he was HIV-positive. Each act of unprotected sex exposed her to the lethal virus. There was nothing whatsoever in the evidence to suggest that the complainant, believing rightly or wrongly that she was HIV free, consented to such

\textsuperscript{217} The Williams case, paragraphs [12-14].

\textsuperscript{218} The Williams case, paragraphs [27].

\textsuperscript{219} The Williams case, paragraphs [28] and [30].

\textsuperscript{220} The Williams case, paragraph [35].
The Cuerrier principle was applied in this case. The complainant never consented to have sexual intercourse with a partner who was HIV-positive. As of November 15, 1991, he knew that he was HIV-positive and she did not, and at all relevant times, she believed that both she and the respondent were HIV free. That was enough to reject the respondent’s argument on consent.

The court, further, pointed out that the differing results in Cuerrier and this, Williams case, simply reflect the different factual circumstances. The conduct of this respondent after November 15, 1991 is no less reprehensible. The abuse of the complainant’s trust, the obtaining of her consent by deceit, and the sexual activity itself are all common to both cases. The difference here is that, unknown to the respondent at the time, there was a reasonable doubt on the evidence that the life of the complainant was capable of being endangered after 15, 1991 by exposure to a virus she had likely already acquired.

The court then left open the question of whether there would be consequences of unprotected sex between HIV positive infected partners. The court concluded by holding that in the case, actus reus of aggravated assault ‘is present in an incomplete but more-than-merely-preparatory way’. The respondent stood properly convicted of attempted assault. The court then affirmed the respondent’s convictions for aggravated assault and common nuisance but dismissed the Crown’s appeal with respect to the charge of aggravated assault.

The Williams case followed and applied Cuerrier’s principle in holding that consent is vitiated by non-disclosure by an HIV positive person to his or her sexual partner. And also, that similar to the Cuerrier case, the complainant in the Williams case also never consented to have sexual intercourse with a partner who was HIV-positive. The court in the Williams’s case was correct when it pointed out that the two cases had similarities such as the abuse of the complainant’s trust, the obtaining of her consent by deceit, and the sexual activity itself.

However, the court noted that there was a difference between the two cases being that, unknown to the respondent at the time, there was a reasonable doubt on the evidence that the life of the complainant was capable of being endangered after November 15, 1991, by exposure to a virus she had likely already acquired.

The Williams’s case also was able to prove the ineffectiveness of the health care system and the justification of criminalisation of harmful transmission by HIV-positive people to their sexual partners. This is proved by the fact that, also in this case, the respondent was counselled three times by two doctors and a nurse.

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221 The Williams case, paragraphs [36] and [38].
222 The Williams case, paragraphs [40].
223 The Williams case, paragraphs [57].
224 The Williams case, paragraphs [66] and [67].
225 The Williams case, paragraphs [71].
226 The Williams case, paragraphs [57].
227 The Williams case, paragraphs [57].
but nevertheless chose not to follow their advice of informing his sexual partner about his HIV status and to practise safe-sex by using, for instance, condoms during the sexual intercourse. Instead, despite that counselling, he continued to have unprotected sexual intercourse with his sexual partner for another year after that counselling. Furthermore, to clearly demonstrate his intention of infecting the complainant with HIV, the respondent gave the public health authorities the names of only two of his past sexual partners, but not the name of the complainant. The reason why he withheld the name of the complainant might be that he wanted them not to notify the complainant about his HIV status.

Finally, though the court may seem to be justified in dismissing the appeal for aggravated assault and affirming attempted aggravated assault due to the evidence that was before it at the time, it was correct for the court to leave open the question of whether there would be consequences of unprotected sex between HIV-positive infected partners. Medical evidence may in future show that harm may arise between people who are both infected by HIV and who continue to engage in unprotected sex, as they stand the risk of infection and reinfection. Reinfection may cause an HIV positive person to deteriorate quicker and to die in a short space of time, unlike a person who has been infected only once.228

The Cuerrier and Williams cases were followed by a recent Canadian case of R v Mabior.229 The accused, in this case, was diagnosed HIV-positive on January 14, 2004. At the time of his diagnosis and many times, thereafter, the accused was advised by a public health nurse to inform his sexual partners of his HIV status and to always use condoms.230 The accused began antiretroviral therapy (ART) shortly after his diagnosis. The therapy resulted in an undetectable viral load between early October and December 2005. From January 2004 to March 2006, he engaged in sexual intercourse with multiple women without disclosing his status. The trial court convicted the accused on six counts of aggravated sexual assault for not disclosing his status to his sexual partners. He was sentenced to fourteen years’ imprisonment.231 The decision was appealed to the Manitoba Court of Appeal. The Canadian HIV/AIDS Legal Network sought and was granted intervener status. The principal issue on the appeal was whether the trial judge erred in her application of the legal test of ‘significant risk of serious bodily harm’, a principle established by the Cuerrier’s decision, in the particular circumstances of the case. According to the trial judge, even when a condom was used there was a significant risk of HIV


229 R v Mabior 2010 MBCA 93 (hereafter referred to The Mabior case).

230 The Mabior case.

231 The Mabior case.
transmission for the purpose of criminal law. She also concluded in the similar manner for an undetectable viral load. According to her, the risk would only be sufficiently reduced when a person has both an undetectable viral load and uses a condom.\textsuperscript{232} The Court of Appeal, applying the \textit{Cuerrier}'s decision, disagreed with the trial judge and stated clearly that the test set out in \textit{Cuerrier} was not a ‘no risk’ test but required the presence of a significant risk. Significant risk meant something other than an ordinary risk. It meant an important, serious, substantial risk. The court also expressed the view that legal assessments of risk in this area should be consistent with the available medical studies and acknowledged that the application of the legal test in \textit{Cuerrier} must evolve to account appropriately for the development in the science of HIV treatment.\textsuperscript{233} The court then held that the careful use of a condom or an undetectable viral load can reduce the level of risk below the threshold test of a significant risk. Based on these findings, the accused was acquitted of four counts of aggravated sexual assault with respect to those sexual encounters in which he carefully used a condom (even though his viral load was detectable) or did not use a condom but had an undetectable viral load.\textsuperscript{234}

The \textit{Mabior} case, therefore, could be described as an attempt of the court to clarify the \textit{Cuerrier} standard.\textsuperscript{235} In fact, as Elliot and Symington point out, many Canadian lower courts have since \textit{Cuerrier}, managed to interpret and apply the ‘significant risk’ threshold in making determinations about the duty to disclose and criminal liability, or lack thereof, for not disclosing.\textsuperscript{236} Until recently, the bulk of those cases have taken the correct view that the use of condom would preclude criminal liability for not disclosing.\textsuperscript{237} However, Elliot and Symington still feel that there remains a degree of uncertainty and inconsistency in the Canadian law, as some courts still dispense entirely with any assessment of the risk of harm. They therefore feel that the Supreme Court has a key role to play in refining and clarifying the law, in accordance with good science and with larger public policy objectives, so as to give clear guidance to lower courts that certain conduct, for example, sex with condoms, or sex in circumstances where there is low or undetectable viral load, falls below the criminal legal threshold of ‘significant risk’.\textsuperscript{238}

\begin{itemize}
\item \textsuperscript{232} The \textit{Mabior} case.
\item \textsuperscript{233} The \textit{Mabior} case.
\item \textsuperscript{234} The \textit{Mabior} case.
\item \textsuperscript{235} Elliot R and Symington A \textit{Mabior and D.C.: Does HIV Non-Disclosure Equal Rape?} (Part 1) http://www.thecourt.ca/2012/02/07/mabior-and-d-c-does-hiv-non-disclosure-equal-rape-p... (visited 22 June 2012).
\item \textsuperscript{236} Elliot and Symington http://www.thecourt.ca/2012/02/07/mabior-and-d-c-does-hiv-non-disclosure-equal-rape-p (visited 22 June 2012).
\item \textsuperscript{237} Elliot and Symington http://www.thecourt.ca/2012/02/07/mabior-and-d-c-does-hiv-non-disclosure-equal-rape-p (visited 22 June 2012).
\item \textsuperscript{238} Elliot and Symington http://www.thecourt.ca/2012/02/07/mabior-and-d-c-does-hiv-non-disclosure-equal-rape-p (visited 22 June 2012).
\end{itemize}
The Mabior case, indeed, though it attempted to clarify the Cuerrier legal test, also left out some uncertainties. Though the Appeal Court acquitted the accused of four counts of aggravated sexual assault with respect to those sexual encounters in which he carefully used a condom (even though his viral load was detectable) or did not use a condom but had an undetectable viral load, however, there seems to be no explanation why the accused decided to engage in several sexual encounters with the complainants without informing them of his HIV-positive status. It could still be argued that even though the accused might have felt that there could be no significant risk of infecting the complainants if he used the condom or when he had an undetectable viral load, however, he still had to inform the complainants about his HIV status, in order for them to make informed decisions on whether they would sleep with an HIV-positive person or not. The facts of this case, again like Cuerrier and Williams cases, might also serve as an example of the ineffectiveness of the public health system, as the accused was also advised to inform sexual partners of his HIV-status, but failed to do so. The Mabior case highlights the dilemmas that the courts will have to face in dealing with a complicated disease such as HIV/AIDS. The courts will have to make such difficult decisions of whether non-disclosure of an HIV-positive person should be regarded as rape or not in a case where the accused has used a condom or had an undetectable viral load.

The first case that dealt with HIV transmission in South Africa was the case of S v Nyalungu (the Nyalungu case). In this case in 2003, the Pretoria regional court had convicted a man who was HIV-positive and raped a young woman while he was aware that he was HIV-positive, of rape and attempted murder. The case was referred to the High Court for sentence. The court sentenced the man to the minimum sentence of life imprisonment. The importance of this case is that the court referred to both Cuerrier’s case and William’s case in reaching its decision.

The Nyalungu case ruling was followed in the case of S v Snoti (the Snoti case). In this case, the appellant, a 29-year-old man, was charged as accused 1 with the rape of the complainant, a 9-year-old girl. One Eunice Wezi Cingi Makana, a woman, appeared as accused 2, and was charged with being an accomplice to the aforesaid rape. She was, however, eventually acquitted due to insufficient evidence. The appellant appealed to the Full Bench of the Eastern Cape Division against the sentence of life imprisonment, imposed by Jones J.

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239 S v Nyalungu 2004 JDR 0189 (T) (hereafter referred to as The Nyalungu case).
See The Nyalungu case, where the court cited Cuerrier case, for instance, as having pointed out that the criminal law does have a role to play both in deterring those infected with HIV from putting the lives of others at risk in protecting the public from irresponsible individuals who refuse to abstain from high risk activities. Where public health endeavours fail to provide adequate protection to individuals the criminal law can be effective.

240 S v Snoti 2007 (1) SACR 660 (E) (hereafter referred to as The Snoti case).

241 The Snoti case.
following a conviction of rape in the South East Cape Local Division. The trial court found that there were no substantial and compelling circumstances to justify not imposing the life sentence. The court considered two aggravating factors in particular. First, that the complainant was a helpless little girl and that the appellant had been in a position of trust. Secondly, and what placed this case in the very worst category of rape cases, according to the court, was that the accused knew that he was HIV-positive at the time of the offence. The court held that the trial court correctly found that in the light of the aggravated factors that there were no substantial and compelling circumstances justifying a lesser sentence than that of life imprisonment. The appellant’s conduct in raping a 9-year-old girl entrusted to his care, knowing of his HIV status, was reprehensible in the extreme. The court further held that the fact that the complainant had fortuitously escaped being infected with HIV had no bearing on the appellant’s moral blameworthiness. The appeal was, therefore, dismissed.

In both these cases, Nyalungu and Snoti, it seems clear that the courts wanted to send a strong message to the would be offenders that the law will not tolerate people who rape women or other people whilst knowing that they are HIV-positive and thereby infect them with the virus on the process. The court, in Snoti case, correctly emphasised the fact that that case was placed in the very worst category of rape cases. Furthermore, the court also correctly held that the fact that the complainant had luckily escaped being infected with HIV had no bearing on the appellant’s moral blameworthiness.

It is important, however, to note that both the South African cases of Nyalungu and Snoti were rape cases, unlike the two Canadian cases of Cuerrier and Williams which involved consensual sexual intercourse. The Criminal Law Amendment Act, section 3, points out that, any person (‘A’) who unlawfully and intentionally commits an act of sexual penetration with a complainant (‘B’), without the consent of B, is guilty of the offence of rape. The scope of rape, according to the Criminal Amendment Act, therefore, has been widened to include any complainant, who might be a man or female. It is not clear yet, whether South African courts would consider a consensual sexual intercourse between an HIV-positive person and a complainant who was not informed that the other person was HIV-positive to be rape or not. South African courts seem prepared to sentence heavily those individuals who, while knowing that they are HIV-positive, rape women and children. The idea that people

243 The Snoti case.
244 The Snoti case.
245 The Snoti case.
246 The Snoti case.
247 The Snoti case.
249 Van der Bijl C “Rape as a materially-defined crime: Could ‘any act which causes sexual penetration’ include omissions?” 2010 SACJ 235.
should take responsibility and always insist on condom use, is not feasible in the traditional context of Africa because, as already discussed above in chapter 3, women normally do not initiate sex and so cannot insist on condom use in marriage as a strategy for the prevention of infection against diseases, including HIV.\textsuperscript{250}

Criminalisation of HIV transmission, however, is an extremely controversial issue and has been widely debated.\textsuperscript{251} There seems to be two sides, that is, the proponents for and opponents against criminalisation of HIV transmission.\textsuperscript{252} These arguments for and against criminalisation, according to Van Wyk, seem to be based on two international models for combating AIDS.\textsuperscript{253} The first model emphasises the rational nature of people and their fundamental rights. It promotes non-coercive measures, such as education, information, voluntary testing, counselling and voluntary behavioural change and is very often accompanied by anti-discrimination legislation. It assumes that when people are informed, they will exercise self-discipline, adapt their behaviour to protect themselves and others, and act in a socially responsible way.\textsuperscript{254} The second model emphasises state intervention and coercive measures in the private lives of people, for instance, by prescribing compulsory testing for couples who are to be married or even of the whole population, and by imposing quarantine, isolation and criminal sanction, and stresses the individual’s responsibility to protect others.\textsuperscript{255} This model probably overestimates the success of state control.\textsuperscript{256}

South Africa has consistently applied the first model. The emphasis has been laid on information and education about HIV and on the right of people with HIV. A national Advisory Group was established as early as 1998, while a massive education and information campaign was launched and leaflets in nine languages as well as free condoms were distributed.\textsuperscript{257}

4.10.1 Proponents for criminalisation

Van Wyk, one of the proponents of criminalisation, criticised South Africa’s stance of adhering to the first model, discussed above, by pointing out that it is clear that the escalating figures of HIV show that this approach has


\textsuperscript{251} Van der Bijl 2010 SACJ 234, points out that this is evidenced by the fact that deliberate infection of HIV/AIDS was included as part of the definition of rape in the Draft Bill on Sexual Offences Act 50 of 2003, but was consequently removed from the proposed definition and made a separate offence in the Working Paper of 2004. An omission to disclose such information was made punishable under that Draft Bill.

