UGANDA NETWORK ON LAW ETHICS AND HIV/AIDS (UGANET)

JUDICIAL HANDBOOK ON HIV, HUMAN RIGHTS, AND THE LAW IN UGANDA

JUDICIARY OF UGANDA

WITH SUPPORT FROM

CONTENTS

Foreword

The enactment of the HIV and AIDS Prevention and Control Act, 2014 in Uganda introduced serious challenges in litigating and adjudicating HIV/AIDS related cases in the court room. The law introduced among others involuntary disclosure of one's HIV status more especially those with knowledge that are HIV+. This disclosure is wide as it relates to all persons in social contact with the person making the disclosure. This has created negative discriminatory approaches in handling cases of PLHIV in the court room. The Act has been in place for now about 7 years but most of the cases prosecuted in our courts have not been commenced under this Act instead under the Penal Code Act Cap. 120, specifically under Section 171 of the Act.

Despite this legislation, limited legal literature exists on litigation and adjudication of HIV/AIDS cases in Uganda and most of the existing literature is foreign especially, the UNAIDS HIV and Human Rights Adjudication, 2007. Challenges faced by Judicial officers are several in this area and some relate to comprehending matters of science and especially proving whether or not the accused had the intention to transmit HIV/AIDS to the victim. Scientific evidence may prove to the contrary, taking into account the viral load of an accused person.

This Handbook has come at the appropriate time when cases concerning HIV/AIDS adjudication are increasing in the criminal justice system in Uganda. The Handbook is presented in a user-friendly language and style with reference to clear jurisprudence on HIV/AIDS litigation and adjudication domestically, regionally and on the global arena.

It is my sincere hope that this Handbook will go a long way in contributing to the fulfilment of the mandate of the Judiciary and improving adjudication of HIV/AIDS cases in our criminal justice system.

The Judiciary is grateful to UGANET and its partners for steering this process and for coming up with this valuable product.

The Honourable Alfonse Chigamoy Owiny-Dollo
Chief Justice of Uganda
10 December 2021

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Acronyms

ACHPR	African Charter on Human and Peoples' Rights
ADA	American with Disabilities Act
ADF	Australian Defence Force
ACRWC	African Charter on the Rights and Welfare of the Child
AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Treatment
ARVs	Anti-Retroviral Vaccines
BLR	Botswana Law Review
CEHURD	Centre for Human Rights Development
CRC	Convention on the Rights of the Child
EAC	East African Community
HAART	Highly Active Antiretroviral Treatment
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
HRW	Human Rights Watch
ICESCR	International Covenant on Economic Social and Cultural Rights
ILO	International Labour Organization
MWIRC	Malawi Industrial Relations Court
NODPSP	National Objectives and Directive Principles of State Policy
OVC	Office of Victims of Crime (US Department of Justice)
OHCHR	Office of the High Commissioner for Human Rights
PEP	Post-Exposure Prophylaxis
PLHIVs	People Living with HIV/AIDS
PMTCT	Prevention of Mother-to-Child Transmission
SA	South Africa
SERAC	Social and Economic Rights Action Centre
STIs	Sexually Transmitted Infections
TRIPS	Trade Related Aspects of Intellectual Property
UAC	Uganda Aids Commission
UDHR	Universal Declaration on Human Rights
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNCSTS	Uganda National Council for Science and Technology
VCT	Voluntary HIV Counselling and Testing
WHO	World Health Organization
WTO	World Trade Organization

List of Legal and related Instruments

International

United Nations

- UN Convention on the Elimination of All Forms of Discrimination against Women, 1979
- UN Convention on the Rights of the Child, 1989
- UN Convention on the Rights of People with Disabilities, 2006
- CEDAW General Recommendation No. 15—Avoidance of Discrimination against Women in national strategies for the prevention and control of acquired immunodeficiency syndrome, 1990
- CEDAW General Recommendation No. 24—Women and health, 1999
- Declaration of Commitment on HIV/AIDS, GA Res S-26/2, June 27, 2001
- Political Declaration on HIV/AIDS, 2006
- Political Declaration on HIV and AIDS, 2011

International Labour Organization

- ILO Code of Practice on the Protection of Workers' Personal Data, 1997
- ILO Code of Practice on HIV and the World of Work, 2001
- ILO Discrimination (Employment and Occupation) Convention No. 111, 1958
- ILO Recommendation No. 200 concerning HIV and AIDS and the World of Work, 2010

UNAIDs

- UNAIDS International Guidelines on HIV/AIDs and Human Rights, 1996 and 2006

World Health Organization

- WHO Guidelines on HIV Infection and AIDS in Prisons,1993

Regional

African Union

- African Charter on Human and Peoples' Rights, 1981
- African Charter on the Rights and Welfare of the Child, 1990
- Protocol to the African Charter on Human and Peoples' Rights on Rights of Women in Africa, 2003
- Abuja Declaration and Framework for Action for the fight against HIV/AIDS, tuberculosis, and other related infectious diseases in Africa, April 27, 2001
- African Commission on Human and Peoples' Rights HIV Resolution, 2011

East African Community

- East African Community HIV and AIDs Prevention and Management Act, 2012

National

Constitution

- Constitution of the Republic of Uganda, 1995 (as amended)

Legislation

- Children Act, Cap 59 (as amended by Act, 2016)
- Domestic Violence Act, No 3/2010
- Employment Act, No 6/2006
- Employment (Sexual Harassment) Regulations, SI No 15/2012
- Equal Opportunities Commission Act, 2007
- HIV and AIDS Prevention and Control Act, 2014
- Penal Code Act, Cap 120
- Penal Code (Amendment) Act, No 8/2007
- Prevention of Trafficking in Persons Act, No 7/2009
- Prohibition of Female Genital Mutilation Act, No 5/2010

Policies, Plans& Strategies

- National Health Policy,1999 & 2010
- National Policy Guidelines for Voluntary HIV Counselling and Testing, 2003
- National Policy Guidelines for HIV Counselling and Testing, 2005
- National Policy for Reduction of the Mother-to-Child HIV Transmission, 2003
- National Policy on HIV/ AIDS and the World of Work, 2003
- UAC National HIV and AIDS Strategic Plan, 2015/16-2019/20

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- Dijaje Makuto v. The State [2000] BWCA 21 (Botswana CA)
- Diau v. Botswana Building Society [2003] (2) BLR 409 (Botswana IC)
- Jimson v. Botswana Building Society [2005] AHRLR 86 (Botswana IC)
- Lejony v. State [2000] (2) BLR 145 (Botswana CA)
- Lemo v. Northern Air Maintenance (Pty) Ltd [2004] 2 BLR 317 (Botswana HC)
- Maje v. Botswana Life Insurance [2001] (2) BLR 626 (Botswana HC)
- Monare v. Botswana Ash (Pty) Ltd [2004] 1 BLR 121 (Botswana IC)

Kenya

- AIDS Law Project v. Attorney General & 3 Others [2015] eKLR (Kenya HC)
- J.A.O. v. Homepark Caterers Ltd & 2 Others [2004] eKLR (Kenya HC)
- Midwa v. Midwa [2000] 2 EA 453 (Kenya CA)
- Patricia Asero Ochieng& 2 Others v. Attorney General & Another [2012] eKLR (Kenya HC)

Malawi

- Banda v. Lekha [2005] MWIRC 44 (Malawi IRC)

Namibia

- Nanditume v. Minister of Defence [2000] NR 103 (Namibia LC)

Nigeria

- Mr X v. Mr Jakobus Brink & 4 others, Suit No NICN/ABJ/464/2016 (Nigeria IC)
- Odafe v. Attorney General [2004] AHRLR 205 (Nigeria HC)

South Africa

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- C v. Minister of Correctional Services [1996] (4) SA 292 (South Africa HC)
- Hoffman v. South Africa Airways [2000] ZACC 17 (South Africa CC)
- Irvin & Johnson Ltd V. Trawler and Line Fishing Union& Others [2003] 24 ILJ 565 (South Africa LC)
- Jansen van Vuuren & Another v. Kruger [1993] ZASCA 145 (South Africa SCA)
- NM & Others v. Smith& Others [2007] ZACC6 (South Africa CC)
- Minister of Health & Others v. Treatment Action Campaign & Others [2002] ZACC 15 (South Africa CC)
- PFG Building Glass v. CEPPAWU & Others [2003] (24) ILJ 974 (South Africa LC)

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- CEHURD & Others v. Executive Director of Mulago & Another [2017] UGHCCD 10 (Uganda HC)
- Ederema Tomasi v. Uganda [2019] UGCA 203 (Uganda CA)

- Komuhangi Silvia v Uganda [2019] UGHC 39 (Uganda HC)
- Olivia Kugonza v Sinohydro Corporation Ltd, Civil Suit No. MSD-002/2016
- Rosemary Namubiru v. Uganda, HC Crim. Review No 50/2014 (Uganda HC)
- Uganda v. Bonyo Abdu [2009] UGHC 200 (Uganda HC)
- Uganda v. Natukunda Faith, HCT/ICD/CO-001/2012 (Uganda HC)

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- Kingaipe & Another v. Attorney General [2010] 2009/HL/86 (Zambia HC)

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- Perfect Ngwenya v. The State [2017] ZWBHC 59 (Zimbabwe HC)
- PittyMpofu & Another v. The State [2016] ZWCC 16 (Zimbabwe CC)
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- R v. Mabior [2012] 2 SCR 584 (Canada SC)
- R v. Martineau [1990] 2 SCR 633 (Canada SC)

United States

- Bragdon v. Abbott [1998] 524 U.S. 624 (United States SC)
- Doe v. City of New York [1994] 15 F.3d 264 (2d Cir.) (United States CA)

Asia & Oceania

Australia

- Hall v. Victorian Amateur Football Association [1999] VCAT 627 (Australia VCAT)
- Harvey & Another v. PD [2004] NSWCA 97 (Australia NSWCA)
- R v. Reid [2006] QCA 202 (Australia (Queensland SC))
- X v. Commonwealth of Australia [1999] HCA 63 (Australia HCA)

India

- MX v. ZY [1997] AIR (Bom) 406 (India HC)

New Zealand

- R v. Mwai [1995] 3 NZLR 149 (New Zealand CA)

Europe

Ireland

- Child and Family Agency v. A.A. & Another [2018] IEHC 112 (Ireland HC)

United Kingdom

- R v. Dica [2004] EWCA Crim 1103 (England & Wales CA)
- R v. EB [2006] EWCA Crim 2945 (England & Wales CA)
- R v. Konzani [2005] EWCA Crim 706 (England & Wales CA)

Executive Summary

The *Judicial Handbook on HIV, Human Rights and the Law in Uganda* comprises of five parts that address the issues relating to HIV/AIDS and raises pertinent issues relating to its existence as may affect Judges' decisions as well as possible recommendations for a start. Specifically, it has a background in which the current status of the HIV/AIDS epidemic and response to it is included.

Part I enunciates the International Law and Human Rights Frameworks as applicable to HIV/AIDS in Uganda. These include among others, the International Guidelines on HIV/AIDS and Human Rights, International Convention on Economic Social and Cultural Rights (ICESCR), Convention on the Rights of the Child (CRC) and the WHO Guidelines on HIV Infection and AIDS in Prisons (1993). Thereafter, the Regional Instruments and Case law on HIV AIDS is considered. For example, the African Charter on Human and Peoples' Rights (ACHPR) (the "Banjul Charter") 1981, The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol). Uganda is a commonwealth country and the member of the United Nations and has ratified all the aforementioned international statutes.

Part II concentrates on the National Law and Human Rights Frameworks as applicable to HIV in Uganda. There are number of policies and laws implementation of which is still poor or lacking. These include among others The National Health Policy, the National Policy Guidelines for Voluntary HIV Counselling and Testing (VCT) (2003) and National Policy Guidelines for HIV Counselling and Testing (HCT) (2005) and the Policy for Reduction of the Mother-to-Child HIV Transmission. Briefly the laws include the Constitution of the Republic of Uganda 1995, the HIV and AIDS Prevention and Control Act and the Employment Act.

Part III is about gaps/issues/shortfalls in national law and human rights frameworks as applicable to HIV and discusses policies on HIV. Importantly, it also discusses stigmatisation and prohibition of stigmatization against PLHIV

Part IV pertains to criminalization of transmission of HIV and its adverse effects. It enunciates the penal code act provisions on criminalization and singles out the offence of criminal assault, criminal negligence particulalrly s. 171 of the PCA.Under the same chapter is an outlay relating to what non-disclosure,exposure and transmission under the HIV and AIDS Prevention and Control Act, 2014. It explains the elements of criminalization and also discusses the issue of possible defences.

Under this chapter, the handbook considers HIV testing and whether it is conclusive proof of transmission; enunciates the incidence of HIV and AIDS and its link to GBV ; illustrates how domestic violence is linked to HIV. and AIDS and brings out how certain criminal offences are aggravated by HIV AIDS, discusses the link between trauma and HIV and AIDS, the employment issues relating to HIV such as testing prior to recruitment and at the work place as well as dismissal of an employee who has HIV. Further, it discusses HIV and AIDS in relation to access to healthcare and treatment

Part V is about things to remember when judging and adjudicating HIV cases, what the disposition of a judicial officer should be as well as the role of a judicial offcer in the courtroom whilst handling such cases.

Background

HIV/AIDS epidemic remains a global concern because of the number of deaths it causes annually.

The Sub-Saharan Africa remains the region most severely affected by the HIV epidemic. In this region, nearly 1 in every 20 adults is living with HIV and it accounts for 24.7 million (nearly 71%) of the 35 million people living with HIV worldwide. In this region, 58% of the total numbers of people living with HIV are women. Ten countries in Sub-Saharan Africa, three of which are EAC Partner States (Kenya, Uganda, and the United Republic of Tanzania) account for 81% of all people living with HIV in the region. Additionally, 2.9 million children aged 0–14, 2.9 million young people aged 15–24 and more than 2.5 million people aged 50 years and older are living with HIV in Sub-Saharan Africa. Of the estimated 1.8 million people living with HIV who were affected by conflict, displacement, or disaster in 2006, 1.5 million were living in Sub-Saharan Africa, with this number continuing to increase. Over the past 30-40 years, the response to HIV/AIDs has been a confluence of policy and programmatic approaches that underpinned a context of both the great fear for HIV and the control and prevention of HIV transmission. The programmatic approaches primarily centred on medical responses in efforts to control and prevent transmission in terms of condom-use; voluntary counselling and testing (VCT); Prevention of mother-to-child transmission (PMTC) and Anti-Retroviral Treatment (ART). Policies were, by and large, adopted to underpin medical responses and, in effect, public health interventions. Yet, as national response to HIV unfolded, States and governments argued that protection of public health warranted more intrusive approaches, e.g., mandatory testing, use of 'public health' provisions in penal laws (to penalize transmission), named reporting of HIV+ individuals (and mandatory notification of partners, family, employers, etc.). Taking cue from governments, the private sector embraced similar stances of requiring, for instance, HIV-testing and, in many instances, dismissing HIV+ employees. In the past 15 or so years, many States have adopted specific HIV and AIDs prevention and control legislation which, while laudable for the public health goals, have also sought the specific criminalization of HIV transmission (and, often the criminalization is pegged to results of a public health intervention, e.g., a HIV+ result from voluntary test as evidence of deliberate transmission of HIV).

In Uganda, responses to the epidemic initially focused on health interventions such as HIV prevention campaigns, care for the sick, voluntary counselling and testing, and more recently antiretroviral treatment. There has been considerable investment in communication and awareness-creation to stem the further spread of HIV. Over time, some responses to the human rights violations of people living with, affected by, and at risk of HIV have been designed in the form of legal services. Many of these are still yet to take root and ensure accessibility by those they target.

As a country, Uganda has put in a lot of effort to end the HIV epidemic in the country. It has formulated various laws and policies in order to curb the spread of the virus amongst the people, to protect the rights of those already infected with the disease and protect those not yet infected from being infected by the same. Uganda has therefore used a number of national, regional and international policies in order to fight the HIV epidemic and its related effects.

Since the onset of the HIV/AIDS pandemic, governments and the courts have responded in a variety of ways. Some responses have been sensitive to the needs of those with HIV, in terms of seeking to guarantee heightened levels of confidentiality or freedom from discrimination. Others have sought to use the law as a tool to limit spread of HIV, for example, as noted, by imposing criminal liability for its transmission or restricting the freedoms of those who are HIV+. Elsewhere, doctors and researchers have grappled with the legal and ethical problems surrounding testing for a condition which many people

may not want to be aware of, and with the conflicts which can arise between respect for individual autonomy and the promotion of public health.

Overtime, in spite of the intrusive approaches to HIV prevention by the State (and private actors), the courts have sought to strike a balance between public health concerns and human rights in applying traditional elements of crime to penal provisions; jealously safeguarding privacy rights and confidentiality of medical results in wake of HIV reporting and notifications; disapproving and sanctioning HIV-based discrimination in employment, etc. Additionally, the courts have been at the centre for the right of access to HIV treatment and medicines, including, importantly antiretroviral treatment (ART).