\textsuperscript{252} Ndawula LLM dissertation 30 and Anyangwe 408.

\textsuperscript{253} Van Wyk 2000 Codicillus 3.

\textsuperscript{254} Van Wyk 2000 Codicillus 3.

\textsuperscript{255} Bhamjee 2008 Obiter 319.

\textsuperscript{256} Van Wyk 2000 Codicillus 3.

\textsuperscript{257} Van Wyk 2000 Codicillus 3.
not been successful and further that it had probably been too idealistic. The then proposes a middle course between the two extremes or that a combination of the two models rather be adopted. This approach would accept that rights to equality and non-discrimination go hand in hand with duties and responsibilities, and that once a certain level of awareness and information about HIV/AIDS is reached in a community, those who continue to act in an irresponsible manner must be held accountable. While it is accepted that coercive measures are not suitable as a first line of attack in combating HIV, they are a suitable back-up for accommodating and enabling non-coercive efforts made by the public health authorities. However, it must be generally accepted that public health measures should first be exploited before recourse is had to criminal sanctions. Van Wyk concludes by pointing out that there should be a serious consideration of criminalising the negligent transmission of exposure to HIV as a uniquely South African solution to the problem of harmful HIV-related sexual behaviour.

Bamjee, though claiming not to be advocating for the criminalisation of HIV status but only reckless, harmful behaviour thereof, contends that criminal law does have a role to play, but not as the only means or measure for curbing the spread of the virus. Bamjee states that it is hoped that this will bring to the attention of prosecutors the length and breadth of the notion, that successful prosecutions can be instituted in instances where HIV is an element of criminal misconduct. Van der Bijl argues for the omission of non-disclosure by an HIV-positive person who deliberately infects another with a life-threatening illness during consensual intercourse, to be considered a form of conduct which causes the condition of sexual penetration prohibited by definition of rape. She contends that the phrase ‘any act which causes sexual penetration’ of section 3 of the definition of the Criminal Law Amendment Act does not suggest that it includes or excludes omissions. That the use, therefore, of the term ‘any act’ is arguably extremely wide, and could be used to refer to both act and an omission. She argues, further that, if the legal convictions of the community are taken into consideration, it would be reasonable to regard the term ‘act’ to include an omission, so that in a situation where a person intentionally fails to disclose his or her HIV status, or infection with another form of life-threatening illness during

Bhamjee 2008 Obiter 320.
Bhamjee 2008 Obiter 328.
Van der Bijl 2010 SACJ 224.
See section 3 of the Criminal Law Amendment Act 32 of 2007, which stipulates that: ‘Any person (A) who unlawfully and intentionally commits an act of sexual penetration with a complainant (B), without the consent of B, is guilty of the offence of rape.
Van der Bijl 2010 SACJ 228.
sexual penetration, such a person’s omission could arguably qualify as an act which caused the sexual penetration. If that person had informed his sexual partner of his status, it is doubtful whether the former would have engaged in the act had she been aware of all the facts. The failure to disclose, therefore, is the act which caused the penetration. 267 However, the Criminal Law Amendment Act does not criminalise intentional infection of another with HIV or other life-threatening illnesses, and the current definition of rape contains no reference to the deliberate infection with HIV or life-threatening illnesses. The reason given for this is that it is believed that South African women have the highest prevalence rate for HIV and that failure to disclose their HIV status would only increase discrimination against such women. 268 According to Van der Bijl, there seems to be authority for the view that the deliberate infection of another person with life-threatening illness should be regarded as rape, as such infection is a material fact which should negate consent, but the position has not been taken further as it has been felt that the common-law crimes are sufficient in this regard. 269

Chalmers contends that while there is a role for the criminal law in restricting the spread of HIV, it is one that pales into insignificance alongside broader public health measures. He maintains that criminal law nevertheless does have a role in shaping attitudes and hopefully altering behaviour. 270 He furthermore proposes that if a specific legislation is to be drafted to address issues of HIV transmission and exposure, the scope of any offence created must be carefully delineated. 271 Matthieson points out that she believes that a person, who knowing that she or he is HIV-positive, has sexual intercourse with another who has not consented to the risk of transmission, engages in in a morally unacceptable conduct. 272 The challenge is to confront the complexities and formulate criminal law response that effectively targets blameworthy conduct, while at the same time remaining sensitive to those living with HIV. Indeed, it accepted that criminalisation of the reckless transmission of HIV via consensual sexual intercourse presents a plethora of both moral and legal problems. 273 HIV cannot be analogised with non-fatal offences against the person and its transmission invariably takes place during an intimate relationship. Decisions made in this context intersect with concepts of trust and attraction that are inept for legal examination. 274 Moreover, unlike other sexual transmitted diseases (STD), HIV carries a stigma of blame, which holds that certain ethnic groups and homosexuals have brought the disease upon themselves. Notwithstanding this, however, it can be broadly accepted that something has gone wrong when a person learns

267 Van der Bijl 2010 SACJ 229.
268 Van der Bijl 2010 SACJ 235.
269 Van der Bijl 2010 SACJ 235.
272 Matthieson 2010 KLJ 123.
273 Matthieson 2010 KLJ 132.
274 Matthieson 2010 KLJ 132.
that she or he is infected with HIV and continues to have unprotected sexual intercourse with another who has no reason to know that she or he is being put at risk of infection.\footnote{275} Provided the elements are applied as suggested, the criminal law will represent a morally sound response to the HIV pandemic which positively supplements public health.\footnote{276}

Proponents for the criminalisation of HIV transmission agree that, although there are challenges and complexities concerning criminalisation, criminal law has role to play in fighting the spread of the virus through deliberate and reckless transmission.

The public health system does not seem to offer solutions in these instances, which is why it could be argued that criminal law has role to play as a supplement to public health, in order to deter such individuals from wilfully and recklessly spreading the virus by having intercourse with unsuspecting sexual partners.\footnote{277} An integrated approach, as advocated by Van Wyk, should be considered, that is, where an HIV-positive individual will first be counselled and advised by health care workers to inform his or her sexual partner or partners about his or her HIV status and using protection if they agree with the partner to have sexual intercourse.\footnote{278} If such an individual, however, fails to adhere to the advice of health care workers and continues to have unprotected sexual intercourse with his or her sexual partners or partners, then criminal law can be used to serve as deterrence to such an unacceptable behaviour.

\subsection*{4.10.2 Opponents of criminalisation}

One of the opponents of criminalisation of HIV transmission is Viljoen, who in his reply to Van Wyk, argues that the existing common law has not been used adequately, for understandable reasons.\footnote{279} He contends that ‘Bedroom offences’ are notoriously difficult to police. But the existing common law can certainly be used to convict a flagrant and persistent infector.\footnote{280} Transforming the discourse on HIV/AIDS into a criminal law

\begin{thebibliography}{99}
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\item \footnote{275} Matthieson 2010 \textit{KLJ} 132.
\item \footnote{276} Matthieson 2010 \textit{KLJ} 132, who suggested the following: “First, the prosecutors should only charge the complete offence where the evidence proving causation is overwhelming. Where there is doubt, the prosecution should charge attempted assault. Secondly, to assuage the disincentive effect of criminalisation, the meaning of ‘recklessness’ should be include something less than actual knowledge of infection. This expansion of recklessness should be mediated by a more scrutinising assessment of the level of risk to which the defendant exposed the complainant. Thirdly, if the law expects members of high-risk groups to be more aware of the risk of infection for the purpose of determining recklessness, it should likewise expect more responsibility form complainants when determining whether they consented to the risk of transmission.
\item \footnote{277} Van Wyk 2000 \textit{Codicillus} 4.
\item \footnote{278} Van Wyk 2000 \textit{Codicillus} 4.
\item \footnote{279} Viljoen F “Stigmatising HIV/AIDS, stigmatising sex? A reply to Professor Van Wyk” 2000 (41;1) \textit{Codicillus} 11-16, 15.
\item \footnote{280} Viljoen 2000 \textit{Codicillus} 15.
\end{thebibliography}
discourse will be at the expense of cultivating a discourse of openness and tolerance. It will polarise society into two groups of ‘us’, the innocents, and ‘them’, the guilty. Rather, the answer lies in facing up the realities. The HIV virus is spreading because information aimed at prevention is not getting through or is not taken seriously. Policy makers and those informing public policy should focus on creating an enabling environment in which people will feel free to ‘come out’ with HIV/AIDS and not on questioning common scientific wisdom, masquerading with red ribbons, or engaging in symbolic actions with a counter-productive effect. Weait and Azad argue that it is no doubt true that a partner’s disclosure that he is HIV-positive is the most immediate and direct way in which a person may be made aware of the risk of contracting HIV through unprotected sexual intercourse. They suggest that it is wrong in principle that a person in receipt of this information should be able to assert that a criminal act has been committed if he or she is infected through consensual sex with that partner. But the question of whether a partner’s non-disclosure ought automatically to mean that a criminal act has been committed is not so easy to sustain.

The criminal law is a blunt instrument that deploys general, universally applicable principles in determining liability. The neutral categories of harm, fault, causation and consent are ones ill-suited to judge conduct that takes place in the context of relationships characterised by infinitely various manifestations of intimacy, sexual desire, trust and honesty. Similarly, the impartial criteria of evidential sufficiency and the ‘public interest’ that inform the prosecution process are ones that may serve to conceal discriminatory effects, however, unwitting and unintended those are. They further argue that there is a strong consensus in the HIV sector against the criminalising of reckless transmission. Weait and Azad state that the response to criminalisation must be part of a wider effort to return United Kingdom (UK) to its initial successful response to HIV, one grounded in public health and human rights.

Merminod contends that even though the deterrence rationale is used in every HIV case, deterrence as a goal of sentencing is only speculative. Non-legal literature, as well as expressed opinions by judges, is openly sceptical of the deterrence objective. This scepticism is based on the conclusions of a number of studies showing that potential offenders do not know the legal rules, do not make rational choices, or do not perceive
the exact cost for a violation that outweighs the expected gain.\textsuperscript{289} The need to set sentences appears to be outweighed by significant potential negative impacts arising from criminal procedures in Canada. In fact, criminal laws in Canada are not likely to stop HIV/AIDS transmission. Instead they appear to create a hostile environment enhancing stigmas of HIV/AIDS and thus prevent people from seeking testing and advice for fear of being identified as HIV-positive.\textsuperscript{290}

Criminalisation creates the belief that only HIV-positive people should carry the burden of protected sex. Rather than criminalising HIV, a combination of education, persuasion, social support, and increased informed media coverage represents the best hope for decreasing the incidence of risk taking in sexual conduct.\textsuperscript{291}

\subsection*{4.11 CONCLUSION}

The right to privacy, which includes confidentiality, is not absolute.\textsuperscript{292} This chapter has discussed some of the justifiable limitations of this right.

Although there is no legal duty upon an infected individual to warn his or her partner about his or her HIV-positive condition, it is encouraging that if such an HIV-positive individual engages in an unprotected sexual intercourse and thereby transmits HIV to his or her sexual partner, criminal and civil liabilities may be laid against such an individual. Also, in cases where an HIV-positive person has raped a woman or child whilst knowing that he is HIV-positive, the courts have imposed heavy sentences in order to deter the-would be offenders.\textsuperscript{293} It has also been shown that, though reliance should, first and foremost, be on the health care system to educate infected people with HIV about informing their sexual partners or practising safe sex, however, where such efforts fail (as was the case in the two Canadian cases of \textit{Cuerrier} and \textit{Williams}),\textsuperscript{294} criminal law sanctions should be applied. Whether this takes the form of existing provisions or new legislation will depend on the effectiveness of existing criminal provisions.

\begin{footnotesize}
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\item \textsuperscript{289} Merminod 2009 \textit{Lex Electronica} 29.
\item \textsuperscript{290} Merminod 2009 \textit{Lex Electronica} 29.
\item \textsuperscript{291} Merminod 2009 \textit{Lex Electronica} 29.
\item \textsuperscript{292} Section 36 of the Constitution of 1996, Currie & De Waal 163 and Mureinik 33.
\item \textsuperscript{293} See \textit{The Snoti and Nyalungu} cases.
\item \textsuperscript{294} See \textit{The Cuerrier and Williams} cases.
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CHAPTER 5

INDIVIDUALISM VERSUS UTILITARIANISM, COMMUNITARIANISM AND AFRICANISM

5.1 INTRODUCTION

Philosophically, there are various schools of thought and theories concerning the rights to privacy, confidentiality and medical confidentiality. Different philosophers have different views about the keeping of confidentiality or its limitation by its competing and corresponding duty of disclosure.¹ These schools of thought, which will be discussed in this chapter, include individualism, utilitarianism and communitarianism or Africanism. These philosophical models, in one way or the other, have a direct or indirect impact on the manner in which people (individually or as a group) behave or make decisions, especially in cases of sickness or when faced with death. Parker, for instance, argues that in times of stress, families often adopt individualistic values of the medical world and this leads them unintentionally to trample on the values and concerns which sustain families.² For example, an individual who lives an urban setting may tend to be influenced by individualism, in terms of which freedom of choice (eg to decide to keep confidential or disclose HIV-positive status to others) is emphasised at the cost of communitarian values. However, the same may not be the case with someone who lives in a rural, communitarian setting, where people often share feelings and views with each other for social and moral support. In such circumstances, an individual would feel more obliged to share his or her HIV status with other community members. This chapter will first discuss three schools of thought with the purpose of evaluating which theory best supports an understanding of issues relating to disclosure and confidentiality of HIV status.

5.2 A PHILOSOPHICAL OVERVIEW OF INDIVIDUALISM

The term ‘individualism’ is said to have been invented by Alexis de Tocqueville. De Tocqueville noted that the word was ‘a novel expression, to which a novel idea has given birth.’ By this he meant that the ‘novel’ idea of celebrating individual wants and intentions, discussed by moralist and social critics for a century or two, had reached the point where it needed a name of its own and could be regarded as the touchstone of a culture or national character, for better or for worse. The important philosophical watershed of individualism was the Protestant reformation of the sixteenth century during which Martin Luther asserted sovereignty of individual conscience and the right of the individual to commune directly with God, which no human institution, including the church itself, could overrule. Subsequently, the eighteenth-century period of Enlightenment advanced the compelling and intoxicating idea that human reason could unlock a pattern of unending improvement in science and politics.

The roots of individualism as a method can be traced in the approach of Hobbes, who was England’s greatest political thinker and whose self-appointed mission was to harness the emerging scientific spirit of his age, the

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4 Ketcham 138 and Kirkpatrick 35.
5 Ketcham 138, points out that Tocqueville’s comment and vocabulary on the point reveal the ambiguities when he stated that: ‘Our fathers were only acquainted with egotism. Egotism is passionate and exaggerated love of self, which leads a man to connect everything with his own person, and to prefer himself to everything in the world. Individualism is a mature and calm feeling, which disposes of each member of the community to sever himself from the mass of his fellow creatures; and to draw apart with his family and his friends; so that, after he has thus formed a little circle of his own, he willingly leaves society at large to itself. Egotism originates in blind instinct: individualism proceeds from erroneous judgment more than from depraved feelings; it originates as much in the deficiencies of the mind as in the perversity of the heart. Egotism blights the germ of all virtue; individualism, at first, only saps the virtues of public life, but, in the long run, it attacks and destroys all others and is at length absorbed in downright egotism. Egotism is a vice as old as the world, which does not belong to one form of society more than another: individualism is of democratic origin and it threatens to spread in the same ratio as the equality conditions.’
7 Kingdom 8. See also Elliot A and Lemert C The New Individualism: The Emotional Costs of Globalization (2006, Oxon: Routledge) 43, who observed that in 1782, when the culture of the modern world, modernity was taking shape, one of the Europe’s most influential and controversial writers, Jean-Jacques Rousseau, began a most unusual book with the following astonishing proclamations: ‘I have begun on a work which is without precedent, whose accomplishment will have no imitator. I propose to set before my fellow mortals a man in all truth of nature; and this man shall be myself. I have studied mankind and know my heart; I am not made like any one I have been acquainted with, perhaps like no one in existence; if not better, I at least claim originality and whether Nature has acted rightly or wrongly in destroying the mold in which she cast me, can only be decided after I have been read.’ In these words, Rousseau seemed to claim nothing less than to set forth the claim that he was an utterly unique human being.
latter to enhance understanding of the natural world for the benefit of society.\textsuperscript{8} When Hobbes analysed society, he identified at its core the individual acting in accordance with certain psychological principles, which were certain self-evident axioms discovered by introspection.\textsuperscript{9} His most fundamental axiom was that of the instinct to avoid death surpasses all others. He argued that every person shuns death by a certain impulsion of nature, no less than that whereby a stone moves downwards. From this could be inferred the notion that all complex willed behaviour was explicable in terms of aversions and appetites, always reflecting the desire for self-preservation. The individual was a calculating machine living a cost-benefit analysis existence.\textsuperscript{10} From these individual postulates, Hobbes deduced a vision of life as a ‘state of nature’. This was, according to him, a nightmare in which egocentric individuals forever torment each other with their selfish ambitions; a war of all against all lived in ‘continual fear and danger of violent death’. He famously declared life in nature to be nasty, brutish and short.\textsuperscript{11} Egoism was not, according to Hobbes, an ethical idea; it was a cold reality. His prescription was that the only way people could be saved from the troublesome life which nature offered was to place themselves voluntarily under an all-powerful, self-perpetuating sovereign. Obligation to the ruler was based upon prudence: self-interest was a perfectly sound basis for morality.\textsuperscript{12}

This was a daring and radical leap in thought, reversing the traditional view that morality could only be derived from nature (conscience) or the will of God, backed by the threat of an eternal netherworld of hell-fire. Hobbes believed that he had deduced universal moral obligation from fact; he had determined what ought to be from what was.\textsuperscript{13}

This notion was fraught with danger. In placing self-interest before the morality of religion, Hobbes relived the fable of Adam. Not only was God cast out, the idea of community with claims above individuals lost meaning and life itself had no purpose beyond individual self-interest.\textsuperscript{14} Ironically, though Hobbes’ inferences led to decidedly illiberal conclusions, those who followed his methodology were to find a basis for a liberal state.\textsuperscript{15} One such person was John Locke, who held a contrasting view of the individual in a state of nature, and who is

\begin{itemize}
  \item[8] Kingdom 8 and Kirkpatrick 8.
  \item[9] Kirkpatrick 17. See also Kingdom 9, who pointed out that Hobbes expressed these axioms of introspection in this manner: ‘Nosce teipsum, read thy self: whosoever looketh into himself, considereth what he doth, when he does think, opine, reason, hope, feare, etc., and upon what grounds; he shall thereby read and know, what are the thoughts and passions of all other men, upon like occasion.’
  \item[10] Kirkpatrick 19 and Kingdom 10.
  \item[12] Kingdom 10.
  \item[14] Kingdom 10.
  \item[15] Kirkpatrick 23.
\end{itemize}
Locke regarded as the father of liberalism.\textsuperscript{16} Locke’s notion did not dispense with God; however, he placed the individual at the centre of his earthly universe. He also invoked the state of nature, but unlike Hobbes’s jungle, Locke’s natural people behaved like English gentlemen. Far from imposing order by means of force, his government required but a minimal role, merely protecting the sacred natural rights bestowed by God.\textsuperscript{17} According to Locke, therefore, individuals in a state of nature possess rights to life, limb and liberty. From these derive a right to the produce of one’s own labour, implying a share of the human inheritance of the earth; that is, ownership of property which to toil.\textsuperscript{18} However, on the face of it, the right to property is not unlimited. Since, according to him, no one can have the right to cause another to starve in core of God’s plenty, the right is restricted to an amount required to sustain life, whatever is beyond this is more than a person’s share and belongs to others. Locke’s own logic, however, led him away from this egalitarian principle.\textsuperscript{19}

Locke did not offer a complete institutional model of government; however, but wished to see it being kept to a minimum. According to him, government must not create rights but should merely protect those already in nature, which should not be removed from persons without their consent.\textsuperscript{20} The government must be assumed to be based on the notional contract, implied in the very existence of the society; an assumed tacit consent amongst people to forgo certain natural rights for prudential reasons. He therefore supported the idea of limited constitutional government and a separation of powers. This was no absolutist Leviathan with power to appoint its successors, but a government of the majority. However, Locke’s democratic inclinations, like those of other liberals, were limited.\textsuperscript{21} Through his democratic precepts, Locke managed the amazing feat of justifying inequality even to the extent of curtailing the property rights of others, a conclusion most welcome to the large-scale property-owning class, as well as to the newly developing bourgeoisie. This was accomplished through the concept of money, since without money; the production of more food than would be eaten leads to waste and offends God’s law.\textsuperscript{22}

Money, however, enables excess produce to be sold and the profits stored, eventually to become interest-earning capital. Locke thus grounded capitalistic appropriation and accumulation in nature, with no natural limitation on individuals having more than their fair share. His state of nature was hence no primitive jungle but

\textsuperscript{16} Kingdom 10 and Kirkpatrick 23.
\textsuperscript{18} Kirkpatrick 25 and Kingdom 11.
\textsuperscript{19} Kingdom 11.
\textsuperscript{20} Kingdom 11.
\textsuperscript{21} Kingdom 11.
\textsuperscript{22} Kingdom 12.
a fantastical place where one finds not only a natural right to unlimited property, but money, wages and capitalist markets. Locke viewed capitalism as natural and unequal possession of property as a right which people bring to civil society; it is not created by the state and should not be removed by it. This inequality tendency was the ironical result of all individualist doctrines; although starting from postulates of equality they reached contrary conclusions. The societies were not truly atomised but contained competing groups of insiders and outsiders; which were class societies, divided by ownership of property. If this was implicit in Hobbes and Locke, it became starkly obvious when individualists invented a world which they believed could work, not by means of government but by clockwork. This delicate, self-regulating mechanism, working with the precision of a Victorian gold-plated pocket-watch, was the market. This situation as was envisaged by Hobbes and Locke, still prevails even today in many states in the world, including South Africa. This inequality, where individuals who are rich become richer and the poor poorer, has led to many revolts around the world in countries such as Egypt, Tunisia and Libya. In South Africa, also, there had been many service delivery demonstrations, not to mention violent strikes for higher wages in certain sectors, as people feel that there is little being done to improve their lives.

23 Kingdom 12.
This was confirmed by Deputy President Kgalema Motlanthe as reported by the Daily Sun of Friday 31 August 2012. The paper depicted this as “Blame capitalism for poverty – Motlanthe”. The Deputy President is reported as having charged that the gap between rich and poor is getting bigger and bigger and imperialism and capitalism were making it worse. He said these two forces were responsible for the poverty which was no longer a problem only for the developing world but also for the first world. He further stated that the global crisis of capitalism and imperialism was negatively affecting growth, widening social inequality, increasing levels of poverty and worsening unemployment figures. He therefore called for a radical shift in the approach.

24 An example of these demonstrations is reported by the Daily Sun of Monday 3 September 2012. The paper described this as “Man shot in protest for water”. This paper reported that what this man wanted was clean water. But what he got was death and no one knew who shot the unidentified man. He was with a crowd of angry people from Taflkop in Limpopo who marched that Friday morning to demand clean water. They blocked the main road leading to Groblersdal, threw stones at passing vehicles and tore down street signs. Schoolchildren and workers were forced to join the march. These service delivery demonstrations seem to have found support even from the Deputy President of the country, Kgalema Motlanthe, who is reported by the Daily Sun of Friday 31 August 2012, which depicted this as “Blame capitalism for poverty – Motlanthe”, as having expressed sentiments in parliament that the poor were right to protest against service delivery.

25 The most violent of which was the Marikana mine strike as reported by many newspapers around the country. The Daily Dispatch of Thursday 23 August 2012 depicted this as “EC’s Marikana death toll: 19.” This paper reported that police last week opened fire on protesting miners armed with machetes and sticks, killing 34. More than 70 were injured and 259 arrested. In total 44 people were killed in the week long dispute, including two police officers and two security guards. The Daily Sun of Thursday 23 August 2012 depicted this as “We are sorry.” The paper reported that two weeks ago 34 people died and 78 injured in violent clashes when about 3 000 rock drill operators entered into an illegal protest, demanding wage increase. Their demand was for an increase from R4 000 to R12 500. The paper further reported that President Zuma told the striking miners in Marikana outside Rustenburg that he believed that the massacre could have been avoided and that was the reason why he set up a judicial commission of inquiry to investigate. The City Press of 16 September 2012, which portrayed this as “Beyond Marikana: the crisis”, reported that on 10 August 2012, about 3 000 workers launched a wildcat strike at Lonmin’s Marikana mine, demanding a salary of R12 500. Three days of clashes killed 10 people. The paper further reported that on 16 August 2012, police and strikers clashed and 34 miners were shot dead. The Sunday Times of 28 October 2012 described this as “Ramaphosa to testify: wants to address Marikana Commission on claims he supported
One also finds this dichotomy in the health care context, namely between two sets of values; that is, those individualistic values which underlie patient-centred medicine and those which sustain families and communities. Hilde and James Lindemann Nelson argue that modern medicine’s overriding focus on the good

violence.” It reported that businessman and ANC heavyweight Cyril Ramaphosa has asked to testify before the Marikana Commission in a bid to clear his name, following claims that he had a hand in events leading to the killing of 34 miners by police on 16 August 2012. It further reported that President Zuma appointed the commission to investigate what led to the death of at least 44 people, 34 of whom were killed by police on August 16, during an illegal strike at Marikana. The other reportedly violent strike was that of truck drivers. The Daily Dispatch of Friday 28 September 2012 depicted this as “Petrol truck bombed on N6: vicious attack has been linked to ongoing drivers’ strike.” The paper reported that a truck carrying 40 000 litres of fuel exploded yesterday when it was petrol bombed on the N6 between East London and Stutterheim. The driver survived and is being treated for burns. The Daily Sun of 9 October 2012, also described this as “Trucker strike blazes on: and so does crime wave.” This paper reported that lorries on the East Rand were ablaze yesterday as the truck drivers’ strike raged on. In Kempton Park, an electrical contractor’s truck was stoned and set on fire at 9 am. At 9.30, a four-ton Isuzu bread truck was smashed with stones and burned in Boksburg. All the drivers escaped unhurt. The other, not widely reported strike was that of the forest workers. The Times of Friday 6 July 2012 portrayed this as “Forest fires pinned on strike.” The paper reported that a forestry strike had been linked to more than a 100 fires started across Limpopo and Mpumalanga. The fires had been raging over the past three days following a deadlock between the government-owned South African Forestry Company Limited and the Food and Allied Worker’s Union. The union was demanding a 15% wage increase while the company was offering an 8% increase. The fires started on Monday on the company’s Komatiland plantation in Limpopo, the lowveld and the Highveld, damaging more than 600ha of forests. Private plantation owners and farmers have also been targeted after racing to assist the company workers in extinguishing the blazes. Emergency workers and private fire fighters from Tzaneen are were also believed to have been assaulted while trying to put out fires on Tuesday and Wednesday. And, recently, the strike for higher wages hit the farming sector. This was reported by the Daily Dispatch of Tuesday 20 November 2012, which depicted this as “Cape police monitoring farmworkers.” This paper reported that the Coalition of Farm Worker Representatives said that it gave the government until 4 December 2012 to institute a wage of R150 a day and concede to worker demands. The New Age of 26 Monday 2012, also described this as “WC farmers concerned.” This paper also reported that earlier this month two people died and several farms were burnt in the Hex and Berg River Valleys in violence linked to action for higher wages. The Department of Labour said that it would review the minimum wage for farm workers, currently at about R70 a day, in response to the strike action. The workers said the industry sectoral determination needed to be finalised by December 4. Farmworkers are demanding a daily wage of R150.