The realities of stigma, discrimination and neglect of human rights protection has been an integral component in the responses to HIV. The high degree of stigma and discrimination associated with HIV/AIDS has made human rights protection not only a priority to ensure the rights of people living with and at-risk of HIV (PLWHAs) but to address public health goals as well. It is this factual reality that has borne out the confluence between HIV, human rights and the law and it has become a seminal theme of policy, academic and even judicial discourse on HIV/AIDS. The issues that underscore this reality inform this *Judicial Handbook on HIV, Human Rights and the Law in Uganda*.

Part I: International and Regional Human Rights Frameworks

1.1 Introduction

Under international human rights laws and treaties, and international obligations such as the 1948 Universal Declaration of Human Rights and the 2030 Agenda for Sustainable Development, every person has a right to health and to access HIV and other healthcare services. People also have a right to equal treatment before the law and a right to dignity. However, many people continue to face human rights-related barriers to essential and often lifesaving health services. These barriers arise from discriminatory laws and practices connected to people's health status, gender identity, sexual orientation and conduct. The people facing these barriers are often the most marginalised and stigmatized in society, and the most vulnerable to HIV. This makes protecting, promoting, respecting, and fulfilling people's human rights essential to ensure they can access the health services they need, enabling an effective response to HIV and AIDS.

The protection of human rights is essential to safeguard human dignity in the context of HIV/AIDS and to ensure an effective, rights-based response. When human rights are protected, fewer people become infected and those living with HIV/AIDS and their families can better cope with HIV/AIDS.

1.2 HIV/AIDS and International Law

1.2.1. General Framework

UNIVERSAL DECLARATION OF HUMAN RIGHTS (UDHR)

This Declaration defines the right to health by stating that**:**

> Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, and housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or the lack of livelihood in circumstances beyond his control. (UDHR, Article 25(1))

The drafters of the UDHR should be applauded for including the right to health in the Bill of Rights. The claw back of this definition is that it is not conclusive because it gives health as part of adequate standard of living. Health was not given much weight yet health is such a crucial right for the wellbeing of society. Nevertheless, the UDHR provides for a right to protect inventors and exploit the benefits of science. However, this has to be read together with General Comment 14 of CESCR which elaborates on the

right to health to include access to health facilities, goods and services, appropriate treatment as well as provision of essential drugs. It creates levels of obligation upon the State to include:

- Availability of essential drugs as defined by the WHO.
- Accessibility to goods and services including medicines.
- Acceptability of available medicines.
- Quality of goods and services.

According to **Article 1** of the Declaration, all human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.

In addition, **Article 7** of the same Declaration is to the effect that all are equal before the law and are entitled without any discrimination to equal protection of the law. All are entitled to equal protection against any discrimination in violation of this Declaration and against any incitement to such discrimination.

1.2.1.1. *International Covenant on Economic, Social and Cultural Rights (ICESCR)*

The right to health was further defined under the International Covenant on Economic Social and Cultural Rights (ICESCR) which provides that State parties "recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (Article 12).

> The right to health, like all human rights, imposes three types or levels of obligations on States parties: the obligations to respect, protect and fulfil. In turn, the obligation to fulfil contains obligations to facilitate, provide and promote. (23) The obligation to respect requires States to refrain from interfering directly or indirectly with the enjoyment of the right to health. The obligation to protect requires States to take measures that prevent third parties from interfering with article 12 guarantees. Finally, the obligation to fulfil requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional, and other measures towards the full realization of the right to health.
>
> ICESCR, para. 33

The steps to be taken by the State Parties to the present Covenant to achieve the full realization of the right shall include those necessary for:

- The provision of the reduction of stillbirth-rate and of infant mortality and for the healthy development of the child;
- the improvement of all aspects of environmental and industrial hygiene;
- the prevention, treatment and control of epidemic, occupational and other diseases;
- The creation of conditions which would assure to all medical service and medical attention in the event of sicknesses.

The ICESCR has expounded on the right to health.

The obligation to fulfil requires States parties, *inter alia*, to give sufficient recognition to the right to health in the national political and legal systems, preferably by way of legislative implementation, and to adopt a national health policy with a detailed plan for realizing the right to health. Further obligations include the provision of a public, private or mixed health insurance system which is affordable for all, the promotion of medical research and health education, as well as information campaigns, in particular with respect to HIV/AIDS, sexual and reproductive health, traditional practices, domestic violence, the abuse of alcohol and the use of cigarettes, drugs and other harmful substances.

The obligation to fulfil (facilitate) requires States *inter alia* to take positive measures that enable and assist individuals and communities to enjoy the right to health. States parties are also obliged to fulfil (provide) a specific right contained in the Covenant when individuals or a group are unable, for reasons beyond their control, to realize that right themselves by the means at their disposal.

The obligation to fulfil (promote) the right to health requires States to undertake actions that create, maintain and restore the health of the population. Such obligations include: (i) fostering recognition of factors favouring positive health results, e.g. research and provision of information; (ii) ensuring that health services are culturally appropriate and that health care staff are trained to recognize and respond to the specific needs of vulnerable or marginalized groups; (iii) ensuring that the State meets its obligations in the dissemination of appropriate information relating to healthy lifestyles and nutrition, harmful traditional practices and the availability of services; (iv) supporting people in making informed choices about their health.

> One of the core obligations of the State is "to ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups."
>
> (per General Comment No. 14 (para. 43(a)).

The above provisions are very important for PLHIV considering the discrimination they face in their day-to-day lives, especially accessing basic medication. Indeed, Mugambe J in CEHURD v Executive Director of Mulago & Another, relied on Article 12 of the ICESCR in finding the defendant hospital liable.

1.2.2. Thematic Frameworks

1.2.2.1. *Children*

Convention on the Rights of the Child (CRC)

The Convention on the Rights of the Child directs States to ensure access to essential health services for the child and his or her family, including pre- and post-natal care for mothers. The Convention links these goals with ensuring access to child-friendly information about preventive and health-promoting behaviour and support to families and communities in implementing these practices. Implementation of the principle of non-discrimination requires that girls, as well as boys, have equal access to adequate nutrition, safe environments, and physical as well as mental health services. The UNAIDS Joint UN Programme on HIV/AIDS has noted:

> The most recent trends are alarming: in most parts of the world the majority of new infections are in young people between the ages of 15 and 24, sometimes younger. Women including young girls are also increasingly becoming infected. In most regions of the world, the vast majority of infected women do not know that they are infected and may unknowingly infect their children. Consequently, many states have recently registered an increase in their infant and child mortality rates and child mortality rate. Adolescents are also vulnerable to HIV/AIDS because their first sexual experience may take place in an environment in which they have no access to proper information and guidance. Children who use drugs are at high risk.
>
> (accessed at: https://www.unicef.org/aids/files/UNHCHR_HIV_and_childrens_rights_2003.pdf).

The CRC also expressly provides for the right to health of children and stipulates that:

> State parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health services, including those related to family planning (CEDAW, Article 12)

1.2.2.2. *Women*

Convention on the Elimination of all Forms of Discrimination against Women (CEDAW)

CEDAW is considered the women's rights Convention and constitutes the fundamental bill of rights for women. It is unique among the existing human rights instruments in that it is exclusively concerned with promoting and protecting women's human rights on a wide range of areas, including health. Article 12 of CEDAW requires that:

> States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services (CRC, Article 24(1)).
>
> General Recommendation No 24 on article 12 (Women and health)

The Committee on the Elimination of all Forms of Discrimination against Women has provided interpretative comments on the scope and import of Article 12 of CEDAW in regarding women's health rights in the context of HIV/AIDs. This is encapsulated in the General Recommendation No 24 (on Women and health) in 1999 as:

> …
>
> 5. The Committee refers also to its earlier general recommendations on … human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), … violence against women and equality in family relations, all of which refer to issues which are integral to full compliance with article 12 of the Convention.
>
> …
>
> 17. … The Committee asks States parties to report on what they have done to address the magnitude of women's ill-health, in particular when it arises from preventable conditions, such as … HIV/AIDS.
>
> 18. The issues of HIV/AIDS and other sexually transmitted disease are central to the rights of women and adolescent girls to sexual health … Harmful traditional practices, such as female genital mutilation, polygamy, as well as marital rape, may also expose girls and women to the risk of contracting HIV/AIDS and other sexually transmitted diseases.
>
> General Recommendation No. 15 (Avoidance of discrimination against women in national strategies for the prevention and control of AIDS)

The Committee has also provided interpretative comments on the national strategies to prevent and control HIV/AIDs as a crucial part of women's rights to health in General Recommendation No. 15 that it issued in 1990, in recommending:

> *(a) That States parties intensify efforts in disseminating information to increase public awareness of the risk of HIV infection and AIDS, especially in women and children, and of its effects on them;*
>
> *(b) That programmes to combat AIDS should give special attention to the rights and needs of women and children, and to the factors relating to the reproductive role of women and their subordinate position in some societies which make them especially vulnerable to HIV infection;*
>
> *(c) That States parties ensure the active participation of women in primary health care and take measures to enhance their role as care providers, health workers and educators in the prevention of infection with HIV;*
>
> *(d) That all States parties include in their reports under article 12 of the Convention information on the effects of AIDS on the situation of women and on the action taken to cater to the needs of those women who are infected and to prevent specific discrimination against women in response to AIDS.*

1.2.3.2. *Labour*

ILO Conventions, Recommendations and Codes of Practice

The International Labour Organization has issued a number of legal instruments that address HIV/AIDs in the in the context of work and employment. These include, *inter alia*, code of practice, e.g.

- ILO Code of Practice on the Protection of Workers' Personal Data, 1997
- ILO Code of Practice on HIV and the World of Work, 2001

Additionally, ILO has issued, as it has done with other aspects of employment, key recommendations, as reflected in the ILO *Recommendation No. 200 concerning HIV and AIDS and the World of Work*, 2010.

1.2.3.3. *Health*

The main UN organization with a mandate on health is the World Health Organization (WHO) and, specifically to HIV/AIDS is the Joint United Nations Programme on HIV/AIDS (UNAIDS). Under both WHO and UNAIDS, specific guidelines have been issued regarding HIV/AIDS that provide a framework and benchmarks for actions by States as regards prevention, control and treatment (and, in many respects, underpin and bear on human rights).

UNAIDS International Guidelines on HIV/AIDs and Human Rights

The guidelines arose because of various calls for their development in light of the need for guidance on how best to promote, protect, and fulfil human rights in the context of the HIV epidemic. Although not binding, the guidelines provide compelling policy guidance from the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the Office of the High Commissioner for Human Rights (OHCHR) on how to ensure that internationally guaranteed human rights underlie national HIV responses. There are twelve guidelines however, in this Handbook, three crucial ones are relevant.

Guideline 3: Public Health Legislation

This guideline enjoins States to review and reform health laws and ensure that their provisions applicable to casually transmitted diseases are not inappropriately applied to HIV and that they are consistent with International Human Rights obligations. The above guideline further goes on to state what the components of the legislation should include, for example, pre- and post-test counselling, the HIV status of an individual should be protected from unauthorized collection, etc.

Guideline 4: Criminal Laws and Correctional Systems

The guideline stipulates that States should review and reform criminal laws to ensure consistency with Human Rights and Obligations and are not misused in the context of HIV. It also provides that criminal or public health legislation should not include specific offences against the deliberate and intentional transmission of HIV but rather should apply general criminal offences to deal with elements of foreseeability, intent, causality, etc. This guideline is crucial since the criminalization of HIV/AIDS is likely to increase the stigma PLHIV face and it will encourage many people not to test for fear of penal sanctions.

Guideline 5: Anti-Discrimination and Protective Laws

This provides that States should enact or strengthen anti-discrimination and other protective laws that protect vulnerable groups, people living with HIV and people with disabilities from discrimination in both the public and private sectors, that will ensure privacy and confidentiality and ethics in research involving human subjects, emphasize education and conciliation and provide for speedy and effective administrative remedies.

The effect of the guidelines is to prevent discrimination in workplaces and to ensure the privacy of PLHIVs. The States are required to pass relevant laws for the protection of PHLIVs.

WHO Constitution

The WHO Constitution defines health as the general wellbeing and not merely the absence of disease.

The preamble of the same constitution provides; the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, and political belief, economic or social condition.

The WHO Constitution was the first international instrument that attempted to define the right to health. The importance of this definition is the fact that health is not restricted to merely the absence of disease. This covers the measures that have been taken to reduce the spread and transmission of HIV/AIDS. The preamble also prohibits discrimination in the enjoyment of the right on any ground. This is important for people living with HIV/AIDS (PLHIV) because of stigma they often find it difficult to access health care services.

WHO Guidelines on HIV Infection and AIDS in Prisons

These guidelines were prepared on the basis of technical advice provided to WHO prior to and during a consultation of experts convened in Geneva in September 1992. The consultation included

representatives of international and non-governmental organisations and government departments with a wide range of experience and background in the health, management, and human rights aspects of HIV/AIDS in prisons.

The guidelines provide standards from which prison authorities should strive to achieve in their efforts to prevent HIV transmission in prisons and to provide care to those affected by HIV/AIDS. The general principles governing these guidelines are to the effect that:

(a) All prisoners have the right to receive health care, including preventive measures, equivalent to that available in the community without discrimination, in particular with respect to their legal status or nationality.

(b) The general principles adopted by national AIDS programmes should apply equally to prisoners and to the community.

(c) Preventive measures for HIV/AIDS in prison should be complementary to and compatible with those in the community.

1.2.3. Other Frameworks

1.2.3.1. *Access to Medicines in the context of HIV/AIDS*

Access to medicines is an important component of the right to health. The WHO defines 'essential medicines' as those medicines which 'satisfy the priority health care needs of the population'. The new international legal regime brought upon by the 1994 WTO Agreement on Trade Related Aspects of Intellectual Property (TRIPS) rendered pharmaceutical products such as ARVs too expensive and at times inaccessible for poor countries like Uganda. The granting of a patent over the manufacture of a medicine or pharmaceutical product gives the patent holder a monopoly.

However, the TRIPS Agreement has in-built flexibilities such as compulsory licensing, which enables the government to license the use of a patented invention to a third party without the consent of a patent holder against payment of adequate remuneration.

1.2.3.2. *Doha Declaration*

The Doha Declaration is a significant development aimed at re-formulating intellectual property as a social policy tool for the benefit of the society as a whole. The Doha Declaration re-affirmed the flexibilities in the TRIPS Agreement. The delegates agreed that the TRIPS Agreement does not prevent members from taking measures to protect health, in particular to promote access to medicines for all. The approach taken reiterates General Comment 14 of the ICESCR which guarantees access to essential medicines. This is particularly important for PLHIVs who are required to access medication in a timely manner. In the Kenyan case of ***Patricia Asero Ochieng & Others v Attorney General & Another,*** three Kenyan petitioners affected by HIV were receiving generic ARVs. They petitioned the High Court challenging the ***Anti-Counterfeit Act,* 2008**. They argued that the Act confused *generic* medicines with *counterfeit medicines* and if implemented would significantly affect PLHIV thus constitute a violation to the right to life guaranteed under the Constitution and ICESCR.

1.3 HIV/AIDS and African Human Rights Law

1.3.1. African Charter on Human and Peoples' Rights (ACHPR)

The African Charter on Human and Peoples' Rights (ACHPR) is the foundational instrument for the protection and promotion of human rights in Africa. It has been applauded as a document which departs from the norms in that it contains civil, political, economic, social and cultural rights. It provides for "peoples' rights," several rights not found in other instruments; specific "third-generation" or collective rights such as the right to development; the right to a satisfactory environment; the right to peace; and the right of people to dispose of their wealth and natural resources. It espouses many vital principles e.g., that of freedom, equality, justice and the dignity of the human person, non-discrimination etc.

Among the more specific obligations is for States parties to take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick (Article 16(2)). The African Commission has expounded on this right using General Comments. The Commission has for example noted that women and young girls are adversely affected by HIV. State parties are therefore obliged to create enabling and supportive environments to protect women from HIV.

1.3.2. African Charter on the Rights and Welfare of the Child (ACRWC)

The African Charter on the Rights and Welfare of the Child ensures the traditional Human rights; civil, political, social, cultural rights; such as a right to life (Article 5), right to health (Article 14), the right to parental care and protection (Article 19). It emphasizes the welfare principle, which notes that primary consideration in all actions concerning the child is the child's best interest. According to Article 14, every child shall have a right to enjoy the best attainable state and physical, mental and spiritual health. For instance, States have to ensure appropriate health care for expectant and nursing mothers. In order to ensure compliance by the states, a committee of experts on the rights and welfare of the child was formed (Article 32). Some of the committee's thematic discussions have focused upon issues related to health including the impact of HIV/AIDS on children.