Parker, to illustrate an example of this conflict, points out that Hilde and James Lindemann Nelson recount the case of a man whose daughter is suffering from kidney failure. The daughter is spending six hours, three times a week on a dialysis machine and the effects of this are becoming hard for her and her family to bear. She has already had one kidney transplant which her body rejected and her doctors are unsure whether a second one would work but are willing to try if they can find a suitable donor. After some tests the paediatrician privately tells the father that he is indeed compatible. It may seem inconceivable that a father would refuse to donate his kidney to his daughter under such circumstances. Yet he does refuse and justifies his decision not only on the basis that the outcome is uncertain but also on his concerns about the operation itself. He is frightened and worried about what would happen to him and his other children if his remaining kidney were to fail. He is ashamed to feel this way and cannot bear to refuse openly so he asks the doctor to tell the family that he is in fact not compatible. His doctor, however, after having some sympathy for him, informs him that she cannot lie for him. After a silence, the father then says, ‘Ok then I’ll do it. If they knew that I was compatible but wouldn’t donate my kidney, they would wreck the family.’ In order to understand such cases and the conflicts which characterise them it is important to recognise the subtle differences and conflicts between the values in families and those found in medicine. The man who was afraid to donate his kidney thought he had failed his daughter because he was not willing to do everything he could to save her life; he thought he was being cowardly and bad father and perhaps he was. However, another possibility he had not considered was that he was adopting the morality of medicine rather than honouring what’s valuable about families. Both the father and the doctor believed that the only legitimate question they were answering here was, ‘What is in the best interest of the patient?’ Yet families are made up of a number of people, all of whose interests have to be honoured. The single focus, therefore, on individual may be fine for medicine, but it’s less fine for families, who have their own, different, mechanisms for protecting their vulnerable members. In times of illness, families, anxious, needy and swayed, are drawn into medicine’s overwhelming commitment to patient care. Family members lose sight of the value of family life at these
of the individual patient has distorted the ways in which family members interact with one another and in particular with those who are sick. They argue that at times of stress, families often adopt the individualistic values of the medical world and this leads them unintentionally to trample on the values and concerns which sustain families. They argue that families in their devotion to values which are family-oriented, themselves sometimes have created distortions in medicine. For instance, for couples who see their need to have a child and subfertility as a medical problem and families who want their relatives kept alive no matter what the likelihood that there will be any life other than simply the organic, place demands upon medicine which it is impossible to meet. The claim that there are important tensions between the values of patient-centred medicine and those which sustain families and communities, reflects an on-going and important contemporary debate in health care ethics and in ethics more generally between individualistic approaches and those which have come to be known as communitarian. For liberal individualists, the human world is made up of individual people each with his or her own desires, interests and conception of the good, each with the ability to choose freely his or her own way of life. This means that they tend to explain moral problems in terms of the competing needs and interests of such individuals and they have, as a consequence, a tendency to focus on the differences between people, the variety of their needs and values, and their separateness, that is, they concentrate rather less upon what people have in common; their similarities, shared values, and projects and rather more on their diversity. The liberal individualist, therefore, interprets human relationships as the expression of individual needs and wishes and conceptualise moral problems in terms of ‘autonomy’, ‘rights’, ‘justice’ etc. This normally leads to a model of health care ethics focused on ‘patient-centred care’, ‘informed consent’ and the ‘best interests of the patient’. In this sense the liberal individualist approach can be said to resonate with one the most moral intuitions, for as Berlin suggests: ‘I wish my life and my decisions to depend on myself, not on external forces of whatever kind. I wish to be the instrument of my own and not of other men’s acts of will. I wish to be a subject, not an object, to be moved by reasons, by conscious purposes, which are my own, not by causes.’
Liberal individualism and its focus on individuals, however, has come under criticism from many directions, for despite the advantages of the liberal individualist conception of the subject it can in some ways be seen to create more problems than those it solves. Some communitarians, such as Lindemann Nelsons, argues that the problem with individualism as an approach to ethics is that its focus on the individual means that it unavoidably undervalues the relationships between people, their shared interests and values and implies that families and other social entities can have no value other than that of the individuals of which they are constituted. That is, that the needs of families ought never to be put above those of individual family members, for from a liberal individualist perspective it makes no sense to attribute value to groups or to relationships. The communitarians in general argue that this inevitably leads to a one dimensional view of the moral world and that from this individualist perspective the very possibility of people being the moral beings that they are in any sense at all is brought into question. Persons' understanding of questions as specifically moral is only made by virtue of the fact that they are engaged in a world with others and are not individuals in the liberal individualist sense. Communitarians suggest that only through such engagement, people come to understand the world and their relationships with others as ethical or moral. Therefore, if ethical problems are considered from an individualistic perspective, such a consideration is unavoidably incomplete, for there are aspects of all moral problems which are not susceptible to analysis in terms of individuals.

Confidentiality and individualism have also been criticised from the cultural point of view. This concerned the cultural origins of these concepts and the appropriateness of applying these in South Africa in the midst of an epidemic which has taken a very different form, in much less affluent social circumstances, to that of North America and Western Europe. Three main demographic differences presented themselves between HIV/AIDS in Africa on the other hand and in North America and Western Europe on the other. Firstly, in South Africa, as in the rest of Africa, the epidemic is generally heterosexual. Secondly, most of those affected are relatively poor and do not have extensive, if any, formal education. Thirdly, the figures in Africa are simply overwhelming.

35 Parker 4.
36 Parker 4.
37 Parker 4.
38 Parker 4.
39 Parker 4.
40 Parker 4.
41 Cameron 15.
42 Cameron 15.
43 Cameron 15.
44 Cameron 15.
Considering this background, it was perhaps not surprising that public health bureaucrats and others had expressed their impatience at the application of concepts they claimed may inhibit effective responses to the disease.\textsuperscript{45} The particular form the attack had taken is the suggestion that the notion of confidentiality is an alien import to Africa, foreign to the continent and its cultures. The first claims along these lines came, ironically, not from a cultural ‘Africanist’ but from the (white) head of the apartheid government’s AIDS Unit in 1991, Dr Holmshaw.\textsuperscript{46} Attacking Western-style adherence to individualism as an import ‘introduced by outsiders dealing with Africa in a non-African context’, she claimed that in Africa, perceptions of community versus individuality exist but notions of confidentiality are irrelevant.\textsuperscript{47} More recently, in 1996, the (black) then chief executive, Dr Shisana, of the post-apartheid national Health Department advocated an ‘open disclosure policy’.\textsuperscript{48} She claimed that partner notification had not been implemented in South Africa because time had not been taken to discuss with communities whether the restrictive policy on disclosure to partners was hindering or enabling the spread of HIV infection.

These comments provoked a storm in South Africa, with non-governmental organisations providing AIDS information and services expressing concern that abridgement of confidentiality would further stigmatise persons with HIV, already disadvantaged by ignorance and prejudice about HIV/AIDS.\textsuperscript{49} The ‘Africanist’ challenge to confidentiality as a ‘Eurocentric’ import to Africa drew on an older and even deeper-going criticism of privacy itself. From a socialist and communitarian point of view, the very distinction between what is private and what is public has been mocked as a product of classical liberal ideology.\textsuperscript{50} Criticism of this kind suggested that the idea of a private sphere tends to place the individual outside society, minimising the scope for the notion of social responsibility. This seems to foreshadow the essence of the ‘Africanist’ attack on confidentiality, which derived from what had been described as the communal dimension of all human existence in Africa. On one account, this suggested that the well-known statement of Descartes, ‘I think, therefore I am’ (\textit{cogito, ergo sum}), must in Africa be rendered as ‘I belong through kinship, therefore I am’ (\textit{cognatus, ergo sum}) instead.\textsuperscript{51} This has led to calls for ‘shared confidentiality’, as opposed to rigidly individualised confidentiality, to

\textsuperscript{45} Cameron 15.
\textsuperscript{46} Cameron 15.
\textsuperscript{47} Cameron 15.
\textsuperscript{48} Cameron 15.
\textsuperscript{49} Cameron 15.
\textsuperscript{50} Cameron 15.
be applied in Africa. However, these calls for shared confidentiality on their own had been criticised, especially as they seemed to create the impression that individual autonomy of confidentiality is swallowed or submerged by aspirations of the community.

Cameron, for instance, argues that the fact that ‘information-sharing’ is a basic cultural value, or that a culture includes supportive responses of a communitarian nature does not mean and cannot mean either that someone who is part of that culture automatically waives his or her right to individual autonomy, or that the culture itself demands that respect for individual choice in relation to confidentiality must be overridden. Still less does insistence on confidentiality inhibit the enactment of prompt measures to discourage stigma, violence and discrimination, which are the true obstacles to free disclosures in a free environment. This therefore means that public health concerns, as much as respect for individual autonomy, suggest that confidentiality, subject always to individual consent and excepted only for imperative public health necessities such as significant and real risk to another, should be a central value in the public health response to the epidemic. This leads to the conclusion that although individualism has been widely criticised, there seems that, as Gyekeye and other writers argue, that there is a place for an individual even in a communitarian African context.

5.3 A PHILOSOPHICAL OVERVIEW OF UTILITARIANISM

Utilitarianism is one of the most powerful and persuasive approaches to normative ethics in the history of philosophy. Utilitarianism is generally held to be the view that the morally right action is the action that produces the most good. This theory, therefore, is the form of consequentialism: the right action is understood entirely in terms of consequences. What distinguishes utilitarianism from individualism has to do with the scope of the relevant consequences. In fact, as Ilori emphasises, utilitarianism, hedonism and Epicureanism are all

52 Cameron 15.
54 Cameron 19.
55 Cameron 19.
56 Gyekeye 154 and Gyekeye 31.
ethical theories which judge conduct as right or wrong, not on the basis of some inherent quality, as formalism, but in relationship to some end or goal that is considered good.\textsuperscript{60} According to utilitarianism, one ought to maximise the overall good, that is, consider the good of others as well as one’s own good. Its roots are traced through the traditional utilitarians, Jeremy Bentham and John Stuart Mill, who identified the good with pleasure.\textsuperscript{61} So, like Epicurus, they were hedonists about value.\textsuperscript{62} They also held the view that people ought to maximise the good, that is, bring about the greatest amount of good for the greatest number.\textsuperscript{63}

Utilitarianism accepts as the foundation of morals, utility, or the Greatest Happiness Principle and it holds that actions are right in proportion as they tend to promote happiness, wrong as they tend to produce the reverse of happiness.\textsuperscript{64} Mill accepted the general position of Bentham who used the phrase ‘the greatest happiness of the greatest number’. For Bentham, nature had placed man under the guidance of two masters, pleasure and pain and according to him, man is a pleasure-seeking, pain avoiding creature.\textsuperscript{65} Bentham was influenced by both Hobbes’ account of human nature and Hume’s account of social utility.\textsuperscript{66} However, the important change that Mill brought into this Bentham’s theory of utilitarianism was a qualitative standard. According to Mill, human beings with refined faculties are not satisfied with the pleasure of the body but they continue to seek the higher pleasure of the mind.\textsuperscript{67} Once a man has lived on higher level, he can never really wish to sink into a lower level of existence. This is because of the sense of dignity. It is better to be a human being dissatisfied than a pig satisfied.\textsuperscript{68} Mill, therefore, maintained that the good of all men or the greatest happiness of the greatest number must be the standard of what is right in conduct. To promote not individual pleasure but the greatest total happiness is the essence of Mill’s position.\textsuperscript{69} The utilitarians, therefore, stress the consequences of conduct. The morality of an act depends, not on the motive from which it originates, but on the effects on the society. It therefore emphasises that truth is that which produces the greatest happiness for the greatest number of

\begin{thebibliography}{99}
\bibitem{63} Irori 25 and Kahn 9.
\bibitem{66} Kahn 11 and Irori 26.
\bibitem{67} Irori 26 and Kahn 11.
\bibitem{68} Irori 26 and Kahn 11.
\end{thebibliography}
Utilitarianism is also known by its impartiality and agent-neutrality. Everyone’s happiness counts the same and when one maximises the good, it is the good *impartially* considered. However, all these features of this approach to moral evaluation and moral decision-making have proven to be somewhat controversial and subsequent controversies have led to changes in the classical theory. Utilitarianism, unlike individualism, depends on the consequences of the action, whether they are good or not. If actions promote happiness, then they are good, but then they are wrong if they produce unhappiness. Utilitarianism, also, unlike individualism is also concerned with the greatest happiness of the greatest number of people and not that of individuals.

5.4 A PHILOSOPHICAL OVERVIEW OF COMMUNITARIANISM AND AFRICANISM

5.4.1 Communitarianism

The word ‘communitarianism’, also referred to as ‘communalism’, originates from ‘community’. Mwimnobi argues that although writers, such as Gyekye, use the terms ‘communitarianism’ and ‘communalism’ interchangeably to mean the same, no attempt is made to explain the exchangeable use of the terms. Mwimnobi points out that the principles that underlie these concepts are different. Communalism is a very old idea used by great thinkers in Africa such as Nyerere and Senghor in relation to ‘African Socialism’. In this regard, for instance, Nyerere developed the concept of ‘Ujama’ to indicate the kind of principles that underlie the socio-political life of traditional African communities. This term ‘Ujama’, plainly means ‘familyhood’. Communitarianism, on the other hand, has been defined as the notion that a person, when born, finds himself or herself not in isolation but among other individuals and thus establishing the relational nature of a person.