1.2.3. Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa

It was originally adopted by the Assembly of the African Union in Maputo, Mozambique on July 11, 2003. Hence, it is also known as the Maputo Protocol. It guarantees comprehensive rights to women including the right to take part in the political process, to social and political equality with men, improved autonomy in their reproductive health decisions, and an end to female genital mutilation.

It is a comprehensive Protocol on women's rights and it contains a number of provisions such prohibition of harmful traditional practices e.g. FGM (Article 5(b); Equal rights in marriage (Article 6); protection of women in armed conflict (Article 11); protection of economic, social and cultural rights of women the most important of which is the guarantee to women (Article 13); protection of widows from inhuman, humiliating or degrading treatment (Article 20); rights of women to inherit property (Article 21); protection of elderly women regarding their physical, economic and social needs and especially to ensure their right to freedom from violence (Article 22); protection of women with disabilities and adopt measures to facilitate their access to employment, professional and vocational training (Article 23). However, the most crucial provision of the Protocol relating to health issues is Article 14(1) which is reproduced below and, importantly, it construes the right to include protection against HIV/AIDS and information as regards HIV status.

States Parties shall ensure that the right to health of women, including sexual and reproductive health is respected and promoted. This includes:

(a) The right to control their fertility;

(b) The right to decide whether to have children, the number of children and the spacing of children;

(c) The right to choose any method of contraception;

(d) The right to self-protection and to be protected against sexually transmitted infections, including HIV/AIDS;

(e) The right to be informed on one's health status and on the health status of one's partner, particularly if affected with sexually transmitted infections, e.g., HIV/AIDS, in accordance with internationally recognized best practices;

f) The right to have family planning education.

This is a very pertinent instrument because in most parts of Uganda violence against women is accepted as justified by "traditional values." Many women have been exposed to HIV because of this vulnerability. About 77% of women in Uganda seem to accept this treatment.

More than 78% continue to experience domestic violence. A potential link between HIV status and domestic violence has also been recognized, with studies from Africa showing an increased risk of violence when the man is HIV positive or when the woman perceives herself to be at high risk of acquiring HIV from the man.

The above instruments contain guarantees which are very pertinent in addressing HIV/AIDS issues. Kuper notes that they include: the rights to non-discrimination, equal protection, and equality before the law; to life; to the highest attainable standard of physical and mental; of women and children; and to be free from torture and cruel, inhuman or degrading treatment or punishment, just to mention a few examples.

The African Commission on Human and Peoples' Rights deliberated on Article 16 in Social and Economic Rights Action Centre & Another v Nigeria, where the communication alleged that the military government of Nigeria was guilty because it condoned and facilitated illegal operations of oil corporations in Ogoniland. The Commission ruled that the Ogoni had suffered violations of their right to health contrary to Article 16 of the African Charter.

Abuja Declaration on HIV/AIDS, Tuberculosis, and Other Related Infectious Diseases

In the Abuja Declaration, among the issues highlighted at the summit included high rates of mother-to-child transmission; the greater vulnerability of women, girls and youth; injected drug abuse; forced migration; and stigma and discrimination.

The declaration recognises AIDS as constituting a "state of emergency" in Africa and resolves to consolidate the prevention and control of HIV and AIDS, tuberculosis, and related infectious diseases, through a comprehensive multi-sectoral strategy. The declaration also records how African governments committed themselves to scaling up the role of education and information in reducing HIV and AIDS.

The Declaration provides under Article 22 that AIDS is a state of emergency in the continent and, to this end, all tariff and economic barriers to access to funding of AIDS–related activities should be lifted.

1.4 HIV/AIDS and Sub-Regional Law

1.4.1. East African Community HIV/AIDS framework

At the sub-regional level, Chapter 21 (Article 118) of the Treaty for the Establishment of the East African Community, the Partner States of the East African Community (EAC) are required to undertake, among other activities, harmonization of national health policies and regulations and the promotion of exchange of information on health issues in order to achieve quality health within the Community. The need to harmonize regional responses in law, regulation and policy to HIV and AIDS is a priority for the EAC. In the EAC as in the rest of Africa and the world, there is a growing recognition of the need to formulate rights-based laws, policies and strategies to promote responses to HIV which effectively protect the human rights and promote universal access to HIV prevention, treatment, care and support.

Within the same spirit espoused above, the ***East African Community HIV & AIDS Prevention and Management Act* 2012,** was enacted. It seeks to harmonize and strengthen the national responses to HIV and AIDS in the EAC Partner States by providing a regional legal framework for the attainment of a synergistic and more coordinated response which shall, in turn, contribute to the overall reduction in HIV incidence and prevalence rates in the EAC. The Act takes a progressive approach by emphasizing on prevention whilst embracing the other key aspects of the response to the pandemic, namely, treatment, care, and support. It takes the Rights–Based Approach (RBA) in its content and spirit and provides for the application of the RBA in its application and in HIV & AIDS programming in the region. Further, in a more progressive fashion, it fosters the promotion, actualization, and protection of human rights of all in the context of HIV/AIDS.

Objects and purposes of Act.

> 3. (1) The objects and purposes of Act are to—
>
> *(a) promote a rights-based approach to dealing with all matters relating to HIV and AIDS;*
>
> *(b) promote public awareness about the causes, modes of transmission, means of prevention and management and consequences of HIV and AIDS;*
>
> *(c) extend to every person living with or affected by HIV, the full protection of the person's human rights by—*
>
> *(i) providing HIV related services as provided for in this Act;*
>
> *(ii) guaranteeing the right to privacy of the individual;*
>
> *(iii) prohibiting HIV related discrimination;*
>
> *(iv) ensuring the provision of quality health care and social services for persons living with HIV and their care-givers;*
>
> *(d) promote utmost safety and universal precautions in practices and procedures that carry the risk of HIV transmission; and*
>
> *(e) Positively address and seek to eradicate conditions that aggravate the spread of HIV infection.*
>
> (2) A person applying this Act shall interpret its provisions so as to give effect to—
>
> *(a) the letter and spirit of the Treaty;*
>
> *(b) compliance with international obligations;*
>
> *(c) The objects and purposes set out in subsection (1).*

1.5 Application of International and Regional Standards by National Courts

The existence of international (United Nations), regional (African Union) and sub-regional (EAC) standards on HIV/AIDS should act as a guide to national courts and judges in determining matters involving HIV/AIDS issues. Significantly, there are already in existence decisions by national courts across Africa that have accepted the relevance of international, regional, and comparative law. Firstly, the courts have acknowledged in the instance of the ILO Code of Practice on HIV/AIDS and the World of Work that, although it is not binding, it is a useful guide or reference on labour standards on HIV/AIDS at the workplace. In ***Monare v. Botswana Ash (Pty) Ltd,*** Botswana Industrial Court has held that that ILO Code of Practice on HIV/AIDS is not binding but provides "useful guidelines, based on internationally accepted labour standards". The Botswana High Court adopted a similar position in ***Lemo v Northern Air Maintenance (Pty) Ltd.***

> *[T]he International Labour Organisation Code of Practice on HIV/AIDS ... although not having a force of law, is persuasive in so far it is consistent with Botswana's international obligations, (see Convention No 111 (Discrimination, Employment and Occupation Convention, 1958), which Botswana has ratified).*
>
> *Lemo v Northern Air Maintenance (Pty)Ltd [2004] 2 BLR 317 (Botswana HC)*

A similar recognition is evident in the decision of the South African Labour Court in ***PFG Building Glass v. CEPPAWU &Others,*** that acknowledges the importance of the ILO Code of Practice to HIV/AIDS as a *workplace issue*.

> *South African anti-discrimination legislation derives its mandate from International Labour Organisation Conventions, including C111 Discrimination (Employment and Occupation) Convention of 1958, which prohibits workplace discrimination on a number of specific grounds, but does not proscribe HIV discrimination. More recently, the ILO Recommendation concerning HIV and AIDS and the World of Work 200 of 2010 has recognised the impact of discrimination based on real or perceived HIV status and its increasing prevalence.*
>
> *Allpass v Mooikloof Estates (Pty) Ltd t/a Mooikloof Equestrain Centre [2011] ZALC 2 (South Africa LC), para 40.*

In ***Allpass v Mooikloof Estates (Pty) Ltd t/a Mooikloof Equestrain Centre,*** the Labour Court considered the ILO Code within a broader context of ILO labour conventions.

> *Although the ILO Code of Practice on HIV/AIDS and the World of Work is not binding on the Labour Court, it is fortifying to note that as an international instrument, it echoes some of the important provisions of our law. Its key principles include an acknowledgement that HIV/AIDS is a workplace issue; promotion of non-discrimination against workers on the basis of real or perceived HIV status; prohibition of HIV testing at the time of recruitment or as a condition of continued employment; prohibition of mandatory HIV testing; recommendations about conditions for voluntary testing at the insistence of employees and adherence to strict confidentiality and disclosure requirements.*

PFG Building Glass v. CEPPAWU & Others [2003] (24) ILJ 974 (South Africa LC), para 7.

Secondly, the courts have adopted the position that *domestic legislation* whether on employment, HIV/AIDS, healthcare, or the constitution itself is to be interpreted in compliance with obligations underpinning

the international instruments. Thirdly, the courts have regarded actions taken in the context of HIV/AIDS to amount to an infringement of the international instruments, especially human rights treaties.

In ***Kingaipe & Another v. Attorney General*****,** the Zambia High Court referred to the rights guaranteed under the ***International Covenant on Civil and Political Rights*** **and the** ***African Charter of Human and Peoples' Rights*** in reaching the decision that mandatory HIV testing violated the right to privacy and freedom from inhuman and degrading treatment. In ***Hoffmann v South African Airways***, the South African Constitutional Court used international and regional law (and SADC sub-regional law) to support its decision to strike down discrimination on the basis of HIV status in employment.

South Africa has ratified a range of anti-discrimination Conventions, including the African Charter on Human and Peoples' Rights. In the preamble to the African Charter, member states undertake, amongst other things, to dismantle all forms of discrimination. Article 2 prohibits discrimination of any kind. In terms of Article 1, member states have an obligation to give effect to the rights and freedoms enshrined in the Charter. In the context of employment, the ILO Convention 111, Discrimination (Employment and Occupation) Convention, 1958 proscribes discrimination that has the effect of nullifying or impairing equality of opportunity or treatment in employment or occupation.

In terms of Article 2, member states have an obligation to pursue national policies that are designed to promote equality of opportunity and treatment in the field of employment, with a view to eliminating any discrimination. Apart from these Conventions, it is noteworthy that item 4 of the SADC Code of Conduct on HIV/AIDS and Employment, formally adopted by the SADC Council of Ministers in September 1997, lays down that HIV status 'should not be a factor in job status, promotion or transfer.' It also discourages pre-employment testing for HIV and requires that there should be no compulsory workplace testing for HIV.

Hoffman v. South Africa Airways [2000] ZACC 17 (South Africa CC)

Part II: National Legal and Human Rights Frameworks on HIV in Uganda

2.1 Introduction

This part of the Handbook sets out the policy, legal and human rights framework on HIV in Uganda. As a Judge or judicial officer, it is imperative that one has a grasp and understanding of the policy and legal framework against which to address and determine HIV related matters that may come up in cases or disputes before the courts. This Part provides a general outlay of pertinent provisions of the policies on HIV/AIDS as well as the constitutional and legislative provisions that have a bearing on HIV/AIDs in Uganda.

2.2 National Policies and Strategies on Health and HIV/AIDs in Uganda

2.2.1. Policies

2.2.2.1. *National Health Policy*

The *National Health Policy* emphasizes a minimum health care package for all, and seeks to strengthen the decentralization of health care services to ensure participation and management at lower levels. The prevention and control of HIV/AIDS is listed as one of the areas to be addressed under the components of the minimum health care package. The elements of intervention under this include mitigation of the socio-economic impact of the HIV/AIDS epidemic.

The policy also addresses sexual and reproductive health and rights, including antenatal and obstetric care, family planning, adolescent reproductive health, and violence against women. Under "legal aspects," the policy provides for updating, formulating, and disseminating laws, regulations and enforcement mechanisms relating to, among other things, stigmatization, and denial due to ill-health or incapacity.

2.2.2.2. *National Policy Guidelines for Voluntary HIV Counselling and Testing (VCT and HCT)*

The *National Guidelines for Voluntary HIV Counselling and Testing* were adopted in 2003. These guidelines apply to all actors involved in VCT service provision and provide that VCT services should be considered a public preventive service and should be provided free in public health institutions.

They spell out the following:

The guidelines emphasize the right of the individual to consent to an HIV test, irrespective of the reasons for the test.

i. According to the guidelines, it is also the client's decision whether and how to disclose the results of their HIV test to others.

ii. Requiring HIV testing from people seeking employment, study opportunities or other services can lead to discrimination and should be condemned.

iii. VCT should be provided along with a range of supportive services, including ongoing counselling, post-test clubs, care and support, and referral for additional services.

In February 2005, the VCT Guidelines were reviewed and integrated into the National Policy Guidelines for HIV Counselling and Testing (HCT). The purpose of this was to

develop an all-embracing policy catering for all circumstances under which HIV testing takes place. Some of the areas addressed by the HCT policy include VCT, routine testing and counselling (RTC) and home-based HIV counselling and testing (HBHCT), testing of people seeking employment, studies or certain services, testing following occupational exposure, mandatory testing in a clinical setting, testing of legal minors (above 18 but incapable of functioning like an adult), and testing of special categories. National Policy for Reduction of the Mother-to-Child HIV Transmission (PMTCT)

The *Policy on Prevention of Mother-to-Child Transmission (PMTCT) of HIV* was adopted in 2003, includes provisions relating to treatment, voluntary counselling and testing, breastfeeding, infant feeding, vitamin supplementation, and STI diagnosis and treatment, all in relation to PMTCT. In particular, the policy recommends that:

i. HCT services should be available in the same facility where antenatal services are provided to ease integration of the two services.

ii. Every HIV-positive mother and her partner should be given information about the benefits and risks of breastfeeding and the use of alternative feeding options to enable them make informed choices on infant feeding.

iii. All women should be supported in a non-judgmental manner irrespective of their choices with regard to infant feeding. HIV positive women who choose not to breastfeed their infants should be supported to safely adopt replacement feeding options.

iv. Routine administration of multivitamins in pregnancy and vitamin in postpartum mothers and in children.

2.2.2.3. *National Policy on HIV/ AIDS and the World of Work*

The goal of the policy is to "provide a framework for prevention of further spread of HIV/ AIDS and mitigation of the socio-economic impact within the world of work in Uganda." The guiding principles of the policy related to law and human rights include the following:

i. Non-discrimination at the place of work on the basis of known or perceived HIV status (including provisions for non-discrimination in recruitment, termination of employment, deployment and transfers, grievance resolution and disciplinary measures, and payment of benefits)

ii. Confidentiality, including the right to privacy and no obligation on employees to reveal their HIV status to the employer

iii. Prohibition of compulsory HIV testing as a condition of recruitment, promotion or career development; and provision of HIV testing.

2.2.2. **Plans and Strategies**

2.2.2.1. *National HIV and AIDS Strategic Plan*

In 2000-2001, the Government of Uganda through the Uganda AIDS Commission formulated the National Strategic Framework (NSF) on HIV/ AIDS to cover a period of five years. The Uganda Aids Commission then developed the NSP 2007/8–2011/12 to guide the national response to HIV/AIDS over the subsequent five years. The latest is the NSP 2015/16-2019/20.

The thematic areas of the NSP are;

Prevention

- *Accelerating prevention of sexual transmission of HIV targeting vulnerable and most at-risk populations.*

- *Improve relevant legislative and policy framework that promotes the support of vulnerable groups and criminalizes deliberate transmission of HIV and AIDS.*

Care and treatment

- *Increase equitable access to Anti-Retroviral Treatment.*
- *Prevention and treatment of opportunistic infections.*
- *Promote positive living and empower PLHIVs networks to lead prevention of HIV transmission*

Social support

- *Ensure legal and appropriate social and community safety nets to benefit PLHIVs households, OVC women, girls, and other disadvantaged groups*
- *Ensure there is sensitization and awareness creation on human rights and protection mechanisms*.

2.3 Legal Framework on HIV/AIDs in Uganda

2.3.2. Constitution

2.3.2.1. *Constitution of Uganda 1995 (as amended)*

The Constitution of Uganda 1995 is the primary legal text of the country and it addresses the issues of governance and relationship between individual and the State (and government). As the primary legal text, it provides the standard for the legitimacy of all legislation, being the *supreme law* of the land. The Constitution is therefore important to HIV/AIDS related matters in multifarious ways.

Firstly, the Constitution is founded on the premise of equal opportunity, including requiring the State to give *highest priority* to measures that protect and enhance the right of the people to equal opportunities in development (objective XI(i)). The equal opportunity is juxtaposed with the freedom from discrimination (Article 21).

Secondly, HIV/AIDS being a health concern, the Constitution enjoins that Ugandans enjoy rights and opportunities and access to, among others, health (objective XIV(b)). Access to HIV-related healthcare, including ARVs, is pivotal to right to health of Ugandans who are HIV+. In any event, the State is required to take all practical measures to ensure provision of basic medical services to the population (objective XX) and that includes to persons who are HIV+. Notably, the rights and opportunities and access extend to, among others, *education* and *work*. In essence, HIV+ status should not act as a bar to education and employment opportunities.

Thirdly, all fundamental rights and freedoms are inherent (and not granted by the State) (Article 20(1)) and implies that persons living with HIV/AIDS are entitled to the full rights and freedoms exercised and enjoyed by every Ugandan and those rights should not be defined by anyone or any organ of the government depending on their HIV/AIDS status. Fourthly, given the medical information that often arises in respect of HIV testing, there is the issue of right to privacy and confidentiality of that information.

Finally, given the criminalization of HIV, especially as an aggravating factor in several offences, it is crucial that fair trial rights (Article 28) are available to persons living with HIV/AIDS charged with offences. Therefore, the presumption of innocence (Article 28(3)) applies to a HIV+ accused person as does the principle of legality (Article 28(12)) in defining the conduct that is criminalized in relation to HIV in either instance, being HIV+ is not in itself

a crime, even though a HIV+ status has been used to qualify severity of penalty for certain offences.

National Objectives and Directive Principles of State Policy.

I. Democratic principles.

(i) The State shall be based on democratic principles which empower and encourage the active participation of all citizens at all levels in their own governance.

XI. Role of the State in development.

(i) The State shall give the highest priority to the enactment of legislation establishing measures that protect and enhance the right of the people to equal opportunities in development.

XIV. General social and economic objectives.

The State shall endeavour to fulfil the fundamental rights of all Ugandans to social justice and economic development and shall, in particular, ensure that—

…

(b) All Ugandans enjoy rights and opportunities and access to education, health services, clean and safe water, work, decent shelter, adequate clothing, food security and pension and retirement benefits.

…

XX. Medical services.

The State shall take all practical measures to ensure the provision of basic medical services to the population.

…

20. Fundamental and other human rights and freedoms.

(1) Fundamental rights and freedoms of the individual are inherent and not granted by the State.

21. Equality and freedom from discrimination.

(1) All persons are equal before and under the law in all spheres of political, economic, social and cultural life and in every other respect and shall enjoy equal protection of the law.

(2) Without prejudice to clause (1) of this article, a person shall not be discriminated against on the ground of sex, race, colour, ethnic origin, tribe, birth, creed or religion, social or economic standing, political opinion or disability.

23. Protection of personal liberty.

(1) No person shall be deprived of personal liberty except in any of the following cases—

(d) for the purpose of preventing the spread of an infectious or contagious disease;

24. Respect for human dignity and protection from inhuman treatment.

No person shall be subjected to any form of torture or cruel, inhuman or degrading treatment or punishment.

27. Right to privacy of person, home and other property.

(2) No person shall be subjected to interference

2.3.2. Legislation

2.3.2.1. *HIV and AIDS Prevention and Control Act 2014*

The long title of the Act stipulates its objects as being to provide for the prevention and control of HIV and AIDS, including protection, counselling, testing, care of persons living with and affected by HIV and AIDS, rights and obligations of persons living with and affected by HIV and AIDS; to establish the HIV and AIDS Trust Fund; and for other related matters.

Beyond certain contentious provisions that have given rise to debate and a petition before the courts, the HIV/AIDS Act addresses certain key approaches that have been at the forefront of efforts at control and prevention of transmission of HIV. These include (i) reasonable precautions to protect oneself and others (including use of protective measures, e.g., condoms) (section 2); voluntary counselling and testing (VCT) (sections 3-9); routine testing and counselling (RTC) (section 13); and prevention of mother-to-child transmission (PMTC) (section 15).

> *2. Reasonable care to be taken to avoid transmission of HIV.*
>
> *(1) A person shall take reasonable steps and precaution to protect him or herself and others from HIV infection.*
>
> *(2) A person shall use protective measures to protect him or herself and others from infection with HIV during sexual intercourse.*
>
> *3. Pre and post-test HIV counselling.*
>
> *(1) A health unit which carries out an HIV test shall in all cases provide pre and post-test counselling to a person undergoing an HIV test.*
>
> *9. Voluntary HIV testing*
>
> *A person may take a voluntary HIV test if he or she gives his or her informed consent.*
>
> *…*

Additionally, the HIV/AIDS Act addresses discrimination on grounds of HIV status in the context of work and employment (including in public service or office), education (schools), travel and habitation, credit and insurance services, healthcare services, as well as children living with HIV (sections 32-39). The Act makes HIV-based discriminatory acts civil wrongs (section 40). The Act sets out the State's obligations in HIV control and prevention (section 24) and the establishment of a HIV/AIDS Fund (sections 25-28) as well as HIV/AIDS biomedical research (sections 29-30).

Further, the Act addresses the contentious issue of disclosure or release of HIV results *vis-à-vis* confidentiality of test results (sections 18-20) and the criminalization of attempted and intentional transmission of HIV (sections 41 and 43).

2.3.2.2. *Children Act, Cap 59 (as amended)*

The *Children Act* is the primary legislation on children in Uganda, addressing their rights and welfare. Section 5 of the Act confers a duty upon parent, guardian or any person having custody of a child to maintain that child and, in particular, that duty gives a child the right to education and guidance, immunization, adequate diet, clothing, shelter; and *medical attention*. Further under (2) that any person having custody of a child shall protect the child from discrimination, violence, abuse, and neglect. Section 7 of the Act prohibits social or customary practices that are harmful to the child's health. Section 3 of the Act provides for the guiding principles to be the *welfare* principles and the *children's* rights set out in the First Schedule to the Act to be the guiding principles in making any decision based on the Act.

2.3.2.3. *Employment Act 2006*

The employment sector in Uganda constitutes a critical point of HIV-related stigma and discrimination. Although such a situation is not unique to Uganda and, as shall be discussed in Part IV of the Handbook, HIV-related issues have pervaded work and employment in many countries. Discrimination occurs in relation to recruitment, termination of employment, deployment and transfers, grievance resolution and disciplinary measures, and payment of benefits. Discrimination on the basis of HIV/AIDS is one of the instances of *unlawful* discrimination under section 6 of the *Employment Act* 2006.

> **129. Defilement of persons under eighteen years of age.**
>
> *(3) Any person who performs a sexual act with another person who is below the age of eighteen years in any of the circumstances specified in subsection (4) commits a felony called aggravated defilement and is, on conviction by the High Court, liable to suffer death.*
>
> *(4) The circumstances referred to in subsection (3) are as follows—*
>
> *…*
>
> *(b) where the offender is infected with the Human Immunodeficiency Virus (HIV);*
>
> *…*
>
> *(6) Where a person is charged with the offence under this section that person shall undergo a medical examination as to his or her Human Immunodeficiency Virus (HIV) status.*

Further section 6(7) of the Act is to the effect that "every employer shall pay male and female equal remuneration for work of equal value". This implies that HIV + employees should not be treated differently from those who are HIV-. Additionally, section 7(2) of the Act prohibits sexual harassment of employees of whichever kind, a prohibition that creates legal protection particularly for female employees who are often placed at the risk of contracting HIV/AIDS through demands for sex by their employers.

2.3.2.4. *Penal Code Act Cap 120 (as amended)*

The *Penal Code Act* is the primary penal law of Uganda under which it criminalizes and prescribes punishment for a wide range of offences. A portion of the offences relate to conduct that dehumanize and degrade women, such as rape, defilement, indecent assault, and other sexual and gender-based crimes. The Penal Code Act, through amendments introduced in 2007, made HIV an aggravating factor for the sexual offences of *defilement*, being one of the aspects of the new offence termed *aggravated defilement*. The offence of aggravated defilement is committed where the accused is infected with HIV (section 129(3) and (4)(b)). The amendment also requires that a person charged with aggravated defilement be examined as regards his/her HIV status (section 129(6)). The amendment in the penal Code in 2007 was largely viewed as a deterrent measure to provide protection to young girls and boys at risk of HIV through sexual violence and exploitation.

> *6. Discrimination in employment.*
>
> *(3) Discrimination in employment shall be unlawful and for the purposes of this Act, discrimination includes any distinction, exclusion or preference made on the basis of race, colour, sex, religion, political opinion, national extraction or social origin, the HIV status or disability which has the effect of nullifying or impairing the treatment of a person in employment or occupation or preventing an employee from obtaining any benefit under a contract of service.*

Additionally, the *Penal Code Act* provides an offence of engaging in negligent acts likely to spread infection of disease (section 171). This provision has been applied in recent years to prosecute persons who are HIV+ and whose actions are deemed to have been negligent as to likely occasion infection of others with HIV.

> **171. Negligent act likely to spread infection of disease**
>
> *Any person who unlawfully or negligently does any act which is and which he or she knows or has reason to believe to be likely to spread the infection of any disease dangerous to life commits an offence and is liable to imprisonment for seven years.*

The use of section 171 of the *Penal Code* is best illustrated in the cases of ***Rosemary Namubiru v. Uganda*, *HC Crim. Rev 50/2014 (HC) and Komuhangi Silvia v Uganda, [2019] UGHC 39 (HC).***

2.3.2.5. *Equal Opportunities Commission Act 2007*

The *Equal Opportunities Commission Act* establishes the Commission charged with monitoring, evaluating and ensuring that policies, laws, plans, programs, activities, practices, traditions, cultures, usages and customs of various State organs and agencies are *compliant with equal opportunities* (section 14(1) of the Act).

The Commission is created under the Act pursuant to provisions of article 32 of the 1995 Constitution. The Commission's remit to address equal opportunities is undertaken in the context that State organs and agencies take actions regardless of sex, age, race, colour, ethnic origin, tribe, birth, creed, religion, *health status,* social or economic standing, political opinion or disability. The inclusion of "health status" is crucial for HIV/AIDS, in that equal opportunity in the sense of same treatment or consideration in the enjoyment of rights and freedoms, attainment of access to social services, education, employment and physical environment or participation in social, cultural and political activities should be available to persons living with HIV/AIDS. HIV+ persons should not be marginalized from opportunities in life as result of HIV/AIDS health status.

> *1. Interpretation.*
>
> *In this Act, unless the context otherwise requires—*
>
> *…*
>
> *"discrimination" means any act, omission, policy, law, rule, practice, distinction, condition, situation, exclusion or preference which, directly or indirectly, has the effect of nullifying or impairing equal opportunities or marginalizing a section of society or resulting in unequal treatment of persons in employment or in the enjoyment of rights and freedoms on the basis of sex, race, colour,*

> *ethnic origin, tribe, birth, creed, religion, health status, social or economic standing, political opinion or disability;*
>
> *"equal opportunities" means having the same treatment or consideration in the enjoyment of rights and freedoms, attainment of access to social services, education, employment and physical environment or the participation in social, cultural and political activities regardless of sex, age, race, colour, ethnic origin, tribe, birth, creed, religion, health status, social or economic standing, political opinion or disability;*
>
> *…*
>
> *"marginalization" means depriving a person or a group of persons of opportunities for living a respectable and reasonable life as provided in the Constitution;*

The Commission should be able to monitor, evaluate and ensure equal opportunity for such persons regardless of the HIV/AIDS health status (and their marginalization as a result of that *health status*).

2.3.2.6. *Prevention of Trafficking in Persons Act 2009*

The long title to the *Prevention of Trafficking in Persons Act* states that it is "An Act to provide for the prohibition of trafficking in persons, creation of offences, prosecution and punishment of offenders, prevention of the vice of trafficking in persons, protection of victims of trafficking in persons, and other related matters." The Act has certain HIV/AIDS specific provisions as reflected in sections 4 and 5. Section 4 provides for *aggravated* trafficking in persons that, includes, among the aggravating factors, where the trafficked victim gets infected with HIV/AIDs (under sub-section (j)), and the offence of aggravated trafficking carries the penalty of life imprisonment.

> *4. Aggravated trafficking in persons.*
>
> *A person commits the offence of aggravated trafficking where-*
>
> *(j) the victim dies, becomes a person of unsound mind, suffers mutilation, **gets infected with HIV/AIDS** or any other life-threatening illness; And shall be liable to imprisonment for life.*

The case that underscores the link between human trafficking of female for sexual exploitation and HIV/AIDS is ***Uganda v. Natukunda Faith, HCT/ICD/CO-001/2012.*** *In this case, the victims had been trafficked to China under the pretext of being given jobs. One of the two victims became infected with HIV AIDS. The prosecutor submitted victim impact statements highlighting the trauma, emotional stress and damage to relationships caused by the victimisation, as well as the long-term physical impacts of forced prostitution (including ongoing pain, infection with HIV and potential fertility problems). The victims had given up employment and businesses on the promise of better opportunities abroad and returned without jobs and with lower earning potential. Both had also incurred expenses related to transport, medical treatment and the criminal case.*

Additionally, section 5(f) penalizes trafficking in children, providing that persons who uses a child or any body part of a child in witchcraft, rituals and related practices, commit the offence of aggravated trafficking in children and may be liable to suffer death.

2.3.2.7. *Prohibition of Female Genital Mutilation Act 2010*

The ***Prohibition of Female Genital Mutilation Act*** prohibits and criminalizes cultural practice of female genital mutilation (FGM) and any other harmful cultural practices that undermine the dignity of women and girls. The Act likewise has HIV/AIDS specific provisions in relation to the offence of *aggravated* female genital mutilation under section

> *3(1)(d), with the likelihood, upon conviction for the offence, of life imprisonment under section 3(2).*
>
> *2. Aggravated female genital mutilation.*
>
> *(1) A person commits the offence of aggravated female genital mutilation where—*
>
> *…*
>
> *(d) the victim is infected with HIV as a result of the act of female genital mutilation;*
>
> *(2) A person who commits the offence of aggravated female genital mutilation is liable on conviction to life imprisonment.*

2.3.2.8. *Domestic Violence Act 2010*

As per its long title, the *Domestic Violence Act* seeks to provide protection of victims of domestic violence and punishment of perpetrators of domestic violence. The Act defines domestic violence in as broadly as to include (i) *physical* abuse, (ii) *sexual* abuse, (iii) *emotional, verbal and* psychological abuse, and (iv) *economic* abuse (section 2). It also includes harassment, harm, injury or endangerment to a victim. Each instance of domestic violence is given further interpretation under section 2 of the Act. The Act expressly makes a prohibition of domestic violence (section 4 (1)) and makes it an offence punishable on conviction with a fine equivalent to 20 currency points and imprisonment of up to 2 years (section 4(2)) or both.

> **2. Interpretation**
>
> *In this Act, unless the context otherwise requires—*
>
> *…*
>
> *"domestic violence" constitutes any act or omission of a perpetrator which—*
>
> *(a) harms, injures or endangers the health, safety, life, limb or well-being, whether mental or physical, of the victim or tends to do so and includes causing physical abuse, sexual abuse, emotional, verbal and psychological abuse, and economic abuse;*
>
> *…*
>
> *"sexual abuse" includes any conduct of a sexual nature that abuses, humiliates, degrades or otherwise violates the dignity of another person;*
>
> *…*
>
> *4. Prohibition of domestic violence*
>
> *(1) A person in a domestic relationship shall not engage in domestic violence.*

Although the Act does not make reference to HIV/AIDS, the prohibition of the multifaceted forms of domestic violence are pertinent to persons living with or affected by HIV, especially women, as partners or wives. As Human Rights Watch noted in 2003, long before the enactment of the Act, that "domestic violence inhibits women's control over sexual matters" given the fact

that "women have equal decision-making power and status within their intimate relationships." The HRW report documented instances in which domestic violence led to "a heightened risk of HIV transmission" and noted that "domestic violence is just one of a number of factors that increase women's vulnerability to HIV transmission" given, among other factors, their (i) lack of bodily autonomy; (ii) perception of sex as a marital obligation; (iii) inability to negotiate condom use; (iv) being forced into sex (marital rape); (v) unequal relations in instances of discordancy; and (vi) susceptibility to violence in situations where they are HIV+.

Part III: Gaps in National Legal and Human Rights Frameworks on HIV in Uganda

3.1 Introduction

While Uganda has received international praise for its responses to the adverse medical effects of the epidemic, it has paid comparatively limited attention to the epidemic's legal and human rights implications. This is especially true for marginalized populations who are most vulnerable to HIV-related human rights abuses: women (especially young women, widows, and women living in fishing communities); sex workers; orphans and vulnerable children; lesbian, gay, bisexual, transgender (LGBTI) persons; and internally displaced persons. Stigmatization and discrimination trigger a wide range of human rights abuses for which the great majority of those affected have not sought justice.