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70 Ilori 26.
72 Gyekye 31 and Gyekye 12.
75 Mwimnobi (unpublished MA Dissertation) 22.
76 Mwimnobi (unpublished MA Dissertation) 22.
77 Mwimnobi (unpublished MA Dissertation) 22.
78 Mwimnobi (unpublished MA Dissertation) 22. See also Gyekye 155, who points out that, Aristotle proclaimed
Communitarianism has also been described as the doctrine that specifies that the group (that is the society) constitutes the focus of the activities of the individual members of the society.\textsuperscript{79} This doctrine places emphasis on the activity and success of the wider society rather than, though not necessarily at the expense of, or to the detriment of, the individual.\textsuperscript{80} Communitarianism has also been associated with morality, as it has been described as the notion that there are certain basic moral goals in life, to be realised in the course of natural life span, and whose realisation is to be supported by society at large.\textsuperscript{81} The distinction has to be drawn between three kinds of communitarianism which are philosophical, political and socio-legal communitarianism.\textsuperscript{82} These three may be seen as historical stages in the development of liberal communitarianism, especially as it relates to jurisprudential matters. This debacle started around 1980 as an intellectual exercise strictly among philosophers.\textsuperscript{83} Subsequently, communitarianism grew into some political movement. Then, in 1990s, a number of distinctly socio-logical studies dealing with law and community were published.\textsuperscript{84}

### 5.4.1.1 Philosophical communitarianism

The protagonists of liberalism were led by John Rawls.\textsuperscript{85} The natural focus of liberalism, neoclassical as well as welfare liberalism is the autonomy and freedom of the individual. Liberal principles of justice differ on one single theme: the priority to be given, always and under all circumstances, to individual rights of freedom.\textsuperscript{86} That is the reason liberals draw a sharp line between the idea of justice on the one hand, and the idea of the good life or the good society on the other. The former is held to be independent from and the antecedent to the latter. In Rawls's own famous maxim: 'The right is prior to the good'. The state, therefore, ought to restrict its activities to

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\textsuperscript{79} Gyekye 155.
\textsuperscript{80} Gyekye 155.
\textsuperscript{82} Van Seters 1.
\textsuperscript{83} Van Seters 1.
\textsuperscript{84} Van Seters 1.
\textsuperscript{85} Kirkpatrick 48. See also Van Seters 2, who points out that, Rawls normative position was referred to as ‘left’, ‘social’, or ‘welfare liberalism’, which was distinguished from ‘right’, ‘laissez-faire’ or ‘neoclassical liberalism’ commonly associated with the names of Friedrich Hayek, Michael Oakshott and Robert Nozick. Apart from Rawls, welfare liberalism in the course of time became prominently associated, particularly in legal circles, with the names of Bruce Ackermann and most recently with Ronald Dworkin.
\textsuperscript{86} Kirkpatrick 48 and Van Seters 2.
the realisation of principles of justice and to refrain from propagating, let alone, from imposing, the good. In the liberal universe, the state is categorically neutral.87

These central tenets of modern liberalism, the focus on moral autonomy; the separation of principles of justice from conceptions of the good life; the defence of a neutral state, became the target of a massive criticism by a number of diverse political philosophers, mainly American, who in the course of the 1980s became labelled as communitarians.88 There were four philosophers that were referred to as communitarians and these were Alasdair MacIntyre, Michael Sandel, Charles Taylor and Michael Walzer.89 Sandel directed his criticism of Rawls first at the axiomatic starting point of liberalism: the autonomous, free-floating individual. Liberals such as Rawls ground their theory in a concept of the person that Sandel claimed was untenable: the person thought of as a unit or identity existing prior to and independent from his or her choice for certain values and ends. This liberal conception of the person Sandel described as the ‘antecedently individuated’ or ‘unencumbered’ self.90 In contrast to this, Sandel saw a person as someone who is defined or constituted by the very values and ends he or she chooses. Normally, that choice is be being made in the larger context of a community of whatever nature, and thus the idea of community was a necessary element in Sandel’s concept of the person. The protagonists of philosophy MacIntyre, Taylor and Walzer, in the 1980s, voiced similar objections against the emotivist, isolated, atomistic individualism that they identified as a central deficiency in modern liberal thought and practice.91 All the four communitarians were united around a conception of human beings as integrally related to the communities of culture and language that they create, maintain and inhabit. As biological and social constructs, human beings are decisively shaped by circumstances not of their own choosing, among which at least are their own family and community.92 This unavoidable relationship creates obligations and responsibilities for the individual that, unlike what is presupposed in liberal tradition, do not depend on free choice and explicit approval. In this way in philosophical communitarianism the idea of personhood or human agency is conceived of as inseparable from the wider circles, the communities, in which the lives of individuals are always and inevitably lived.93

87 Van Seters 2.
88 Van Seters 2.
91 Van Seters 4 and Sandel 20.
93 Van Seters 5.
5.4.1.2 Political communitarianism

Prompted by the communitarian urge in moral, political and legal philosophy, but clearly moving on a different, more practical plane in the United States, a new political movement was founded that called itself ‘communitarian’, in the late 1980s. This movement, from its beginning, was associated with the visions of Amitai Etzioni, a professor of sociology at the Georgetown Washington University. Etzioni had emphasised the need for a new balance between individual rights and social responsibilities. Etzioni also stressed the ‘Responsive Communitarian Platform’, the importance of finding balances between individuals and groups; between rights and responsibilities; between institutions of state, market and civil society.

The American invention of political communitarianism was typically made into a successful export-article by primarily the remarkable talents of Etzioni. He had tirelessly travelled around the world to address meetings and advise political leaders. He had managed to generate worldwide interest in the idea of political communitarianism and this explains, at least to some extent, why communitarianism was involved in what subsequently grew out of New Labour, namely, the Third Way. It is also interesting to observe that Etzioni had not only styled his communitarian movement as a political movement but also as a ‘social movement’.

5.4.1.3 Socio-legal communitarianism

Influenced by both philosophical and political communitarianism, over the past ten to fifteen years, a remarkably strong interest in community or communitarianism also surfaced in the field of socio-legal studies. Socio-legal communitarianism, however, was much broader as it had deep roots in the disciplinary of sociology. The new communitarian perspective in socio-legal studies encompassed both the mysterious questions of philosophical communitarianism and the realistic policy problems of political communitarianism, but it also added to these a

94 Van Seters 5 and Frohnen 150.
95 Frohnen 150 and Van Seters 5.
96 Frohnen 150. See also Van Seters 5, who points out that this ‘basic communitarian quest for balances’ underlay many of the substantive policy ideas in the Communitarian Platform, for instance, with respect to the family (parental leave, protection of the interest of the children in divorces), schools (moral education, integration between work and schooling), workplace (flextime, child care), communities (national and local service, jury duty) and political reform (campaign contributions, social movements).
97 Van Seters 6 and Frohnen 150.
98 Frohnen 150, observed that Etzioni had argued that: ‘when social scientists examine the ways we may significantly alter a society as complex and as free as ours, they often conclude that the government is too heavy-handed, costly and inappropriate an agency to confront most moral and social issues. Social scientists know best and they agree that only movements such as those committed to environmentalism, feminism and civil rights have profoundly shaped and reshaped our values and social lives. So what America needs now is major social movement dedicated to enhancing social responsibilities, public and private morality, and the public interest. We need you, your friends, your neighbours, and others we can reach to join with one another to forge a Communitarian movement.’
99 Van Seters 7.
strongly historical and sociological dimension. This type of sociological communitarianism is particularly manifested in the writings of three scholars who otherwise represented different positions on the spectrum of socio-legal studies. These were Joel Handler, Philip Selznick and Rodger Cotterrell. Handler was interested in the idea of ‘strong’ community, which he distinguished from ‘instrumental’ community and ‘sentimental’ community. The distinction between these types of community, according to Handler, actually formed the historical centrepiece of philosophical communitarianism, namely the Rawls-Sandel debate. Cotterrell too was strongly interested in the projections of communitarian jurisprudence. Unlike Handler, Cotterrell approached the subject from an angle of philosophical communitarianism, but distinctly from a sociological perspective. He particularly employed the Durkheimian tradition by focusing on the essential continuities between law, morality and solidarity.

Though, admittedly, law cannot in any direct way create solidarity or community, Cotterrell argued that it could create conditions for human existence that symbolise a moral commitment of the community in its care for its members as individuals. The main task of communitarian jurisprudence, then, was to explore sociologically the conditions under which law can become a principled component of social life which is a direct expression of community interests, structures and concerns. According to Cotterrell, the content of the concept of community was by no means self-evident. On the contrary, he described the ultimate aim of his study to clarify the almost terminally vague idea of community. Cotterrell took a very different approach from the more orthodox approaches available in the sociological literature which derive the idea of community from the concept of Gemeinschaft. He preferred to conceptualise the idea of community from the interplay of certain general orientations of social interactions and in this interactionist concept community, a key role was played by the notion of ‘trust’. Trust, or rather ‘mutual interpersonal trust’, according to Cotterrell, was the basic building block of community, the fundamental orientation that makes it possible. He saw mutual interpersonal trust as the essence of community. Cotterrell hence defined communities as patterns of interaction that involved a high degree of mutual interpersonal trust. In Cotterrell’s eyes, this theory of community largely determines the role of contemporary law, or ‘law-government’. According to him, regulatory forms and institutions should be designed to foster and support relations of mutual trust within communities. However, in modern conditions, this

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100 Van Seters 7.
101 Van Seters 8.
102 Van Seters 8.
103 Van Seters 9.
104 Van Seters 9.
105 Van Seters 9.
106 Van Seters 10.
kind of mutual interpersonal trust can be achieved only on a relatively local level or in relatively specific social fields. Cotterrell built his communitarian jurisprudence on a fairly strong idea of social, political and legal pluralism.\textsuperscript{107} 

Selznick’s theory regarding communitarian jurisprudence employed both the perspectives of philosophical communitarianism, such as Handler’s, and that of the sociological tradition by Cotterrell.\textsuperscript{108} However, unlike Handler, who embraced the concept of dialogic community and Cotterrell, who preferred an interactionist conceptualisation of community, Selznick stressed the importance of treating community as a variable aspect of group experience as, according to him, groups can be more or less full-blown communities and they can approximate community in different ways. That was why Selznick wanted to define community much more comprehensively than either Handler or Cotterrell.\textsuperscript{109} According to him, a group is a community to the extent that it encompasses a broad range of activities and interests, and to the extent that participation implicates whole persons rather than segmental interests or activities. However, on the basis of this inclusive definition of community, Selznick developed a theory of community that is much more discriminating and much stronger than those of Handler or Cotterrell.\textsuperscript{110} His theory built on the recurrent elements of community which are historicity, identity, mutuality, plurality, autonomy, participation and integration. These seven elements represent the prime values of human life lived in the communities and this presumes anything but homogeneity.\textsuperscript{111} On the contrary, different types of community such as religious, political, occupational, institutional, international will have different mixes of the main elements. Furthermore, the interplay of these elements itself creates variety and diversity. While discussion of community habitually centers on the organic unity of Gemeinschaft, Selznick argued that living communities are plural as well as solidary, that is, communities are characterised by structural differentiation as well as by shared consciousness. Thus, Selznick advanced a theory of community that is as pluralistic as that of Cotterrell.\textsuperscript{112} However, while Handler and Cotterrell relied on trust to hold a community together, Selznick had a broader view. He saw not one but two sources of moral integration competing for pre-eminence as foundation of community, and these were civility and piety. The conflict between these very
different principles formed the heart of Selznick’s communitarian jurisprudence and their reconciliation he saw as a prime object of theory and policy.\textsuperscript{113}

What can be deduced from this review of communitarianism in socio-legal studies therefore can be summed out in three points that stand out. Firstly, the importance of legal pluralism, that is, the deeply plural character of modern law, is recognised and accounted for in the perspective of socio-legal communitarianism.\textsuperscript{114} Secondly, the communitarian perspective emphasises the moral dimension, the moral underpinnings of law and directs the attention to the interdependence of law, solidarity and community. Thirdly, these socio-logical communitarians acknowledged the primacy of community without diminishing the worth of values central to the liberal tradition of freedom, equality and rationality.\textsuperscript{115} Indeed, communitarianism and liberalism are joined in a point of view that has been clearly described, by Selznick himself, as communitarian liberalism. Perhaps the most lasting contribution of socio-legal communitarianism may be seen in the way it helps transcend, dialectically resolve, the polarities that were popularised by philosophical liberals and communitarians some twenty-five years ago.\textsuperscript{116}

5.4.2 Africanism

In his description of African communitarianism, based on the Igbo culture as a case study, Ezekwonna maintains that there have been many accusations that the African community-oriented ethic swallows the individual, that his personal identity remains incognito.\textsuperscript{117} This could be an observer’s impression who is an outsider, but if one is in the system, he will discover that personhood in the African concept is not swallowed but complex. Such criticism normally comes from Western views that have a different concept of a human person.\textsuperscript{118} The Igbo, or indeed the African, notion of the human person cannot be isolated from the community. It is only in relation with the community that the identity of the individual is noticeable.\textsuperscript{119} Without the communitarian relationship, there is no identity for the African person. Further, that only together with others can one become a human person and achieve individual freedom, which, again should be exercised in a communitarian way.\textsuperscript{120} One advocate of the communitarian view, who was referred to as a strict communitarian thinker, is John Mbiti.\textsuperscript{121} According to Mbiti, in traditional life, the individual cannot and does not exist alone.

\begin{footnotes}
\footnotetext[113]{Van Seters 11.}
\footnotetext[114]{Van Seters 12.}
\footnotetext[115]{Van Seters 12.}
\footnotetext[116]{Van Seters 12.}
\footnotetext[117]{Ezekwonna 63, Gyekye 154, and Gyekye 31.}
\footnotetext[118]{Ezekwonna 63, Gyekye 154, Gyekye 31 and Basu 8.}
\footnotetext[119]{Ezekwonna 63 and Basu 2.}
\footnotetext[120]{Ezekwonna 63 and Basu 2.}
\footnotetext[121]{Basu 2 and Mwimmobi 20.}
\end{footnotes}
except corporately and he owes his existence to other people, including those of past generations and his contemporaries.  

He is simply part of the whole. The community must therefore make, create or produce the individual; for the individual depends on the corporate group. Physical birth is not enough; the child must go through rites of incorporation so that it becomes fully integrated into the entire society. Mbili later summed up the African view in the following pithy saying: ‘I am because we are, and since we are, therefore I am’.