3.2 Access to Justice

Access to justice for all is hindered not only by the lack of a supportive legal framework and standard mechanisms for redress, but also by context-based factors such as limited knowledge of rights among people with HIV and those at risk, judicial corruption, inability to identify perpetrators, limited access to and affordability of legal aid services, and the stigmatization, discrimination and powerlessness that stem from being a member of a socially marginalized group. While there are some attempts in Uganda to provide legal services for people living with HIV, legal services targeting those affected by HIV or at risk of HIV are disproportionately fewer. Article 28 of the Constitution of Uganda,1995 provides for the presumption of innocence in all criminal offences, but this is impliedly denied to HIV infected persons when it comes to sexual related offences.

Meeting the demand for timely and affordable legal services is critical to stemming HIV-related human rights abuses in Uganda and elsewhere. In Uganda, legal services are often inaccessible, ineffective, disproportionately accessible, or non-existent.

3.3 Non–Participation of the Affected Population in Assessing and Making Laws and Regulations

Laws and regulations are pertinent to another key human rights principle: that of participation. It has been recognized that participation of affected populations in all stages of decision-making and implementation of policies and programmes is a precondition of sustainable development, and indeed, evidence shows that there is an association between participation of affected populations and health outcomes.

In reality, many affected populations are unable to participate in assessing and making laws and regulations because of on-going discrimination, often associated with increased exposure to violence and disease. For example, some States legally restrict transgender, lesbian, gay or sex-worker identified groups from registering as associations; others enact laws criminalizing their speech. All of these measures affect their ability to work against violence, HIV/AIDS and other issues of great importance to sexual health.

> *At both the international and regional level, courts and human rights bodies have found these kinds of restrictive laws to be violations of fundamental rights of speech, association, and protection from non-discrimination. In the decisions*

emanating from Regional Courts, the basic principles of ensuring rights to participation in society are affirmed.

WHO, Sexual Health, Human Rights and the Law (2015).

3.4 Criminalization of HIV Status and Incarceration

On the issue of criminalization, it is pertinent to note that section 129(4)(c) of the Penal Code Act is couched in terms of strict liability in that once a child is below 14 years the offender is deemed to have known his *sero*-status. Practice, however, demonstrates that many accused persons get to know the *sero*-status upon the commission of the offence. It is, therefore, evident that in a similar manner, the courts would be as biased as the law which they apply.

Although Sections 129 of the Penal Code Act, cap 120 as amended by section 2 of the Penal Code Amendment Act, 2007 and Section 129(6) are largely seen as a deterrent measure to provide protection to young girls and boys at risk of HIV/ AIDS through sexual violence and exploitation, it has been interpreted by some as discriminatory against people living with HIV. In addition to the potentially stigmatizing effect of creating a special crime of HIV transmission, the provision implies that all persons accused of defilement must be subjected to a mandatory HIV/AIDS test, thus exposing the zero-status of both victim and offender.

In his book *Fundamentals of Health Law in Uganda,* Professor Twinomugisha makes the argument that there is no need for a law to specifically target a disease such as HIV/AIDS, and asks the question: "why target HIV/AIDS? Are we going to have a separate legislation to tackle TB, hepatitis, typhoid and other communicable diseases?" Additionally, being compulsorily confined to one location, people in prison and other detention facilities are reliant upon the incarcerating authority for access to health services.

Sexual activities take place in correctional facilities. Few studies have examined the public health impact of access to sexual health services in correctional settings, but it has been found that high levels of discrimination against those living with HIV motivate prisoners to hide their HIV status and that those with a history of incarceration within 12 months of initiating highly-active antiretroviral treatment (HAART) are more likely not to adhere to treatment.

According to section 1(u) of the ***Public Health Act*** an infectious disease is any disease which can be transmitted directly or indirectly by any person suffering from it to any other person. This definition makes HIV to fall under Article 23(1)(d) of the Constitution and the implication of this is that an HIV victim can unlawfully be detained on that basis under the cover of that Article.

Under section 10(a) of the Act, the Minister may by statutory order declare any infectious disease a notifiable disease for the purpose of the Act. According to section 12 of the Act, a medical officer of health is empowered to inspect premises where he has reasonable grounds to believe that any person(s) suffering from an infectious disease has or have resided on the premises. The Act provides for other such measures to be taken. However, implementation of the above measures may have serious implications for human rights. The measures may adversely affect several human rights, including freedom from torture, cruel, inhuman and degrading treatment, privacy, confidentiality, the right to refuse medical treatment and bodily integrity.

The measures taken may even increase stigma and discrimination against persons suffering from such a disease.

The Act violates many rights such as privacy and confidentiality, security of the person, the right to health and freedom from cruel, inhuman and degrading treatment.

More progressive enforcement mechanisms such as public awareness may be more productive than criminal sanctions.

3.5 Stigmatization and Prohibition of Discrimination against PLHIV

Good public health legislation to tackle STIs necessitates use of the best available evidence as a basis of its enactment. Prevention of the STI should be the primary objective of the legislation, which must respect human rights. Any infringement of human rights of persons suffering from STIs must be sufficiently justified.

HIV-related human rights abuses abound in Uganda, affecting people living with, affected by and at risk of HIV. Stigmatization and discrimination trigger a wide range of human rights abuses for which the great majority of those affected have not sought justice.

PLHIV or presumed to be PLHIV experience stigma, exclusion, abandonment, and even physical violence. They are excluded from, among others, access to housing, employment, health-care services, immigration, and education.

Stigmatized, criminalized sex workers are unable to access programmes of HIV prevention and care. HIV criminalization has been a critical aspect of the debate on stigmatization. International human rights experts as well as the United Nations have cautioned against HIV specific criminal laws, urging that existing criminal law is sufficient to punish the few cases in which individuals transmit HIV with malicious intent. Uganda's provision needs to be subjected to further review in order to ensure that the protection of vulnerable children does not negatively affect the rights of others.

HIV-related issues arise in a wide array of legal proceedings. Courts in different jurisdictions have had mixed records in their response to HIV. Some court decisions have contributed to an environment that protects human rights and advances effective HIV prevention, care, treatment and support; others have resulted in injustices and fuelled stigma.

There has been potential impact of criminalization on public health initiatives that have included—

A. Stigmatization through the introduction of HIV-specific criminal laws, or inflammatory media coverage or statements by public figures regarding individual prosecutions, contributes to the stigma surrounding HIV/AIDS and people living with the disease as 'potential criminals' and as a threat to the 'general public.'

B. Spreading misinformation about how HIV is transmitted. This occurs through the inappropriate, overly-broad use of the criminal law which also risks resulting in very serious charges and sentences where there is no significant risk of transmission.

C. Consequential harm to public health by deterring HIV testing. If the person who knows their HIV-positive status is exposed to possible criminal prosecution, policy-makers must assess whether any effect the criminal law has in deterring risk activity could ultimately be outweighed by the harm it does to public health by deterring HIV testing.

D. Undermining the confidence of PLHIV in counsellors. Criminalizing risky conduct by a PLHIV could undermine their confidence in counsellors if the information that people living with HIV/AIDS discuss with a counsellor is not protected from search and seizure by police and prosecutors. Compromising confidentiality may also have an effect not just with respect to HIV, but also on the willingness to seek treatment of other sexually transmitted diseases, the presence of which increases the risk of HIV transmission.

Creation of false sense of security among people who are or think they are HIV-. When criminalization is done, those who are not charged may expect that the existence of criminal prohibition for 'other' (i.e., HIV+) people means that the remnants are not at risk and so may carry on their lives in a risky manner. This may result in reducing the risk of unprotected sex. As such, it could undermine the public health

message that everyone should take measures to reduce or avoid activities/behaviour that could increase their risk of HIV transmission.

The criminalization of HIV non-disclosure, exposure and/or transmission is controversial. Proponents of criminalization of HIV non-disclosure, exposure or transmission by the infected person often assert that invoking the criminal law promotes public health by deterring and punishing behaviour that exposes others to the risk of HIV transmission. There is little evidence that criminal prosecutions help prevent new infections by increasing safer sex practices or disclosure to sexual partners. Rather, there are indications that overly broad criminalization of HIV non-disclosure, exposure or transmission undermines public health and can result in miscarriage of justice.

Part IV: Legal and Human Rights aspects in the context of HIV—Critical Areas and

4.1 Criminalization of Transmission of HIV

It is increasingly being established that criminalization of transmission of HIV is not beneficial.

4.1.1. Adverse Effects of the Criminalization of HIV

Catherine Hanssens, executive director of the Center for HIV Law and Policy in New York, says HIV criminalization is unjust, bad public health policy and is a barrier to testing if a person doesn't know their status, they can't be charged with nondisclosure. She said that criminalization fuels the epidemic rather than reducing it. [--] She added that the available data shows that HIV criminalization disproportionately affects people of color, in particular African-American men. Further, that "the availability of the criminal law to pursue so-called HIV exposure and failure to disclose cases can serve as a proxy for pursuing people on the basis of race, sexual orientation society's outlaws. It is just not appropriate even in those relatively rare cases when HIV transmission actually occurs to treat people with HIV as dangerous felons, sex offenders and murderers who deserve decades in prison for a disease that all of us can and must be empowered to protect ourselves against, "Hanssens stated. Scott Schoettes a Lawyer working with Lambda Legal stated that:

> *"What drives these laws is ignorance regarding the real routes and risks of transmission," Schoettes said. "It's much harder to transmit than people think, and I think the sentences are driven by the misunderstanding of the current-day consequences of living with HIV."*
> *The laws are being used to stigmatize and marginalize people with HIV. "If you engage in safe sex, you have not committed a crime. If you put on a condom, you have engaged in safe sex.*

Rep. Barbara Lee, D-California expressed the opinion that:

> *"Laws that place an additional burden on HIV-positive individuals because of their HIV status lag far behind the medical advances and scientific discoveries in the fight against the epidemic. Instead of progress against the disease and protection for PLWHIV, criminalization laws breed fear, discrimination, distrust and hatred." There is no need to single out one disease, particularly one already burdened with stigma. Those who cause harm to others by purposefully transmitting HIV can still be held accountable, without the need to unfairly criminalize all those living with HIV."*

> *The Illinois Law was criticized for singling out HIV, an illness that disproportionately affects LGBTQ, Black and Latino people and attach criminal penalties, while other contagious illnesses (including COVID-19) are treated as public health issues. They say that the 30-year-old Illinois HIV law doesn't take into account the effectiveness of modern antiretroviral drugs, which are capable of reducing the risk of sexual transmission of HIV to basically zero. Also, the CDC noted "this same standard is not applied to other treatable diseases. Further, these laws have been shown to discourage HIV testing, increase stigma, and exacerbate disparities.*

The Illinois HIV Action Alliance which lobbied for the Bill, stated:

> *The case of John Savage*
>
> *It illustrates the need to decriminalise HIV. Cicero police detective John Savage, who is HIV-positive, was charged under an Illinois law that makes it a felony, punishable by up to seven years in prison, for a person carrying the virus to have unprotected sex without first disclosing his HIV status. The felony charge emanated from a complaint made by a man with whom he had gone on a date. Savage's criminal charge was eventually reduced to a single misdemeanour with no jail time. The complainant had not contracted HIV, and in court, Savage was able to demonstrate that he had been taking medication for blocking transmission of the virus. This spoiled his name as Chicago newspapers and TV stations had broadcast the allegations. Some of Savage's relatives, people who hadn't known he was gay and HIV-positive, turned their backs on him. He lost his confidence in the criminal justice system and his passion for police work.*
>
> *Currently, a number of countries in Africa criminalize the transmission of HIV. Uganda's Penal Code Act cap 120; the HIV and AIDS Prevention and Control Act, 2014 are an examples of such a laws*

Penal Law Criminalization I: Criminal Assault and Consent

Prior to the enactment of specific legislation on the transmission of HIV including Uganda's *HIV and AIDS Prevention and Control Act* 2014, the punishment of acts of intentional transmission of HIV have been under traditional penal law provisions on 'assault' especially 'sexual assault' causing bodily harm, rape, negligent or reckless spread of disease, etc.

> *The issue before us arises out of the fact that this appellant is HIV positive … and he knew about his HIV status. Even on his own account he did not inform the complainant about his HIV status . Where one party to sexual activity has a sexually transmissible disease which is*

not disclosed to the other party any consent that may have been given to that activity by the other party is not thereby vitiated. The act remains a consensual act. However, the party suffering from the sexual transmissible disease will not have any defence to any charge which may result from harm created by that sexual activity, merely by virtue of that consent, because such consent did not include consent to infection by the disease.

R v. EB [2006] EWCA Crim 2945 (England & Wales CA), paras 7, 17.

In the context of criminal assault and, in particular, *sexual assault*, the criminalization of HIV is premised on the lack of consent. 'Consent' defined as the voluntary agreement of a person to engage in the sexual act in question. The issues for courts and judges in situations in which there is alleged lack of consent to sexual relations are critical. Does non-disclosure of a sexual partner's HIV+ status vitiate *consent*? Does non-disclosure constitute a form of *fraud* as to invalidate consent to sex? This has led to discussions on consent as relating not only to the sexual act but also to the nature and quality of the act, i.e., would the victim have consented if she knew it was with a person who was HIV+? Therein lies the effort to distinguish (and separate) consent to the 'sexual act' from the consent to 'harm' that arises from the act. In ***R v. EB***,[1] where the accused, who was HIV+, had sexual relations with the complainant without disclosing his status to her, the issue for the court was whether the apparent consent given by the complainant was ineffective as a result of the accused's failure to disclose his status. The Court of Appeal rejected a charge of rape, holding that the act remained a consensual act, but that left open the question of vitiated consent available in instances of harm created by the sexual act.

R v REID [2007] 1 Qd R 64.

In the case of R v Reid, the appellant was convicted after a trial in the District Court on an indictment charging two counts: (1) that between1 January 2003 and 4 March 2003 with intent to transmit a serious disease to the complainant he transmitted a serious disease to that complainant; and, in the alternative, (2) that between those two dates he unlawfully did grievous bodily harm to the complainant. The offence in count 1 is constituted under s. 317(b) of the Criminal Code, and that in count 2 under s. 320 of the Code. At the trial, the Crown called Dr James McCarthy, a medical practitioner specializing in infectious diseases and who has been caring for HIV patients since 1986. Dr. McCarthy said that a very common form of transmission of the HIV virus is sexual transmission by reason of the exchange of bodily fluids. Dr. McCarthy also stated that the complainant's hospital records supported the inference that he had become infected with HIV in January 2003. It was on record that they had met each other in mid –January 2003. The complainant said that he became ill in mid-February 2003 when he developed diarrhoea, a high fever and welts all over his body. Dr. McCarthy testified that symptoms of the kind said to have been experienced by the complainant are common in about half the people who contract HIV. The onset of such symptoms usually occurs within two to four weeks of being infected. The appellant was convicted after a trial by jury of unlawfully transmitting a serious disease with intent to do so, in contravention of s. 317(b) of the Criminal Code. He was sentenced to imprisonment for 10 and a half years.

The Appellant was aggrieved, inter alia, that (1) the verdict was unreasonable and could not be supported having regard to the evidence;(2) The learned trial Judge erred in the directions he gave to the jury as to the manner in which they should approach the issue of intent.

1 *R v. EB [2006] EWCA Crim 2945 (England & Wales CA), paras 7, 17. Accessible at* <https://www.bailii.org/ew/cases/EWCA/Crim/2006/2,945.html>.

In his deliberation, McPherson JA stated that the serious disease referred to in count 1 was the virus HIV which, according to the medical evidence at the trial, leads if untreated to AIDS and to death within about eight years. If prescribed medication is taken regularly, the progress of HIV can in most cases be controlled, but otherwise it is in time fatal.10 [3] There was evidence, which it is clear from the verdict the jury accepted, that from about 16 January 2003 the complainant had anal sexual intercourse with the appellant at a frequency of from three to four times a week. They did so without using condoms on any occasion, having agreed that both preferred not to use them. The complainant testified that before doing so he had asked the appellant and was assured by him, that he was not HIV-positive; that is, he was not infected by that disease. The assurance was false, and was known by the appellant to be false. He had been diagnosed HIV positive in November 1987, and had taken no medication to check its development. Without that assurance, the complainant would not have engaged in sexual intercourse with him. The evidence also showed that the disease had been transmitted by the appellant to the complainant probably by 20 February, but in any event by or before 4 March 2003. This suggests that the disease had been communicated at an early stage of their relationship.

The Appellant contended that there was no evidence of actual ill-will on his part towards the complainant which would provide a rational basis for a conclusion that the appellant was motivated by a subjective desire to transmit the disease to the complainant.