The other communitarian, who was influenced by Mbili, is Ifeanyi Menkiti. Menkiti argues that in an African context, society is supreme and primary, while individual identity is merely derivative. He felt that in Africa, it is in the communal context and not the possession of some rationality, will or memory that defines the person. Personhood is viewed as temporal rather than as a given. Thus, one becomes a full person as one proceeds through one’s life and acquires various kinds of social merit or at least gains in wisdom and years. One’s identity as a person is critically contingent, at every stage of a web of social relations and with respect to the conventions and expectations of the larger community. Other proponents of African communitarianism, also referred to as advocates of African socialism, were Nkrumah, Nyerere and Senghor. In terms of their views, it is problematic for an African person to live alone or as an individual in Africa. This is normally summed up in the Xhosa or Zulu saying that says: ‘umntu ngumntu ngabantu’, meaning that a person is a person with other persons.

Proponents of Africanism therefore hold that active participation in the community life is what helps the individual to attain personhood and it must be emphasised that the mere belonging to the community does not make an African person but the interaction, the working together and acting with others help the person to achieve his personhood. It would hence be absurd for someone to conclude that the African community system makes people irresponsible and perpetually dependent on others. Africans see a human person as being who is

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122 Basu 2 and Mwimnobi 21.
123 Basu 2 and Mwimnobi 21.
124 Basu 2 and Mwimnobi 21.
125 Basu 2 and Mwimnobi 21.
126 Basu 3 and Mwimnobi 21.
127 Basu 3 and Mwimnobi 21.
128 Gyekye 31. See also Basu 3, who pointed out that, Leopold Senghor was another proponent of this communitarian tradition who famously claimed that Negro-African society is collectivist or, more exactly, communal, because it is rather a communion of souls than an aggregation of individuals. Julius Nyerere's concept of Ujamaa was yet another attempt to seek a traditional African socialism. Like Nyerere, Nkrumah believed that Africa's collectivist tradition made it compatible with socialism than capitalism.
129 Ezekwonna 64.
inherently and to the core communal and who is deeply rooted in a social relationship and in no way as an isolated individual who acts alone.\(^\text{130}\)

African communitarianism has had its critics and many contemporary theorists have argued that Africa had and still has a robust notion of the individual, an individuality which did not become dissolved in the embrace of a fuzzy communalism.\(^\text{131}\) One such critic is Kaphagawami, whose work had drawn attention to the negative aspects of communalism, which he saw as deployed in Africa in the form of gerontocratic tyranny.\(^\text{132}\) According to him, the elders claimed to speak for the whole clan or tribe and their will was accepted as the general will. Nonetheless, Kaphagawami maintains that Africans, even in such authoritarian structures, were always aware of the autonomy and independence of individuals.\(^\text{133}\) Another critic of radical communitarianism is Kingongo, who argues that traditional African communalism was based on respect for the individual, but the socialist leadership of the modern Africa has perverted this communal notion into an ideology of radical communitarianism, the latter merely an ideological veil for the authoritarian rule of the people.\(^\text{134}\) Perhaps the most scathing and sustained criticism of the communitarian tradition comes from Kwame Gyekye, who alleges private property was after all existent in the African tradition.\(^\text{135}\) Gyekye, furthermore, sees a difference between African communitarianism, which is a socio-ethical doctrine, and European socialism, which is primarily an economic arrangement.\(^\text{136}\)

Gyekye, interestingly, appears to accept that the African community is communal or communitarian in nature.\(^\text{137}\) Although describing the social order of African community as communal,\(^\text{138}\) he argues that it would be more correct to describe the African social order as amphibious, as it manifests features of both communality and individuality.\(^\text{139}\) He argues that to describe that order as simply communal is to prejudge the issue regarding the place given to individuality.\(^\text{140}\) The African social order is, strictly speaking, neither purely communalistic nor

\[^{130}\] Ezekwonna 64.
\[^{131}\] Basu 7, Gyekye 154, Gyekye 31 and Ezekwonna 65.
\[^{132}\] Basu 7.
\[^{133}\] Basu 7.
\[^{134}\] Basu 7.
\[^{135}\] Basu 7.
\[^{136}\] Basu 8.
\[^{137}\] Gyekye 154 and Basu 8. See also Gyekye 31, where he points out that, that the African social order was communal is perhaps undeniable.
\[^{138}\] Gyekye 154 and Gyekye 31.
\[^{139}\] Gyekye 154 and Gyekye 31.
\[^{140}\] Gyekye 154, Gyekye 31, Basu 7 and Ezekwonna 65.
purely individualistic. But the concept of communalism in African social thought is often misunderstood, as is the place of the individual in the communal social order.\textsuperscript{141}

In trying to justify his argument of an amphibious African social order, Gyekye argues that what scholars - usually from noncommunal, individualistic backgrounds and mentalities - say about communalism is that it offers no room for the expression of individuality, the assumption being that individuality is submerged by the communal apparatus; and that communalism is antithetical to individualism, meaning that the two cannot co-exist.\textsuperscript{142} These judgments made by non-African scholars about the African socio-ethical doctrine of communalism seem to have been accepted \textit{in toto} by the advocates of African socialism, such as Nkrumah, Senghor and Nyerere, in their anxiety to find anchorage for their ideological choice in the traditional African ideas about society.\textsuperscript{143}

To illustrate his argument that communalism does not submerge or swallow the individuality, Gyekye, uses the Akan proverb that says that ‘the clan is like a cluster of trees which, when seen afar, appear huddled together, but which would be seen to stand individually when closely approached.’\textsuperscript{144} This proverb emphasises the social reality of the individual. It articulates the notion that the individual has a separate identity and that, like the tree, some of whose branches may touch other trees, the individual is separately rooted and is not completely absorbed by the cluster. Communality, therefore, does not obliterate or squeeze out individuality.\textsuperscript{145} In this he seems to be in agreement with Ezekwonna, who has also argued that as long as a person has every opportunity to be out-going and to be himself in African communities, his personhood is not swallowed up.\textsuperscript{146} Furthermore, to emphasise the fact that individualism is well understood in the African society, Gyekye, uses another proverb that says that ‘the clan is merely a multitude.’\textsuperscript{147} The proverb infers that the individual cannot always and perpetually depend on the clan or group for everything. The saying thus intends to deepen the individual’s sense of responsibility for himself and it clearly suggests that the relevance and importance of the group are exaggerated by the people themselves.\textsuperscript{148}

\textsuperscript{141} Gyekye 154.
\textsuperscript{142} Gyekye 154, Gyekye 31, Ezekwonna 63 and Basu 7.
\textsuperscript{143} Gyekye 31.
\textsuperscript{144} Basu 8. See also Gyekye 31, who cited Annobil of Cape Coast as having explained this proverb by stating that: ‘If one is far away from a cluster of trees, he sees all trees as huddled together. It is when he goes near that he recognises that the trees in fact stand individually. The clan is just like the cluster of trees.’
\textsuperscript{145} Gyekye 32, Gyekye 154, Ezekwonna 63, and Basu 8.
\textsuperscript{146} Ezekwonna 67.
\textsuperscript{147} Gyekye 32.
\textsuperscript{148} Gyekye 32.
The individual’s sense of responsibility for himself or herself is in fact expressed explicitly in the maxim that says, ‘it is by individual effort that we struggle for our heads’. This African social thought offers a clear unambiguous statement on the value of individuality, which is what this concept implies, even though it at the same time makes an equally unequivocal statement on the value of communality. The African thought does not see the two concepts of individualism and communalism as exclusive or antithetical. It tries to steer clear of the Scylla of exaggerated individualism (as found in the West) and the Charybdis of exaggerated communalism (communism, as presently understood and practised in some parts of the world). According to Gyekye, therefore, African social thought seeks to avoid the excesses of the two systems, while allowing for a meaningful, albeit uneasy, interaction between the individual and the society. He admits that one cannot be oblivious of the practical problems involved in the attempt to balance the two concepts. Gyekye further distinguishes what he calls moderate communitarianism, where well-individuated autonomous subjects live in harmonious community. This is contrasted with the argument advanced by Mbiti and Menkiti, discussed above, that personhood is fully defined by a cultural community. This means that a relationship between an individual and a community is associative in character. Such a relationship may be described as a set within a set, in the sense that all the elements of the big set are also found in the small set and it depicts a balanced character.

The meaning of personhood for Mbiti and Menkiti is limited. The main idea that underpins the realisation of personhood, as perceived by these philosophers, is that of primordiality of community rights over the individual rights and accordingly, individual values and interests are de-emphasised. An individual, according to them, does not play any role towards the realisation of his or her personhood, but instead, personhood is wholly defined by a cultural community. In his attempt to explain the notion that underlies primordiality of the community rights over individual rights, Mbiti emphasises that in African societies, whatever happens to the whole group happens to the individual. This was summed up in his famous saying that says that ‘I am, because we are, and since we are, therefore, I am’. This implies that ‘we are’ gives meaning to ‘I am’. Subsequently, ‘I am’
cannot exist independently on its own.\textsuperscript{158} Mwimnobi argues and maintains, perhaps correctly, that since an individual is not created as such by the community, it is problematic to argue that ‘I am’ entirely depends on ‘we are’ for existence. He maintains that the individual does not entirely depend on community for his or her existence. For Mbiti and Menkiti, the notion of radical communitarianism does take into consideration individual freedom to make choices.\textsuperscript{159} Gyekye, reacting against the notion of strict or radical communitarianism of Mbiti and Menkiti, proposes a moderate version of communitarianism,\textsuperscript{160} in terms of which the argument that personhood is absolutely conferred on the individual by the community is rejected. An individual enjoys some inherent rights, despite the sociality of the human person which at once places him or her in a system of shared values and practices. Personhood for him can only be defined partially, never completely by one’s membership of the community.\textsuperscript{161} His notion of moderate communitarianism, therefore, seems to support and promotes an open and democratic society. It does not give ontological primacy to the community; rather, it holds that the attainment of personhood does not wholly depend on the communal structure.\textsuperscript{162} It accepts the reality of the individual autonomy as well as the relational and communal character of an individual. It also ascribes equal moral standing to the community and individual.\textsuperscript{163} Gyekye’s moderate communitarianism describes many African societies or communities more accurately than the theories of Mbiti and Menkiti.

5.5 ADDRESSING PROBLEMS OF HIV/AIDS AND CONFIDENTIALITY IN THE CONTEXT OF INDIVIDUALISM, UTILITARIANISM, COMMUNITARIANISM AND AFRICANISM

This study submits that the problems of HIV/AIDS and confidentiality would be best addressed in South Africa, as well in Africa, if cognisance is taken of the writings of Gyekye\textsuperscript{164} and Cameron.\textsuperscript{165} This means that a consideration of the complexity of confidentiality should be mindful of the nuanced understandings of individualism and communitarianism.\textsuperscript{166} South Africa’s population consists of diverse races and ethnic groups, with different backgrounds and cultures which makes the application of one school of thought, such as the

\textsuperscript{158} Mwimnobi 33.  
\textsuperscript{159} Mwimnobi 33.  
\textsuperscript{160} Mwimnobi 19 and Basu 8.  
\textsuperscript{161} Mwimnobi 35.  
\textsuperscript{162} Mwimnobi 19.  
\textsuperscript{163} Mwimnobi 19.  
\textsuperscript{164} Gyekye 154 and Gyekye 31.  
\textsuperscript{165} Cameron 19.  
\textsuperscript{166} Gyekye 154 and Gyekye 31.
classical liberal idea of individualism in trying to address problems relating to confidentiality, inappropriate and irrelevant. To put this into context: whilst an individual may be expected to share his or her HIV-positive status with his or her family, for instance, especially for emotional support and home based care reasons, such an individual should be allowed space to make his or her free will or choice about informing his or her family about his or her status. Cameron explains that the last-mentioned ‘information-sharing’ is a basic cultural value, and the fact that a culture includes supportive responses of a communitarian nature does not and cannot mean that someone who is part of that culture automatically waives his or her right to individual autonomy, or that the culture itself demands that respect for individual choice in relation to confidentiality must be overridden. Hence, the most appropriate response in order to address the problem of confidentiality in the context of HIV/AIDS, would be to apply the notions of both individualism and communitarianism. Utilitarianism, also, to a certain extent may be considered. For instance, it could be considered that a sexual partner who is diagnosed to be HIV-positive should consider it as being good of his or her sexual partner as well as his or her own good to inform such sexual partner about his or her status in order to protect that sexual partner from being infected with HIV.

5.6 WOULD MAKING HIV/AIDS A NOTIFIABLE DISEASE ADDRESS THE PROBLEM?

5.6.1 The aims and process of notification in South Africa

A ‘notifiable medical condition’ is defined by National Health Act as a medical condition that must be reported in terms of a statutory obligation. Indeed, despite the many shortcomings of a system of compulsory notifications of diseases, notifications are a generally accepted indicator of disease in a population and indeed an important source of information when reconstructing aspects of a population’s disease profile. Some of the most noticeable limitations of such a system are, amongst others, underreporting, duplication in reporting, a lack of uniform diagnostic criteria, all of which result in wrong diagnosis or resistance against reporting because

167 Cameron 19.
168 National Health Act 61 of 2003, Regulations Regarding Communicable Diseases (GG 33107 of 13 April 2010). See also Burr C “The AIDS Exception: Privacy vs. public health” 1997 (279;6) The Atlantic Online 57-67, who describes notifiability as reporting to the local health authorities of the names of those who test positive for infection.
of the stigma attached to certain notifiable diseases. In developing countries, also, some of these limitations bear close relation to the ineffective administration of notifications, and as a result the data of these societies is less reliable. However, despite these inadequacies, compulsory notifications of diseases in South African situation still yield useful information with regards to the population’s disease profile and it can also be accepted that much of the country’s health planning is based on these notifications and the trends so displayed. Furthermore, another important indicator that needs to be mentioned concerning notifiable diseases is the case fatality rate (CFR), which refers to the percentage of all persons notified as having a specific disease who died from the disease. The case fatality rate is of importance because, amongst other things, it gives an indication of: (a) the relative extent to which cases and deaths of notifiable disease concerned are indeed reported; (b) the fatalities of the particular notifiable disease and (c) the measure of skill and success with which patients with this notifiable condition are treated and cared for, that is, the extent to which their lives are being saved.

It becomes clear that notification of diseases in South Africa, despite the shortcomings mentioned above, is important as it yields useful information with regards to the population's disease profile and helps with the country's health planning. HIV/AIDS, however, for various reasons which will be discussed below, has not been made a notifiable disease in South Africa.

5.6.2 How do these aims compare with the situation in other countries?

Early in its history, AIDS was added to long list of infectious diseases in the United States of America (USA), which had to be reported to public health authorities. The reasoning for such reporting was that the information about who had a disease and what risk factors they exhibited were essential for drawing conclusions on how the disease was transmitted and how transmission can be prevented. Reporting also enabled specific infection control measures, such as contact tracing. Since the discovery of AIDS, the Centers for Disease Control (CDC) have been a major source of epidemiological information about the disease. Based on this rationale, however, if some information is good, more information is presumably better, and CDC, in fact, had recommended that states consider making HIV infection, as determined by antibody testing, to be also a

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172 Van Rensburg, Fourie and Pretorius 176.
173 Van Rensburg, Fourie and Pretorius 176.
174 Van Rensburg, Fourie and Pretorius 176.
176 Moskop 418.
As a result, six states already require reporting of HIV. However, unlike the reporting of AIDS, the epidemiological value of these additional data, such as reporting of HIV, may be limited. For instance, unlike AIDS patients, only a small, relatively non-representative group of infected with HIV persons would be reported, that is, blood donors, military recruits and personnel, prisoners and those who voluntarily seek testing. Some individuals would receive false-positive results and incorrectly be reported as infected. Others would avoid voluntary testing out of fear of breach of confidentiality and its subsequent ill effects. According to Jasper, all states in the United States of America (USA) require AIDS reporting and the majority of states require some reporting for HIV. Bayer points out that clinical AIDS has been a reportable condition in every state in the USA since 1983. Bobinski and LeMaistre, in addition, observe that statutes governing HIV and AIDS information, including requirements for reporting information about the person infected to health authorities, differ from state to state. Some states require that HIV infection be reported only statistically, that is, by age, sex, and race. Others require that the names and addresses those infected be reported. There is differences in the measures of protection afforded to the information reported, eg provisions that enforce the reporting of AIDS and HIV; provisions for disclosure of information under certain circumstances and penalties for disclosure of information from public health records. Florida, for instance, requires full reporting, that is, name, address, sex, age, and race in respect of AIDS or AIDS-related complex, but prohibits the reporting of HIV infection by name, address or identity numbers or symbols. Colorado, on the other hand, requires attending doctors and laboratories to report fully to the state or local health departments any ‘diagnosis of AIDS, HIV-related illness or infection, including death from HIV infection.’ Other states go beyond requiring the reporting of HIV/AIDS. States such Minnesota, for instance, extend the requirements to the reporting of any person who may be a ‘health threat to others’ and Georgia requires the reporting of any other person the physician or administrator reasonably believe to be at risk of being infected by the patient. However, privacy

177 Moskop 419.
178 Moskop 419.
179 Moskop 419.
183 Bobinski and LeMaistre 24.
184 Bobinski and LeMaistre 24.
185 Bobinski and LeMaistre 24, also point out that in addition, Georgia law provides that the state’s health department
and confidentiality regulations concerning the storage, access and uses of such information vary among jurisdictions, which is the reason why there was an increased need for uniformity among state confidentiality protections.\textsuperscript{186}

Furthermore, since the inception of HIV testing, there has been a sharp debate about whether the names of all infected persons should be reported to confidential registries of public health departments. Gay groups had opposed HIV reporting because of concern about privacy and confidentiality.\textsuperscript{187} Also, many public health officials opposed such a move because of the potential effect on the willingness of people to seek HIV testing and therapy voluntarily.\textsuperscript{188} By 1991, therefore, only a few states, typically those with relatively few AIDS cases, had required such reporting.\textsuperscript{189} It has been observed that being an infectious disease, HIV/AIDS by its nature should be reported as a public health concern. Some balance has to be struck between the right to confidentiality of the individual and the common good of the public.\textsuperscript{190}

As a matter of policy, therefore, the American Medical Association (AMA) strongly recommended that all states adopt requirements for confidential HIV reporting to appropriate public health authorities for the purpose of contact tracing and partner notification.\textsuperscript{191} It has been argued that HIV status and reporting requirements raise legal issues related to patient confidentiality.\textsuperscript{192} Legal protection of patient privacy and confidentiality depend on whether or not public concern outweighs the interest in preserving the doctor-patient privilege. The balancing of this interest is a particular challenge when it comes to privacy concerns associated with HIV status.\textsuperscript{193} Bobinski and LeMaistre explain that although the reporting of communicable diseases has long been upheld, the


\textsuperscript{188} Bayer 1991 \textit{The New England Journal of Medicine} 1501 and Bobinski and LeMaistre 25.


\textsuperscript{190} Ngotho 17, Jasper 19 and Bayer 1991 \textit{The New England Journal of Medicine} 1501.

\textsuperscript{191} Ngotho 17, Jasper 19 and Bayer 1991 \textit{The New England Journal of Medicine} 1501. See also Bobinski and LeMaistre 25 who point out that to protect the confidentiality of public health records, some states provide penalties for disclosure of information from these records. Colorado public health reports ‘shall not be released, shared with any agency or institution, or made public, upon subpoena, search warrant, and discovery proceedings or otherwise’ except under certain limited circumstances, and anyone who breaches this confidentiality is guilty of a misdemeanour punishable by a fine of $5,000 and/or 6 to 24 months’ imprisonment.

\textsuperscript{192} Ngotho 17, Jasper 19 and Bayer 1991 \textit{The New England Journal of Medicine} 1501.

\textsuperscript{193} Ngotho 17.
reporting of HIV/AIDS has long been criticised for deterring patients from seeking medical treatment;\textsuperscript{194} violating the doctor-patient relationship; advancing discrimination against those individuals reported and ultimately causing the AIDS disease to become more widespread rather than fulfilling the purpose of containing the disease.\textsuperscript{195} Despite all the criticism, required reporting of HIV/AIDS allows the government to track the epidemiology of the disease and provides a mechanism for follow-up behaviour modification, research and notification of latest treatments.\textsuperscript{196}

5.6.3 What about contact tracing and partner notification?

As already mentioned above, reporting of a disease help specific infection control measures, such as contact tracing.\textsuperscript{197} Indeed, attempting to identify, notify, and treat the sexual contacts of diseased individuals is a common method for controlling sexually transmitted diseases such syphilis.\textsuperscript{198} It has therefore been recommended by many writers that this approach be also applied for controlling the heterosexual transmission of AIDS.\textsuperscript{199} Tracing is thought to be cost-effective for heterosexual but not for homosexual contacts, because of the lower prevalence of the disease among heterosexuals and the presumed smaller number of sexual contacts. However, because HIV can be carried for a long period of time, members of either group may have had many sexual contacts.\textsuperscript{200} Notifying a few of these contacts, therefore, may have little overall effect on the spread of the virus. Contacts identified could be tested and counselled, but unlike syphilis patients, not cured. The other important difference between syphilis and AIDS is the issue of the stigma. Syphilis does not confer the same stigma as AIDS does today.\textsuperscript{201} Notification of contacts, therefore, severely compromises the confidentiality of a diagnosis of AIDS or HIV infection, since fearful or angry contacts may have no hesitations about spreading this information within the community. In such circumstances, therefore, contact tracing may be a powerful deterrent to seeking voluntary testing. If that is the case, the expected benefits of contact tracing of heterosexuals, including the reduction of AIDS in children, may not be realised.\textsuperscript{202} Even if HIV transmission could be prevented


\textsuperscript{198} Bayer and Toomey 77, and Moskop 419.

\textsuperscript{199} Moskop 419.

\textsuperscript{200} Moskop 419.

\textsuperscript{201} Moskop 419.

\textsuperscript{202} Moskop 419.
in some cases, it is not clear that this would justify the concomitant loss of confidentiality and the subsequent risk of serious adverse consequences.

A more effective approach may be to urge infected persons themselves to inform their sexual contacts themselves and to be sure that testing and counselling are available for those. Contact tracing has also been associated with partner notification. Indeed, as Dickinson avers, there have been increasing pressures for notifying spouses or sexual partners of an individual’s HIV-positive status and for tracing previous contacts. However, contact tracing, a long-time public health tool, has the limitation that it relies heavily on a voluntary, accurate response from the HIV-positive individual. To the extent that the individual fears the consequences of disclosure or the system becomes punitive, disclosures of contacts will decrease. And to the extent that the individual cannot accurately report past sexual contacts, the contact tracing programme is limited. Many states in the USA, therefore, have contact tracing or partner notification. In some states such as those in Connecticut, Delaware, Maine and Michigan, persons who are HIV infected are encouraged to notify their own partners, and state assistance is provided if requested. However, in some states, such as Colorado, Idaho and North Corolina, named partners are contacted by state officials if the HIV-infected person does not agree to notify them. All states with such programs protect the confidentiality of the infected persons.

5.6.4 Should HIV/AIDS be made notifiable in South Africa?

Surveillance has been said to be a critical component of any disease control strategy. Surveillance data provide the basis for planning, targeting, monitoring and evaluating disease control public health measures. While surveillance can be undertaken in various ways, making a condition legally notifiable is one of the commonest ways of collecting surveillance information where health care workers have a legal duty to inform the health authorities when a patient is found to have the condition. This is normally referred to as passive

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203 Moskop 419 and Burr 1997 The Atlantic Online 57-67.
205 Dickinson 212 and Burr 1997 The Atlantic Online 57-67.
206 Dickinson 212.
207 Dickinson 212 and Burr 1997 The Atlantic Online 57-67.
208 Gunderson, Mayo and Rhame 140.
209 Gunderson, Mayo and Rhame 141.
210 Gunderson, Mayo and Rhame 141.
211 Abdool Karim 1999 SAMJ Forum 609 and Van Rensburg, Fourie and Pretorius 176.
212 Abdool Karim 1999 SAMJ Forum 609 and Van Rensburg, Fourie and Pretorius 176.
surveillance, as it depends on health care workers involved in patient care taking the initiative to notify, while the health authorities are ‘passive’ recipients of the information.213

The former South African Minister of Health, Nkosazana Dlamini-Zuma, indicated her intention, in September 1997, to make AIDS a notifiable disease. Reasons provided for this request were that it would be possible to collect information on how many people have AIDS disease or have died from AIDS; to determine how AIDS manifests itself, how it is transmitted in the population and what the risk factors for AIDS are. The information collected would be used for surveillance of the disease, identification of risk factors, planning of prevention, treatment and supply of medicines, as well as monitoring the epidemic.214

This policy, however, was widely criticised. The criticism was based on the fact that, firstly, from a human rights perspective, concern has been expressed about the potential use or misuse of lists of names of HIV-positive people and secondly, that concern has been expressed that notifiable conditions are so notoriously under-reported that little meaningful information is likely to come from this source.215 However, Abdool Karim argues that whilst both these points of criticism have some merit, they are insufficient grounds against making AIDS notifiable.216 The first concern regarding name reporting may be addressed by a reporting system which does not include names, and as on the other hand the unnamed reporting is also more prone to duplicate reports, a system of confidential named reporting is another option.217 The second concern regarding the current notification system producing little information of value due to serious under-reporting, is borne out of experience. For instance, a common illness such as hepatitis B is hopelessly under-reported and fluctuating reporting rates create artefact epidemics. This concern may be addressed by the fact that, instead of viewing under-reporting as a reason for not making AIDS notifiable, the opposite approach may be more useful, that is, using AIDS notification to improve the entire notification system with the specific aim of rebuilding the foundations of the notification system in order to reduce under-reporting to acceptable levels, or at least to a stable reporting rate so that trends can be interpreted.218

Interestingly, although explaining why he disagrees with the two most commonly used arguments against AIDS notification, Karim argues that the policy of making AIDS a notifiable disease was, in any event, inappropriate for

214 Abdool Karim 1999 SAMJ Forum 609.
216 Abdool Karim 1999 SAMJ Forum 609.
217 Abdool Karim 1999 SAMJ Forum 609, further points out that the latter system has been widely implemented in many countries such as the USA, where it has been shown not to affect voluntary HIV testing rates. Either a confidential system with names or an unnamed reporting system could address the human rights concerns.
218 Abdool Karim 1999 SAMJ Forum 610.
South Africa.\textsuperscript{219} He provides the following reasons for this argument: Firstly, that meaningful estimates of AIDS incidence and mortality rates cannot be obtained from AIDS notification data, as AIDS is complex diagnostic condition which normally involves making a diagnosis of an AIDS indicator disease in the presence of a positive HIV test.\textsuperscript{220} However, the presence of an indicator disease is not enough for a diagnosis of AIDS, since some indicator diseases, such as tuberculosis, are common in HIV-negative patients as well. To get a reasonable estimate of AIDS incidence or mortality, therefore, all patients diagnosed with AIDS indicator diseases must routinely be tested for HIV, with such HIV test carried out for a surveillance requirement and not for clinical indication.\textsuperscript{221} The institution of widespread routine HIV testing for all patients with and deaths from AIDS indicator diseases was questionable, since it may not be the best use of AIDS prevention resources at a time when it was claimed that South Africa could not afford zidovudine (AZT) for pregnant women. At that time, routine testing of patients who had been diagnosed with or have died of AIDS indicator diseases, did not occur.\textsuperscript{222} However, even with 100\% reporting of currently diagnosed patients with and deaths from AIDS, analyses of these data to obtain AIDS incidence and mortality rates would produce estimates that would be at worst misleading and at best uninformative.\textsuperscript{223} Hence, Karim argues that meaningful estimates of AIDS incidence and mortality rates cannot be obtained from AIDS notification data.\textsuperscript{224} Secondly, even if notification data did not provide reasonable incidence or prevalence rates, they can provide useful information on temporal trends. The preconditions, however, are stable reporting rates, a fixed definition of AIDS and stability in the proportion of patients and deaths being tested for HIV.\textsuperscript{225} Therefore, while it is possible that some of the preconditions for the analysis of the trends may be met, it is more likely that the trends may be misleading due to varying reporting and HIV testing rates.\textsuperscript{226}

Thirdly, since AIDS manifests, on average, about seven years after acquirement of HIV, risk factors for HIV, which are identified at present would be those applicable about seven years ago. Risk factors for AIDS, for instance, factors which influence progression to AIDS, are very unlikely to be identified by routine surveillance