"The issue here turns on what the appellant himself actually intended, not upon an objective appreciation of the prospects of his achieving that intention. In this latter regard, there can be no doubt that the appellant well understood that unprotected sex with the complainant was likely to infect him with HIV.That this is so is readily apparent from the "loaded gun" remark in his record of interview. [---] the issue was not what the appellant's intent was at the time of any particular act of sexual intercourse, but whether it can be said that the conduct of the appellant which resulted in the transmission of the disease was informed by the necessary intent."

Keane J.A on definition of "intention"

Rv REID, [2007] 1 Qd R 64

Chesterman J. concurred with Keane J.A but added a statement on 'intention." He noted that:

"The Code does not define "intention". In ordinary, everyday, usage, "intention" means the act of "determining mentally upon some result." Intention is a "purpose or design". If an accused intends to kill, or transmit a disease, he means to kill or transmit the disease. His actions are designed to bring about the result."

Keane JA considered the fact that the appellant's taunting of the complainant may have been seen by the jury as evidence of the proverbial love of misery for company. From the appellant's evident satisfaction that the complainant had been stricken by the same condition with which the appellant was afflicted, the jury were entitled to conclude that the appellant's conduct had indeed been calculated to achieve that result. Further, that from the facts that the appellant knew that the complainant was at risk, and that the appellant refrained from taking steps, which he knew were available, to avert that risk, the jury could reasonably infer that the appellant actually desired that the complainant should become infected. For the reasons stated above, Keane J.A considered that it was reasonably open to the jury to come to an affirmative conclusion on this issue. He was of the considered opinion that the directions given by the

trial judge were adequate to explain to the jury that they could only convict the appellant if they were satisfied that the appellant intended to transmit the HIV virus to the complainant. That direction was sufficient and it was accurate. He held that the appeal against conviction should be dismissed and the application for leave to appeal against sentence should be refused.

> *In R v Reid, Chesterman J. stated:* ***"Intent" and "intention" must have the same meaning wherever they appear in the Code. If an actual, subjective, intention to bring about a particular result, such as death or the infliction of severe pain and suffering, must be proved before a jury may convict of murder or torture, the same must be true of intent in s. 317. What is necessary to prove intent is proof that an accused (here the appellant) meant to transmit his HIV to the complainant****.***
>
> *R v REID, para. 95.*

The principal question on appeal is whether the jury was adequately instructed about an essential element of the offence, which was whether the appellant intentionally transmitted the HIV infection to the complainant.

McPherson JA observed that, it is no doubt correct that, in most cases, intention requires no elaboration or elucidation, and it may often be undesirable to provide it. However, the present case is, I am persuaded, not one that falls into that category. However, in this case, intention was a subjective state of mind for which the prosecution was obliged here to establish beyond reasonable doubt and which in the particular circumstances called for something more than the bland statement that it is an ordinary word. He noted that [5] The problem of satisfactorily defining the meaning of intention in some cases have arisen in relation to the state of mind required for murder. After reviewing how 'intention is defined' in other jurisdictions such as South Africa, he proceeded to consider what it means under s. 317(b) of the Code (Qld) which refers to ***"the intention to transmit a serious disease", that is, the immune deficiency virus HIV. The word "transmit" in this context plainly means communicate or pass on to another person.*** McPherson J concurs with the view held by Chesterman J. says in his reasons in this appeal, that "intent" in s. 317(b) of the Code is that the accused must be proved to have meant to transmit the disease: his actions must have been designed to bring about that result. In order to arrive at a correct interpretation of 'intention, McPherson J posed the question: Did the appellant in his HIV infective condition engage in unprotected anal intercourse with the complainant with the design of passing that virus on to the complainant?

He noted that there was evidence at the trial on which a jury could have used to properly reach such a conclusion that the accused intended his actions. In particular, the appellant knew since1987 that he was HIV positive and that he had been taking no medication to control it. That he misled the complainant about his infective status and thereby induced him to engage in anal intercourse with him, whether unprotected or at all, might seem to be evidence as much of the complainant's intention as of his own; but it is also some evidence that the appellant may have wished or meant to infect the complainant with the HIV. He identified the problem in the lower court as being that the jury were not told that they must, before convicting, be satisfied that the appellant knew that, by having unprotected anal sex with the complainant, it was "probable" or "likely" that the disease would be passed on to him. Without a direction to that effect, I do not consider that the jury were adequately instructed about the meaning of the expression "with intent to transmit" in s. 317(b) of the Code. Hence, in his opinion, his appeal against conviction on that count should be allowed; the conviction should be set aside; and a new trial should follow on that count.

McPherson JA stated that whereas s. 317(b) expressly declared the intention to cause a particular result (namely, the transmission of a serious disease) to be an element of the offence of transmitting the disease "with intent," by contrast, s. 320 embodies no such declaration. The offence under s. 320 in count

2 is therefore constituted solely by the act of transmitting the disease and simply by doing grievous bodily harm. However, he did not see any good reason why he should pronounce himself on the alternative one if the jury had not been given a chance to decide on Count 1.

> *Chesterman J. finally held:* ***"To make good the charge against Reid the Crown had to prove that he engaged in intercourse with the complainant intending, by that conduct, to transmit the HIV virus to the complainant. [--] the Crown had to prove that the appellant's conduct was designed to achieve that result, that his purpose in engaging in intercourse was to infect the complainant."***

Chesterman JA eventually concurred with Keane J.A. that the trial judge's summing up was adequate to instruct the jury as to that element of the offence and that the evidence was sufficient to support the conviction. He joined his colleague Judges to dismiss the appeal and the application for leave to appeal against sentence.

In another case of Cutter v The Queen, Kirby J., stated

> *"Clearly enough, where there is no direct evidence to which Trier of fact can safely resort, so as to draw an inference as to the 'subjective' intention of the accused, the principal focus of attention will ordinarily be the facts surrounding the alleged offence."*
>
> *Cutter v. The Queen,*

The use of similar traditional offence of assault and/or causing grievous bodily harm has been manifest in Canada in decisions of the Supreme Court in cases such as *R v. Martineau*,[2] *R v. Cuerrier*,[3] and *R v. Mabior*.[4] In the *Cuerrier case*, the Court deemed the accused's failure to disclose his HIV status as constituting fraud and, therefore, vitiate consent to sexual intercourse.

4.1.3. Penal Law Criminalization II: Criminal Negligence

Beyond the offence on 'assault', the other common criminal offence that has been used to address HIV transmission is *criminal negligence*, that is, negligence that occasions spread of HIV infection. As noted, this offence of engaging in negligent acts likely to spread infection of disease is provided under section 171 of the *Penal Code Act* Cap 120. This offence has been used in recent years to prosecute persons who are HIV+ and whose actions were deemed to have been negligent as to likely occasion infection of others with HIV.

Under S. 171 of the PCA, the Ingredients of the offence are:

i. An unlawful or negligent omission or act committed by the accused.
ii. The omission or act is likely to spread an infection of disease that is dangerous to life.
iii. The accused knew or had reason to believe that her conduct had that capacity.

This is illustrated in two recent cases decided prior and after enactment of the HIV/AIDS Act.

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2 *[1990] 2 SCR 633.Accessible at* < https://scc-csc.lexum.com/scc-csc/scc-csc/en/646/1/document. do>.

3 *[1998] 2 SCR 371.Accessible at* <https://scc-csc.lexum.com/scc-csc/scc-csc/en/1646/1/document. do>.

4 *[2012] 2 SCR 584.Accessible at* https://scc-csc.lexum.com/scc-csc/scc-csc/en/10008/1/ document.do.

4.1.3.1. *The Komuhangi Silvia v. Uganda*

The accused, who is HIV+, was likewise charged with a negligent act likely to spread an infection of disease under section 171 of the Penal Code Act in relation to suspicion of injecting her blood into the body of a 6 months' old baby. The trial magistrate court found her guilty and convicted her of the offence.

On appeal, the Judge went into great detail to define what amounts to 'negligent'. The Judge noted that negligence does not always involve an illegal act. This means that if the accused commits a legal act under circumstances that are likely to spread such infection of disease that is dangerous to life, he or she can still be held criminally negligent. A person can be convicted under this section only if he or she intentionally, knowingly, or recklessly causes someone else to be exposed to the danger of being infected. Negligence in this context is the omission to do something which a reasonable person, guided upon those considerations which ordinarily regulate the conduct of human affairs, would do, or doing something which a prudent and reasonable man would not do (see Blyth v. Birmingham Waterworks Company (1856) 11 Ex Ch 781). Negligence is to be judged not by an internal, but by an external standard that ignores the actual state of mind of the offender.

The conviction was overturned by High Court, inter alia, the failure to prove the accused's actions were reckless, as a feature of criminal negligence.

It is … a well-settled proposition of law that a person is liable if he negligently exposes another to a contagious or infectious disease … A person though is not to be convicted of this offence unless it is proved that he or she was reckless. If so, the necessary mens rea will be established. Recklessness is a question of fact, to be proved by the prosecution.

… [T]he prosecution can show that, while knowing he or she had the disease, the accused was indifferent to the risk of exposing someone else and engaged in contact that recklessly endangered the other person. From this perspective criminal negligence refers to a mental state of disregarding known or obvious risks to human life and safety. Criminal negligence requires more than merely a mistake in judgment, inattention, or simple carelessness. It only pertains to conduct that is so outrageous and reckless that it marks a clear departure from the way an ordinary careful person would act under similar circumstances. It was also held that, engaging in conduct capable of transmitting an infectious disease through the direct transfer of bacteria, viruses or other germs in a manner that disregards known or obvious risks to human life and safety, is criminal negligence for the purpose of this provision. Criminal negligence exists only if the act itself clearly involves a high degree of danger. Carelessness, thoughtlessness, or even sheer stupidity do not elevate the conduct to criminal negligence, regardless of the consequences.

Komuhangi Silvia v. Uganda [2019] UGHC 39 (Uganda HC), paras 17, 19.

4-610 Rosemary Namubiru v. Uganda

In Rosemary Namubiru v. Uganda, the accused, an HIV+ nurse, was charged with negligently injecting a toddler with a cannula contaminated with her blood knowing or having reason to believe that this could likely cause the spread of HIV infection. The High Court upheld the conviction for the offence by a trial

magistrate court but in light of mitigating factors sentenced her to the period of imprisonment served.

The … matter for consideration was whether the act was negligent as to constitute an ingredient of the offence … What does the evidence show in the present case? The appellant Nurse herein put the cannula in the same tray where the other cannulas were. She cleaned her injured finger, put a plaster on it and resumed the treatment. Her evidence was that she does not recall whether she resumed the treatment with the same cannula or not.

… She was fully aware of the danger of the child being infected with hepatitis B or HIV. This was culpable negligence, failure to exercise that reasonable and proper care and precaution to guard against injury to the child, which negligence having regard to all the circumstances, especially aware of the prevalence of hepatitis B and HIV in this country, it was the imperative duty of the appellant to have adopted. This amounted to gross negligence.

The next issue for determination is whether the accused person knew or had reason to believe that this could likely cause the spread of the infection of HIV, a disease dangerous to life. By the time of this incident the appellant was all too well aware of her HIV status. … She was aware of the modes of transmission of HIV. [O]one of the modes of transmission of HIV is getting in contact with the blood of an infected person. The possibility of infection was higher where the blood contact with that of an infected person was through intravenous administration. The appellant was aware that she was carrying out an operation for exactly that purpose, meaning that the possibility of her blood infecting [the toddler] was all greater. […]

In the end, I was satisfied that the prosecution proved beyond reasonable doubt the ingredients of the offence.

Rosemary Namubiru v. Uganda, HC Crim. Review No 50/2014 (Uganda HC).

4.1.4. HIV-Specific Criminalization

4.1.5. Conduct: Non-Disclosure, Exposure or Transmission

Criminal transmission of HIV is now better known as HIV non-disclosure, which is the criminal punishment for not disclosing an HIV positive status. This can be 'intentionally or unknowingly not disclosing HIV status' and then exposing or transmitting HIV to a person. HIV non-disclosure includes intentional transmission, accidental transmission, unknown transmission, and exposure to HIV with no transmission. People have been accused of and charged for HIV non-disclosure even if no harm was intended and if HIV was not actually transmitted. Countries such as the United Kingdom for example, charge the accused under existing laws with such crimes murder, fraud (Canada), manslaughter, attempted murder, or assault. The criminal law does not require disclosure of HIV in every case. In 2012, the Supreme Court of Canada (SCC) held that criminal law imposes a duty on a person to disclose HIV positive status before sexual activity that poses a "realistic possibility of transmission" so that the HIV negative sexual partner has the opportunity to choose whether to assume the risk of being infected with HIV.

HIV/AIDS has over the past 15-20 years resulted in the enactment and use of HIV-specific penal laws. As an HIV/AIDS control strategy, criminalization has steadfastly been adopted in several African countries

since 2007 including, among others, Burkina Faso, Cape Verde, Chad, Congo, Democratic Republic of Congo, Equatorial Guinea, Kenya, Tanzania, and Uganda. Such HIV-specific penal laws criminalize HIV non-disclosure, exposure and/or transmission. Criminalization by HIV-specific laws has been criticised. The UNAIDS[5] has been urging States to limit the scope of such laws to the intentional transmission of HIV—i.e., where a person knows his or her HIV+ status, acts with the intention to transmit HIV, and does in fact transmit it. The Policy Brief proposed establishing a threshold for criminal liability at 'intentional HIV transmission' in order to ensure that only truly blameworthy cases are subject to prosecution and to avoid an overly-broad application of criminal law that might undermine public health goals and human rights.

41. Attempted transmission of HIV.

A person who attempts to transmit HIV to another person commits a felony and shall on conviction be liable to a fine of not more than twelve currency points or imprisonment of not more than five years or both.…

43. Intentional transmission of HIV.

(1) A person who wilfully and intentionally transmits HIV to another person commits an offence, and on conviction shall be liable to a fine of not more than one hundred and twenty currency points or to imprisonment of not more than ten years or both.

(2) A person shall not be convicted of an offence under subsection (1) if—

(a) the person was aware of the HIV status of the accused and the risk of infection and he or she voluntarily accepted the risk;

(b) the alleged transmission was through sexual intercourse and protective measures were used during penetration.

The ***HIV/AIDS Prevention and Control Act*** of 2014 criminalizes the *wilful* and *intentional transmission of HIV* (section 43). In addition, it criminalizes *attempted transmission of HIV* (section 41).

In a criminal trial, the prosecution has the burden of proving beyond reasonable doubt that the accused caused the actus reus of the offence (The Woolmington Principle, *Woolmington v DPP*, 1935). In addition to this, it must also be proved that the accused formed the necessary mens rea to the offence. If the court thinks that the accused may not have committed the actus reus, or may not have formed mens rea, or has a defence, the accused must be acquitted.[6]

4.1.6. General Intent Crimes vs. Specific Intent Crimes

General intent is less sophisticated than specific intent. Thus, general intent crimes are easier to prove and can also result in a less severe punishment. A basic definition of general intent is the intent to perform the criminal act or actuaries. If the accused acts intentionally but without the additional desire to bring about a certain result, or do anything other than the criminal act itself, the accused has acted with general intent.[7]

4.1.6.1. *Inference of General Intent*

Intent is a notoriously difficult element to prove because it is locked inside the accused's mind. Ordinarily, the only direct evidence of intent is an accused's confession, which the government cannot forcibly

5 *UNAIDS, Policy Brief on Criminalization of HIV Transmission, 2008.*
6 *Rebecca Broadbent, Intention in the English Criminal Law.*
7 *People v. McDaniel, 2011*

obtain because of the Fifth Amendment privilege against self-incrimination. Witnesses who hear the accused express intent are often unable to testify about it because of evidentiary rules prohibiting hearsay. However, many jurisdictions allow an inference of general intent based on the criminal act.[8]

4.1.6.2. *Specific Intent*

Specific intent is the intent with the highest level of culpability for crimes other than murder. Unfortunately, criminal statutes rarely describe their intent element as "specific" or "general," and a judge may be required to define the level of intent using the common law or a dictionary to explain a word's ordinary meaning. Typically, specific intent means that the accused acts with a more sophisticated level of awareness.[9] Crimes that require specific intent usually fall into one of three categories: either the accused intends to cause a certain bad *result*, the accused intends to do *something more* than commit the criminal act, or the accused acts with knowledge that his or her conduct is illegal, which is called scienter.[10] Hence, merely knowing that a result is likely isn't the same as specifically intending to bring it about.[11]

The Zaburoni case[12] is another one where the Court endeavored to define what intent to transmit means. In the court of first instance, Zaburoni was convicted, *inter alia*, of the more serious offence of transmitting a serious disease with intent, contrary to section 317 of the Criminal Code 1899 (Qld) and sentenced to a term of nine and a half years' imprisonment. This conviction was upheld by the majority of the Queensland Court of Appeal. The majority (Gotterson JA and Morrison JA) held that a jury was capable of concluding, on the evidence available, that the appellant intended to transmit HIV. The High Court held that *an accused's foresight of likelihood that an outcome would occur as a result of his actions, cannot be substituted for proof of an accused's intention to cause or bring about that action.* The exception to this case is where an accused is aware that it is a 'virtual certainty' that the conduct will result in the particular outcome (at [42]- [43]). The High Court of Australia also noted a rational inference from the evidence of frequency of unprotected sex, which was open to the jury. This comprised of the fact that the appellant engaged in such conduct because it was more pleasurable, and that he was reckless of the risk of transmission. The High Court of Australia concluded that the evidence fell well short of proving that the appellant believed that it was "virtually certain" that he would transmit HIV via regular unprotected sex.