\textsuperscript{219} Abdool Karim 1999 \textit{SAMJ Forum} 610.
\textsuperscript{220} Abdool Karim 1999 \textit{SAMJ Forum} 610. See also Van Rensburg, Fourie and Pretorius 193, who point out that HIV-infected persons do not necessarily display any signs or symptoms which point to the disease. For this reason, HIV-positive cases can only be established or confirmed by testing body fluids.
\textsuperscript{221} Abdool Karim 1999 \textit{SAMJ Forum} 610.
\textsuperscript{222} Abdool Karim 1999 \textit{SAMJ Forum} 610.
\textsuperscript{223} Abdool Karim 1999 \textit{SAMJ Forum} 610. See also Van Rensburg, Fourie and Pretorius 193, who make a point that for ethical reasons the conducting of HIV test is not compulsory in South Africa; subsequently there is no comprehensive data bank about the incidence of HIV-positive persons. Exact figures in this regard are not available and are in any case incomplete. This makes epidemiological estimates all the more difficult.
\textsuperscript{224} Abdool Karim 1999 \textit{SAMJ Forum} 610.
\textsuperscript{225} Abdool Karim 1999 \textit{SAMJ Forum} 610.
\textsuperscript{226} Abdool Karim 1999 \textit{SAMJ Forum} 610 and Van Rensburg, Fourie and Pretorius 193.
data, since detailed clinical and laboratory data will be required for this purpose. Fourthly, that AIDS-related health service utilisation includes inpatient admissions and outpatient visits. Past experience with Hepatitis B reporting confirmed that notification rates for outpatients were very low, since notification had to occur in the follow-up visit when the HIV result is available. AIDS-related inpatient utilisation is an indication of health service capacity rather than any real disease burden. Estimating the proportion of hospital admissions that are AIDS-related, requires a numerator, that is, AIDS admissions, which can only be obtained if all inpatients are routinely tested for HIV.229

Limited HIV testing of only those inpatients with AIDS indicator diseases is an alternative, though this is less reliable due to the universal presentation of AIDS in the South African setting. AIDS notification is therefore unlikely to provide useful information on outpatient or inpatient health service utilisation for AIDS.230 Finally, alternatively, instead of attempting to collect data on every AIDS patient in South Africa, a more reliable and less costly option is to undertake sentinel AIDS surveillance. This may involve selected sites in each province that will be responsible for routine AIDS surveillance in both outpatients and inpatients.231 Reporting rates and data quality can be closely monitored to ensure that trends will be interpretable. Since sentinel surveillance involves only a few representative sites, more detailed data can be collected to answer specific risk factor questions and denotification process can be set, making the calculation of case fatality rates possible.232 While AIDS surveillance is essential for planning and monitoring, however, the policy of making AIDS notifiable is inappropriate for South Africa and will not produce any of the outcomes expressed in the justification of this policy. Instead, well-planned sentinel surveillance with a limited number of representative sites could produce most of the information required by AIDS policy makers.233 This may explain why HIV and AIDS are still not notifiable diseases in South Africa.

However, for those people who are for notifiability of HIV/AIDS, contact identification and notification are one of best systems to control a communicable disease.234 According to Spencer, case isolation, quarantine, contact identification, notification and the provision of treatment underpin the effective public health to a serious

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227 Abdool Karim 1999 SAMJ Forum 610.
228 Abdool Karim 1999 SAMJ Forum 610.
229 Abdool Karim 1999 SAMJ Forum 610.
231 Abdool Karim 1999 SAMJ Forum 611.
233 Abdool Karim 1999 SAMJ Forum 611.
communicable disease.\textsuperscript{235} South Africa, with regard to the prevention of HIV, took its lead from Europe and North America where HIV exceptionalism had taken root. Notification and identification were deemed to be an infringement of the individual’s rights and likely to drive the epidemic underground.\textsuperscript{236} Maybe the fact that in the earliest days the South African epidemic was focused on the white, middle-class gay community and thus not unlike that of Europe and USA, had prompted this position. Without notification, therefore, the South African government has been able to query prevalence data and contradict research findings.\textsuperscript{237} In contrast, Cuba’s approach had been dramatically successful: the HIV prevalence in Cuba is reported to be currently 0.03%, with only 4 000 infected in a population of more than 13 million.\textsuperscript{238} It took a traditional public health approach incorporating isolation, quarantine and notification of exposed partners.\textsuperscript{239} The other proponents of notification, namely De Cock, Mbori-Ngacha and Marum, advocate that Africa would now benefit most from an approach to HIV/AIDS based on a public health model that includes mandatory, voluntary counselling, testing and partner notification; routine HIV testing in prevention services such as prevention of mother-to-child transmission and treatment for sexually transmitted infections; routine diagnostic HIV testing for patients seeking medical treatment and enhanced access to HIV/AIDS care.\textsuperscript{240}

They further argue that some approaches to HIV/AIDS are poorly adapted to the crisis in Africa because the issue has not been defined as and addressed as an infectious disease emergency.\textsuperscript{241} That a change in the philosophy is necessary to produce a rapid and substantial effect on the African epidemic and to limit its devastation and that HIV/AIDS prevention in Africa has been underfunded; greatly increased resources and strengthened infrastructure are required to tackle the issue. And further, that the emphasis on human rights in HIV/AIDS prevention seems to have reduced the importance of public health and social justice, which offer a framework for prevention efforts in Africa that might be more relevant to people’s daily lives and more likely to be effective.\textsuperscript{242} Finally, that on the basis of the epidemiological data, HIV/AIDS should be considered as the greatest threat to life, liberty and the pursuit of happiness and prosperity in many of African countries.

\textsuperscript{241} De Cock, Mbori-Ngacha and Marum 2002 The Lancet 67.
\textsuperscript{242} De Cock, Mbori-Ngacha and Marum 2002 The Lancet 67.
Interventions must be quantitatively and qualitatively commensurate with the magnitude of the threat posed by the disease.\textsuperscript{243}

\section*{5.7 CONCLUSION}

It has been shown that the schools of thoughts discussed above are important for a better understanding of issues relating to confidentiality and privacy in the context of HIV/AIDS. However, in South Africa, as is also the case in many African societies, both individualism and communitarianism should be considered in addressing the protection of privacy and confidentiality, and to a certain extent, also utilitarianism. Classical liberal notions of privacy and confidentiality emphasise an individualistic understanding of confidentiality, and not a notion of shared confidentiality. This chapter has also shown that, although public health systems of disease control, such as notifiability or reporting, are often criticised for not being appropriate for South Africa, the time may perhaps have come to reconsider this issue.\textsuperscript{244} Africa, and also South Africa, could perhaps benefit from an approach to HIV/AIDS based on a public health model that includes mandatory, voluntary counselling, testing and partner notification; routine HIV testing in prevention services such as prevention of mother-to-child transmission and treatment for sexually transmitted infections; routine diagnostic HIV testing for patients seeking medical treatment and enhanced access to HIV/AIDS care.\textsuperscript{245} Measures of this nature will need to be carefully framed, considering a range of fundamental human rights that may come into play. In the final instance, a balance will need to be struck between protecting confidential information and protecting the interests of the public and other third parties.

\begin{itemize}
\item De Cock, Mbori-Ngacha and Marum 2002 \textit{The Lancet} 67.
\item De Cock, Mbori-Ngacha and Marum 2002 \textit{The Lancet} 67.
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CHAPTER 6

CONCLUSION AND RECOMMENDATIONS

6.1 INTRODUCTION

It has been claimed that HIV/AIDS started in Africa as a rumour, soon became a disease, was later realised to be an epidemic, and has now become accepted as a tragedy.\(^1\) HIV has also been held to be a public health emergency, pronounced as an epidemic by most and a pandemic by many.\(^2\) Since its origins, probably as early as 1884,\(^3\) Africa and especially the Sub-Saharan region remain the most severely affected by HIV/AIDS. It was estimated that approximately 2.2 million Sub-Saharan Africans died of AIDS in 2003 alone.\(^4\) At the end of 2007, around 5.7 million South Africans were believed to be living with HIV.\(^5\) In 2008, UNAIDS and the World Health Organisation estimated that AIDS claimed 350 000 lives in South Africa in 2007 alone, which translates into 1000 people who died of AIDS-related illnesses that year.\(^6\)

The devastation spelt out by these figures is clear. The former president, Nelson Mandela, once summed this up by stating that in Africa, AIDS has claimed more lives than the sum total of all wars, famines and floods and that AIDS was hence no longer a disease, but a human rights issue.\(^7\) Effective interventions are urgently required to curb the spread and destruction that HIV/AIDS have caused. Such interventions should proceed from the understanding that persons living with HIV and AIDS in South Africa still face severe prejudice, accompanied by violence, stigma, discrimination, victimisation and ostracism. The cumulative effect of this stigma, discrimination and victimisation of persons living with HIV/AIDS,

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6. City Press, 24 August 2008 page 1. (The paper depicted this as “The Silent war that kills 1000 a day”).
undermines efforts to curb the spread of HIV. Those who suspect that they may be HIV-positive may be reluctant to have themselves tested for fear that they may be stigmatised, discriminated against or victimised. These factors, in turn, enhance silence and concealment in that those who may get tested and subsequently test positive, may in fear of the shame that goes with having HIV, prefer to conceal their HIV status.  

6.2 RECOMMENDATIONS

This study investigated the right to confidentiality in the context of HIV/AIDS through an interdisciplinary lens. This study indicates that whilst confidentiality is important and should be preserved in order to protect persons living with HIV/AIDS against stigmatisation, discrimination and victimisation, this should be balanced by other equally important interests, such as the protection of public health and individual third parties who may be affected by the intentional or negligent infection of others with HIV.

As the consideration of the legal issues relating to confidentiality and privacy cannot be divorced from the social context in which HIV/AIDS plays out in South African communities, the study closely looked at how victimisation, discrimination and stigmatisation manifest in the lives of persons living with HIV/AIDS. This was followed by a critical exploration of the present legal and ethical framework governing privacy and confidentiality, including medical confidentiality, as well as the duty to disclose a positive HIV-status, in the context of HIV/AIDS. The duty to disclose HIV status is considered not only from the side of the infected individual, but also with regard to health care practitioners. Possible limitations on the right to privacy in this context are also examined, which include, amongst others, a consideration of partner notification and making HIV/AIDS notifiable diseases in South Africa. This discussion cannot be complete without a discussion of the criminalisation of the intentional transmission of HIV.

The study suggested that it is imperative that legal interventions aimed at curbing the spread of HIV will need to be mindful of the unique social, cultural and economic forces that impact on the duty to disclose a positive HIV-status to partners and other affected third parties. In this regard, the thesis also explored socio-cultural factors that underpin consensual sexual relationships in African communities generally.

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These factors impact significantly on infected individuals’ decision to disclose their HIV status. It is submitted present efforts to address the spread of HIV are not always mindful of these unique dynamics.

Insights gained from philosophical theories relating to individualism, communitarianism and utilitarianism are valuable tools in facilitating a clearer understanding of relevant social and cultural factors that keep South African society locked in the present stalemate with regard to the disclosure of HIV status. These theories unlock some of the reasons why the traditional Western (individualistic) notion of confidentiality remains problematical in many African communities. Shared confidentiality is tentatively suggested as a more nuanced expression of confidentiality, which seems a better ‘fit’ for the diverse South African population.

The value and contribution of this thesis lies in the fresh angle that it takes in examining legal and ethical issues relating to confidentiality and privacy in the context of HIV and AIDS, which is informed by relevant social and cultural issues not always considered in conventional discussion on the topic. In addition, philosophical theories more appropriate for the South African context (e.g. strands of communitarianism) are also considered in this thesis, providing a more contextualised and nuanced understanding of confidentiality from a legal point of view.

It has been contended that the societal stigma associated with HIV/AIDS has lessened somewhat and that therefore the over-riding privacy concerns should be re-evaluated.\(^9\) It is now time for South Africa, as well as Africa, to consider applying the public health systems such as notifiability of HIV/AIDS and partner notification, especially if these may help to further reduce spread of the disease and hence strengthen the fight against the epidemic. In addition, voluntary counseling and testing; routine HIV testing in prevention services such as prevention of mother-to-child transmission and treatment for sexually transmitted infections; routine diagnostic HIV testing for patients seeking medical treatment and enhanced access to HIV/AIDS care are all corollary measures that will assist in addressing the spread of HIV.\(^10\)

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<table>
<thead>
<tr>
<th>Country</th>
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<tr>
<td>AUSTRALIA</td>
<td>Disability Discrimination Act 1992</td>
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<td>CANADA</td>
<td>The Criminal Code R.S.C, 1985</td>
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<td>Constitution of the Republic of South Africa Act 200 of 1993</td>
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<td>Criminal Law Amendment Act 105 of 1997</td>
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<td>Criminal Law (Sexual Offences and related Matters) Amendment Act 32 of 2007</td>
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ABBREVIATIONS

(A) - Appellate Division

BCLR - Butterworths Constitutional Law Reports

BMJ - British Medical Journal

(CC) - Constitutional Court

CPD - Reports of the Cape Provincial Division

(D & CLD) - Durban and Coast Local Division

HPCSA - Health Professions Council of South Africa

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ICCPR - International Covenant on Civil and Political Rights

ICESCR - International Covenant on Economic, Social and Cultural
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<tr>
<th>Acronym</th>
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<tr>
<td>ILJ</td>
<td>Industrial Law Journal</td>
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<tr>
<td>J Clin Pathol</td>
<td>Journal of Clinical Pathology</td>
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<td>J Med Ethics</td>
<td>Journal of Medical Ethics</td>
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<td>LC</td>
<td>Labour Court</td>
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<td>Life Offices' Association</td>
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SAJBL - South African Journal of Bioethics and Law

SAJHR - South African Journal of Human Rights

SALJ - South African Law Journal

SAMJ - South African Medical Journal

SANAC - South African National AIDS Council

Stell LR - Stellenbosch Law Review

(T) - Transvaal Provincial Division

Tzu Chi Med J - Tzu Chi Medical Journal

WMA - World Medical Association

WLD - Reports of the Witwatersrand Local Division