In the High Court of Australia, the plurality (the majority) endorsed the use of the terms 'purpose' and 'desire' when characterizing such specific intent, reasoning that 'intention generally does involve desire'. However, on this point Nettle J disagreed with the plurality, reasoning that intention could be established whether or not the accused desired to cause harm. Reference was made to the case of *Willmot,* and the plurality in the Zaburoni accepted the validity of Apple Garth J's application of Willmott to the extent that evidence of awareness, 'taken with other evidence, may support a conclusion that the person intended to produce that harm'.

4.1.6.3. *The Offence of Intentional Transmission of HIV in Uganda*

Under, section 43 of the HIV and Aids Prevention and Control Act, 2014 of Uganda, an offender must have" willfully" and "intentionally" transmitted HIV to another person. Those words are not defined within this Act. In order to convict one of transmission of HIV there must be intention. Definition of 'Intention' may be categorised as follows: Intent means to have in mind 13 a person's acts may

8 *Commonwealth v. Ely, 2011*
9 *Connecticut Jury Instructions No. 2.3-1, 2011*
10 *See* 4.2 Criminal Intent – Criminal Law (umn.edu)
11 *Thornton v. State, 397 Md. 704 (2007)*
12 *Zaburoni v The Queen [2016] HCA 12, 6 April 2016.*

13 *Willmot (No 2) [1985] Qd R 413.*

provide the most convincing evidence of intention.14It seems, therefore, that there would be a need to prove it by considering the circumstances of the case. Among the things the court can look at are: conduct of offender, the means of transmission of HIV and whether the person took steps to use any protective means such condom use or disclosing to the victim who then took on the risk knowingly. Other important factors will be the viral load and whether the HIV was undetectable.

4-724 How HIV Can Be Transmitted

It can be transmitted from an infected person to another through:

- Blood (including menstrual blood): Direct blood contact, including injection drug needles, blood transfusions, accidents in health care settings or certain blood products. Blood contains the highest
- Unprotected sexual contact: Semen, Vaginal/anal secretions. In the genitals and the rectum, HIV may infect the mucous membranes directly or enter through cuts and sores caused during intercourse (many of which would be unnoticed). Vaginal and anal intercourse is a high-risk practice. The second highest concentration of the virus is found in semen then in vaginal fluids. The risk of HIV transmission through the throat, gums, and oral membranes is lower than through vaginal or anal membranes. There are however, documented cases where HIV was transmitted orally;
- Mother to baby: Before or during birth, or through breast milk. The third highest concentration of the virus is found in breast milk.
- HIV is not transmissible through These Bodily Fluids;

i. Saliva
ii. Tears
iii. Sweat
iv. Feaces
v. Urine

4.1.6.7. *Examples of Intention to Transmit HIV*

The issue for courts and judges is to determine the conduct that is being penalised and sanctioned by the *HIV/AIDS Act*. Where a person maliciously and intentionally transmits HIV, and does in fact transmit HIV, this would fall squarely with the ambit of section 43(1) of the Act. What if there is intentional exposure in the sense that the accused knew he or she was HIV+ but there is no transmission of HIV in fact, should they still be prosecuted for *attempted transmission* under section 41? What if the accused did not disclose HIV+ status because of well-founded fear of serious harm by the other person (this is particularly the case with women)?

The issues that arise with intentional HIV transmission are highlighted in number of cases. In ***Perfect Ngwenya v. The State***,[15] the accused was convicted of deliberate transmission of HIV under section 79(1) of the Zimbabwe Criminal Code for, while being aware of his HIV+ status, having unprotected sex with the complainant who stumbled upon the accused's HIV therapy medication. The High Court upheld his conviction for the offence by a magistrate court.

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14 *R v Winner (1995) 79 A Crim R 528*

15 *Ngwenya v S (A144/12) [2014] ZAGPPHC 193 (14 April 2014).Accessible at* http://zimlii.org/zw/judgment/files/bulawayo-high-court/2017/59/2017-zwbhc-59.pdf.

The question of intentional HIV transmission (or *exposure*) in the context of the other known modes of transmission arose in ***Rebecca Ndaizivei Semba v. The State.***[16] In that case, the accused, a 26-year old woman, was charged with the offence of deliberate HIV transmission in relation to what she claims was mistaken breast-feeding of another woman's child. Convicted for the offence by a magistrate court, the High Court set aside the conviction and sentence on the premise that this conduct did not fall within the purview of the penal law and there had been no proof that the accused had knowledge or appreciated that her conduct would result in HIV transmission.

> *… [I]n order to convict, the State needed to prove: —*
>
> *(a) knowledge of the fact that the accused is HIV positive; or*
>
> *(b) a realisation that there is a real risk that he or she is infected with HIV; and*
>
> *(c) the act constituting a method of transmission with the knowledge or realisation that the act involves a real risk or possibility of infecting another person with HIV.*

… It seems to me, however, that what appears to have been uppermost in the mind of the law-maker was the knowledge or awareness of the fact that the accused was HIV positive and, notwithstanding that awareness, conducts himself or herself in a manner that he/she knew or realised that there was a real risk that such conduct would result in the transmission of the HIV virus to that other person … One cannot fail to see that the legislature could not have intended to criminalise a mother who had no information regarding the possibility of breast-feeding as a form of mother-to-child-transmission. Besides, the World Health Organization (WHO) is on record as promoting breast-feeding generally, and therefore in my view, with the advent of this pandemic there would have been need for this piece of legislation to expressly spell out the circumstances in which criminal liability would attach to a breast-feeding mother …

…

[T}he State was required to prove that the appellant was aware that breast-feeding would result in transmission of HIV. It would appear that the prosecution assumed, as did the Court, that the appellant was aware that breast-feeding would expose the baby to HIV. There was no basis for this assumption on the record. There is no indication as to the level of appellant's education on health matters let alone, whether or how sufficiently schooled in this area of medicine, the appellant was. In my view, it was necessary for the State to tender that proof of her knowledge before such a finding was made.

…

There is no indication on the record, in respect of whether the appellant knew that breast-feeding does transmit HIV. The evidence tendered in trial did not establish that the appellant knew how HIV is transmitted. On the contrary, in an affidavit produced during the State case the suggestion is made that medical evidence, presumably though evidenced-based studies, that only 15% of breast-feeding babies contract HIV from their mothers. It says the longer the child breast-feeds the higher the chances of the baby contracting HIV. What the statement suggests is nowhere near the facts disclosed by this case, which is a single act of breast-feeding. There is no way of knowing the quantity of breast milk required in order for there to exist a real risk or possibility of transmission to the baby, let alone whether the appellant was aware of the information on HIV transmission through breast-feeding …

…

16 *Rebecca NdaiziveiSemba v.The State [2017] ZWHHC 299 (Zimbabwe HC).Accessible at* <https://zimlii.org/zw/judgment/files/harare-high-court/2015/299/2017-zwhhc-299.pdf>.

In light of the above it is clear to me that the prosecution was ill-conceived as the legislature did not intend that breast-feeding by infected but ignorant women be criminalised. In any event there was no proof that the appellant fully appreciated that her conduct would result in HIV transmission. In the result she was entitled to an acquittal at her trial.

Rebecca Ndaizivei Semba v.The State [2017] ZWHHC 299 (Zimbabwe HC).

4.1.6.8. *Criminality: Intention and Defences*

As notable from section 43 of the *HIV/AIDS Act*, the criminalized act is a *wilful and intentional transmission* of HIV. Similarly, the provision, under sub-section (2) offers defences to prosecution for intentional transmission. However, beyond stating that a 'person who wilfully and intentionally transmits HIV to another person commits an offence' section 43 of the Act is barebones in terms of ingredients of the offence. The dilemma for a court of judge is to ascertain the elements of the offence beyond the text of the provision. While the *mens rea*—mental element (or state) of the offence is 'intention' (as juxtaposed with *wilfulness* in the text) to transmit HIV, these mental states are usually not well-defined. Should a court or judge require that the accused had knowledge of his or her HIV+ status as well as an understanding as to how HIV is transmitted to find criminal liability? Likewise, closely related, should a court or judge address whether the accused could reasonably foresee that his or her conduct is likely to result in harm (in this case, transmission of HIV)? These questions are what the Zimbabwe High Court reflected upon in *Rebecca Ndaizivei Semba v.The State*.

In a sense, the criminalization of HIV transmission poses a number of problems with regards to the fundamentals of criminal law, e.g., intent, foreseeability, harm, causation, etc.

In R *v. Reid*, the Queensland Supreme Court considered the import of *intent* in HIV transmission as requiring proof an accused's actions were designed to bring about *transmission* of the HIV disease and of *foreseeability* in an accused's *knowledge* of *probability or likelihood* that HIV will be transmitted.

Both R *v. Reid* and *Komuhangi Silvia v. Uganda* were dealing with transmission of HIV on basis of traditional provisions of the Penal Code, in the latter case, the High Court reflected on the question of likelihood of infection of disease as connoting a real or significant possibility of HIV infection. [17]

Further, there is the question of the 'harm' i.e., the transmission of HIV. Very often, it is the case that HIV transmission does not occur. In the attempts to fit the 'harm' of non-disclosure, exposure or transmission into current legal definitions, several jurisdictions have sought to characterize the risks (or harm) of HIV-related sexual conduct. In *R v Cuerrier*, the Canadian Supreme Court referred to sexual conduct posing a 'significant risk of bodily harm' (through transmission of HIV) however, 'significant risk' was not clearly defined. Subsequently, in *R v. Mabior,* the Supreme Court sought to clarify the 'harm', in relation to HIV transmission in the context of disclosure and consent, as the *realistic possibility of transmission of HIV.*[18]

4.1.7. Defence of Ineffective Legal Assistance and Reduced viral load

4.1.7.1. *The Nick Rhoades v State of Iowa. Supreme Court of Iowa.No.12-0180, June 13,2014*

The petitioner in this case, Nick Rhoades,[19] was diagnosed with HIV in 1998. Rhoades met A.P. online and Rhoades had indicated that he was HIV negative. From 1999 to 2005, Rhoades did not receive treatment for his HIV diagnosis. In 2005, Rhoades began consistently receiving medical care for his HIV diagnosis from the University of Iowa Hospitals and Clinics. Every three to six months during this time, Rhoades received treatment. In the

17 *Komuhangi Silvia v Uganda [2019] UGHC 39 (Uganda HC).*

18 *R v Mabior [2012] 2 SCR 584 (Canada SC), p 586.*

19 *Nick C. RHOADES, Appellant, v. STATE of Iowa, Appellant No. 15–1169 of April 15, 2016*

spring of 2008, Rhoades's doctor informed him his HIV viral load was non-detectable. At a later stage, AP and Rhoades engaged in consensual unprotected oral and protected anal sex. Several days later, A.P. learned Rhoades was potentially HIV positive. A.P. contacted the police, and subsequently the State charged Rhoades with criminal transmission of HIV in violation of Iowa Code section 709C.1 Rhoades pleaded guilty to one count of criminal transmission of HIV. The District Court accepted the plea.

At the sentencing hearing, the District Court sentenced Rhoades to a term of imprisonment not to exceed twenty-five years with life parole and required Rhoades be placed on the sex offender registry. Rhodes filed a motion to reconsider the sentence. The District Court then suspended Rhoades's twenty-five-year sentence and placed Rhodes on probation for five years. Rhoades did not appeal. However, about six months later, Rhoades filed an application for post-conviction relief. Rhoades alleged that his trial counsel provided ineffective assistance by allowing him to plead guilty to a charge for which there was no factual basis. The District Court denied relief, and the court of appeal affirmed. He sought further review by the Supreme Court which was allowed.

Before the Supreme Court, Rhoades claimed that his guilty plea was invalid because there was no substantial evidence to support the plea. Among other things, Rhoades stressed that at the time of his offense, his viral load was virtually undetectable. He argued that, in light of the developments in medicine, there was insufficient factual evidence to support the guilty plea. The mere fact that he knew he had HIV was not enough to provide a factual basis for the crime. On further review, in the Supreme Court of Iowa,[20] the court found that the guilty plea record did not contain a factual basis to support the plea. Accordingly, it vacated the decision of the Court of Appeals and reversed the judgment of the District Court. It also remanded the case with directions based on the following reasons.

The legislature codified the crime of criminal transmission of HIV in Iowa. The Iowa Code's section 709C.1 is really a disclosure statute. The crime is committed when a person knows he or she is infected with HIV. He or she needs to disclose this fact to the potential sexual partner before engaging in intimate contact with that person. As the Statute provides, if he or she discloses their HIV status and the partner engages in intimate contact consensually, there is no crime. Section 2 stipulates: For the purpose of this section: *a)* "*Human immunodeficiency virus*" (HIV) means the human immunodeficiency virus identified as the causative agent of acquired immune deficiency syndrome; b) "*Intimate contact*" means the intentional exposure of the body of one person to a bodily fluid of another person in a manner that could result in the transmission of the human immunodeficiency virus. Section 4 provides that "this section shall not be construed to require that an infection with the human immunodeficiency virus has occurred for a person to have committed criminal transmission of the human immunodeficiency virus." Section 5 states that it is an affirmative defense that the person exposed to HIV knew that the infected person had an HIV+ status at the time of the action of exposure; knew that the action of exposure could result in transmission of the HIV and consented to the action of exposure with that knowledge.

4.1.7.2. *Elements of the Crime of Criminal Transmission of HIV in The State of Iowa*

The State must prove the following elements: (1) "the defendant engaged in intimate contact with [the Victim]", (2) at the time of intimate contact the defendant's HIV status was positive, (3) the defendant knew his HIV status was

20 *Rhoades supra, p. 9*

positive, and (4) "[a]t the time of the intimate contact, [the victim] did not know that the defendant had a positive HIV status." [21]

In the particular case of Rhoades, it was argued by his Lawyer that he used a condom during sex, taking precautions to ensure that his male partner wasn't exposed to bodily fluids. In the ruling, Justice Wiggins wrote that modern medical advances and treatment options for HIV-infected people should be considered in Rhoades' case. Wiggins wrote. "The evidence ... shows there have been great strides in the treatment and the prevention of the spread of HIV." Rhoades' sentence cannot be upheld under the HIV transmission law in place at the time of his arrest, Wiggins wrote. The law specifically requires that a defendant "intentionally expose" a partner to the virus, he wrote.

The Supreme Court found that there was insufficient factual basis for the District Court to accept the plea. Therefore, the trial counsel was ineffective for allowing the District Court to accept the plea without a factual basis.[22] The Supreme Court remanded the case back to the District Court with orders that it should enter judgment and find that trial counsel was ineffective; make an order that the sentence in Rhoades's criminal case be set aside. Further, that it accords a chance to the State to establish a factual basis. In the event that the State cannot establish a factual basis, the plea should be withdrawn. Although the State was given an opportunity, it simply withdrew the charges against Rhoades. Rhoades then filed an action under Iowa Code chapter 663A (2015), asserting that he was wrongfully imprisoned by the State and entitled to compensation.

This case illustrates how in medico-legal matters the courts of law should not necessarily be bound by precedent as the Trial court did but should also consider the advanced knowledge about the scientific progress in the area of concern.

4.1.7.3. *Example of Non-Disclosure of HIV Status to Partner and Use of Multifarious*

Aziga had unprotected sex with 11 women without telling them he was HIV-positive. Five of the women became infected, with two dying of AIDS-related cancers. The Crown presented evidence that all the women who contracted HIV had a strain from a shared source, a strain rare in North America but common in areas of Africa. Aziga hails from Uganda.[23]Aziga was found guilty[24] on April 4, 2009 of two counts of first-degree murder, 10 counts of aggravated sexual assault and one count of attempted aggravated sexual assault. His convictions concern times he didn't tell sexual partners that he knew he carried the virus that causes AIDS before having intercourse.

In his defence, he stated "this is an issue in which it takes two to tango, the sex issue,"[25] At sentencing, before the Ontario Superior Court, Aziga stated that he received poor counselling after he learned in 1996 that he was HIV infected. In his own words "I did not disclose my HIV because of socio-ethno-cultural barriers to HIV disclosure; barriers arising from religious restrictions and taboo to sex and sexuality and; also arising from the way I was brought up and educated in sub-Sahara African country of Uganda, where at that time there was no education on sex, sexual health or sexuality both at home and in schools."[26] He also blamed his sexual partners in particular, saying that many of them said they didn't want him wearing a condom for "many reasons ranging from 'I am

21 *Rhoades Case, p. 8*
22 *One Judge dissented on this point.*
23 *Crown v Johnson Aziga, Hamilton Superior Court, (Ontario, Canada) 2 August 2011*
24 *Id. - It was a historic verdict: The first time in Canada – or anywhere in the world, as far as the prosecution is aware – that a criminal case involving the reckless transmission of HIV has resulted in a murder conviction.*
25 *Aziga, Supra*
26 *Id.*

allergic to condoms', and 'I do not like them things', 'it takes the fun away,' etc. and I could not force them."[27] He continued to state that "no one had told me there were ethnocentric legal and social services or financial services specifically designed for people with HIV/AIDS." [28]There was also blame for the world in general. There was even some blame directed at his undescended testicle. "I did not disclose my HIV also because of the fear that my sexual partners could note my other disability congenital malformation, once I talked to them about my HIV," Aziga said.[29]Aziga was convicted of first-degree murders.

4.1.8. Defence of Consent

4.1.8.1. *R v. Brown [1993] 2 All ER 75*

The appellants belonged to a group of sado-masochistic homosexuals who over a 10-year period from 1978 willingly participated in the commission of acts of violence against each other, including genital torture, for the sexual pleasure which it engendered in the giving and receiving of pain. The passive partner or victim in each case consented to the acts being committed and suffered no permanent injury. The activities took place in private at a number of different locations, including rooms equipped as torture chambers at the homes of three of the appellants. The appellants were tried on charges of assault occasioning actual bodily harm, contrary to s 47 of the Offences against the Person Act 1861, and unlawful wounding, contrary to s 20 of that Act. Upon a ruling by the trial judge that the consent of the victim afforded no defence to the charges, the appellants pleaded guilty and were sentenced to terms of imprisonment. The appellants appealed against their convictions, contending that a person could not be guilty of assault occasioning actual bodily harm or unlawful wounding in respect of acts carried out in private with the consent of the victim. The Court of Appeal dismissed their appeals. The appellants appealed to the House of Lords.

Held (Lord Mustill and Lord Slynn dissenting) – Consensual sado-masochistic homosexual encounters which occasioned actual bodily harm to the victim were assaults occasioning actual bodily harm, contrary to s 47 of the 1861 Act, and Three of the appellants were also convicted of wounding contrary to s 20 of the 1861 Act. Although the victim consented to the acts inflicted on him due to public policy, which required that society be protected by criminal sanctions against a cult of violence and that the possible danger of corrupting young men and the potential for the infliction of serious injury be taken into account, a person could be convicted of unlawful wounding and assault occasioning actual bodily harm, contrary to ss. 20 and 47 of the 1861 Act. Thus, persons who commit sado-masochistic acts which inflicted injuries which were neither transient nor trifling should be held liable notwithstanding that the acts were committed in private. This prevails even if the person on whom the injuries were inflicted consented to the acts and no permanent injury was sustained by the victim. It followed that the appellants had been properly convicted and that their appeals would be dismissed. It was held that consent is not a defence to a charge under the 1861 Act. Rather, the courts have accepted that consent is a defence to the infliction of bodily harm in the course of some lawful activities. The question is whether the defence should be extended to the infliction of bodily harm in the course of sadomasochistic encounters.

27 *Id.*
28 *Id.*
29 *Id.*

4.1.9. HIV Testing: Conclusiveness of Status and Proof of Transmission

The basic premise of HIV control and prevention is to provide, as a main entry-point, for voluntary counselling and testing. In that regard, in the context of criminalization of HIV transmission, an HIV+ result is *conclusive of an accused's status* and, where there has been HIV transmission, *proof of the transmission*. The criminalization of HIV transmission may have the effect of dissuading voluntary HIV testing since this might be used as evidence of knowledge of one's HIV+ status and thus reduces the number of people seeking to know their HIV status. However, of concern to courts and judges, especially in incidences of sex-based transmission, is a question of causation. This encompasses the proof that an accused's culpable act (e.g., non-disclosure of HIV status within his or her knowledge, or engaging in non-consensual sex while aware of HIV+ status) correlates, as the cause-in-fact, to the harm of HIV transmission. The pertinent questions here would be: Is the evidence of an HIV+ status proof that the accused is liable for HIV transmission to a victim? Which sexual partner (in consensual sexual relationship) caused the HIV transmission and infected the other?

The difficulty of ascertaining which partner is responsible for HIV transmission arose in *Pitty Mpofu & Another v. The State*,[30] in which the two applicants were separately charged with deliberate transmission of HIV. The first applicant had deliberately infected his wife with HIV sometime between October 2009 and June 2011. On her part, the second applicant had been convicted of HIV transmission to her husband by customary marriage. It was proved at her trial, that in 2009, she fell pregnant and had to undergo routine HIV testing and, although the result HIV+, she did not disclose this fact to her husband but continued to have unprotected sexual intercourse with him until he stumbled upon her antenatal card which disclosed, she was taking medication for HIV/AIDS. Although this was not canvassed during hearing of the constitutional applications, it is difficult to prove that either party, as husband or wife, infected their respective spouses.

4.1.10. HIV and Sexual Offences: Aggravation

The *HIV/AIDS Act* subject's persons arrested for sexual offences to *mandatory* HIV testing albeit for 'criminal proceedings and investigations. It is to be noted that the *National HCT Guidelines* envisage *mandatory* HIV testing in medico-legal cases involving sexual offences. HIV testing is required in respect of certain sexual offences under the *Penal Code*, for instance, *aggravated defilement* (section 129(6)). While the mandatory HIV test for persons arrested for sexual offences (including rape, incest, etc.) look acceptable, it runs into a concern that a court and judge should address as to whether the suspect is responsible for HIV transmission where it occurs. The letter of the penal law provisions is to make HIV-infection proof of HIV+ status and *per se* the premise of aggravating an offence and enhancing the sentence. It is unconcerned with the time when an HIV+ status was acquired.

Additionally, the Prohibition of Female Genital Mutilation Act 2010 provides another aggravation. In s.3, it is stated that:

(1) A person commits the offence of aggravated female genital

mutilation where [--]

30 *Accessible at* https://zimlii.org/zw/judgment/constitutional-court-zimbabwe/2016/5. *For a review and discussion of implications of decision: Feltoe, G., 'Constitutionality of the Offence of Deliberately Transmitting HIV: Case Note on the Case of S v Mpofu& Another' (2017) ZELJ 3.*

(d) the victim is infected with HIV as a result of the act of female genital mutilation;

(2) A person who commits the offence of aggravated female. [--].

Additionally, this runs counter the right to presumption of innocence as guaranteed under Article 28(3) of the 1995 Constitution. Further, it poses the question whether the accused is or was aware at any time before the *mandatory* HIV test that he or she was HIV+. Some of these concerns have been hinted upon by the Botswana Court of Appeal in *Dijaje Makuto v. The State*[31] and High Court in *Lejony v. State*,[32] in which the accused persons, charged with sexual offences, were required as per the penal law to undergo an HIV test, with enhanced sentences where there is an HIV+ result of 10, 15 and 20 years depending on evidence of the accused's awareness of HIV+ status prior to the *mandatory* test. In the *Makuto case*, the pertinent concern for the court was the fact that the HIV test was conducted after conviction for the offence of rape.

In *Ederema Tomasi v. Uganda*,[33] a case involving aggravated defilement, some of the concerns are evident in submissions of counsel on appeal. Appellant's counsel contended that the victim had been examined 2 days after the incident of defilement and found to be HIV+ (a fact he deemed medically impossible) while counsel for the State, as the respondent, claimed that at time of initial medical report, the victim was HIV- but was found to be HIV+ when she testified 2 years later. State counsel argued that in any case "whether the victim was infected or not is not relevant". Without addressing the contestation as to the periods within which the victim was tested and found to be HIV+, the Court of Appeal upheld the conviction on basis of the fact that the appellant knew he was HIV+ at time of commission of the offence.

On the aggravating side, the appellant knew he was HIV positive at the time the offence was committed. Although the victim was initially found to be HIV negative, she tested positive at the time of trial of the appellant. Aggravated defilement carries a maximum sentence of death. Taking into account the period the appellant spent on remand and all mitigating and aggravating factors, we sentence him to 18 years' imprisonment from the date of conviction of 11th June, 2014 …

Ederema Tomasi v. Uganda [2019] UGCA 203 (Uganda CA), p 5.

The fact of knowledge or awareness of an accused of his HIV+ status was stressed by the High Court in upholding a conviction for aggravated defilement in *Uganda v. Bonyo Abdu*.[34]

4.2 HIV/AIDs and Gender Equality/Non-Discrimination

4.2.1. HIV Criminalization: Stigma and SGBV

HIV criminalisation "is a pervasive illustration of how state-sponsored stigma and discrimination works against a marginalised group of people with immutable characteristics," says HIV Justice Network." "As well as being a human rights issue .of global concern, HIV criminalisation is a barrier to universal access to HIV prevention, testing, treatment and care."[35] HIV Criminalization is a term used

31 *[2000] (2) BLR 130.*
32 *[2000] (2) BLR 145.*
33 *[2019] UGCA 203.Accessible at* https://ulii.org/ug/judgment/court-appeal-uganda/2019/203.
34 *[2009] UGHC 200.Accessible at* https://ulii.org/ug/judgment/high-court/2009/200.
35 *The international state of criminalisation of HIV — review, June 5, 2019; <https://www.medicalbrief.co.za/international-state-criminalisation-hiv-review/ >*

to describe laws that criminalize otherwise legal conduct or increase penalties for criminal conduct based on a person's HIV-positive status.[36]

"Stigma is a dynamic process of devaluation that significantly discredits an individual in the eyes of others. It manifests in various forms, including internalized, perceived, enacted, institutional, and compounded stigma. If stigma is acted upon, the result is discrimination, which means treating a person differently because of a personal or perceived characteristic."[37]

The consequence of the stigmatization process sets apart stigmatized person(s) as a distinct category, leading to various forms of disapproval, rejection, exclusion, labeling, stereotyping, and discrimination.[38]

HIV criminalization has profound effects on stigmatization of HIV/AIDS. According to David Fawcett, "one major impact of HIV is isolation due to stigma, shame, fear and depression. The natural reaction to pull away may seem self-protective, but it ultimately removes you from the essential support that is important at every phase of living with HIV."[39]

Living with HV creates one stressful event after another: anxiety about getting tested, dealing with news that one is positive, when to start medications, dealing with anxiety, depression and stigma…The list is endless. "When the Crisis Lasts a Lifetime: HIV, Burnout, and Emotional Survival," Positive Living 2012.

David Fawcett: HIV/AIDS (typepad.com)[1]

Dr. Dianne Rausch, director of the Division of AIDS Research (DAR) at NIH's National Institute of Mental Health defines stigma generally as "a mark of shame or discredit." Anything different from the norm can create stigmatizing attitudes or feelings, and these can stimulate negative behaviors.[40] Additionally, Dr Gregory Greenwood, the program officer and stigma expert, had this to say about stigma:

"People may experience stigma related to health conditions, such as HIV and mental illness, and sociodemographic characteristics, such as race, ethnicity, gender, and sexual orientation. Certain behaviors or experiences, such as substance use and sex work, also can be stigmatized. Many people experience stigmas related to more than one of these categories." [41] Research has shown that when people with HIV experience stigma, they have poorer health outcomes and are less likely to consistently engage in their own medical care and in public health efforts.[42]

Populations disproportionately affected by HIV are also often affected by stigma due to, among other things, their gender, sexual orientation, gender identity, race/ethnicity, drug use, or sex work and they do suffer trauma.

See chart below.

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36 Amira Hasenbush , HIV CRIMINALIZATION IN GEORGIA: Penal Implications for People Living with HIV/AIDS, The William Institute, January 2018.

37 Canadian Public Health Association and Canadian HIV/AIDS Legal Network, Reducing Stigma and Discrimination Through The Protection of Privacy and Confidentiality, 2017(Online article).
<https://www.cpha.ca/sites/default/files/uploads/resources/stbbi/confidentialitystigma_e.pdf >

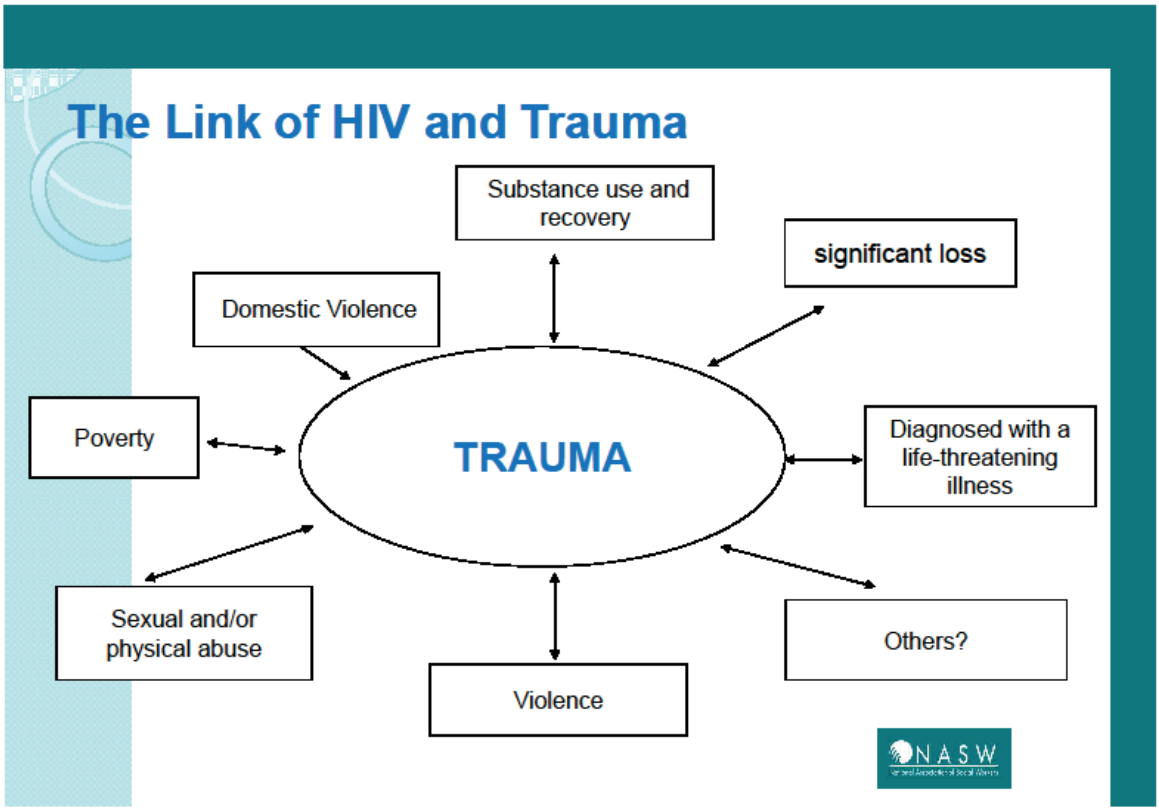
38 Nthomang, K., Phaladze, N., Oagile, N., Ngwenya, B., Seboni, N., Gobotswang, K., &Kubanji, R. (2009). People living with HIV and AIDS on the brink: stigma--a complex sociocultural impediment in the fight against HIV and AIDS in Botswana. Health care for women international, 30(3), 233–234. https://doi.org/10.1080/07399330802662077.

39 (David Fawcett 2016).

40 (Now 2019)

41 id

42 (Goldberg 2020)



HIV stigma drives acts of discrimination in all sectors of society, including health care, education, the work place, the justice system, families, and communities. The term "intersectional stigma" refers to the intersection and interaction of these multiple stigmatized identities."43

Dr. Greenwood discusses also the effects of stigma. She noted that stigma acts as a barrier to getting tested for HIV, accessing HIV prevention and treatment services, and staying in care. Stigma operates at multiple levels. First, there is "Internalized stigma," or self-stigma. This, is the personal endorsement of prejudice and stereotypes, like feeling you are "unclean" or "not worthy." Second there is Stigma which operates at the interpersonal level, it involves a situation where people are treating another person differently or discriminating against that person. Third, people also may experience "anticipated stigma" an expectation of discrimination from others, even if such persons have not experienced discrimination in the past. Furthermore, there is stigma which operates at a structural level, meaning that access, policy, or legal issues hamper one's ability to get the care they need or want.44 According to Dr. Rausch, in order to render assistance in dismantling HIV stigma and help PLWH to normalize, there must be an increase in the awareness of the substantial, evidence-based benefits of HIV treatment. Evidence shows that taking HIV medications daily as prescribed reduces the amount of HIV in the body to an undetectable = transmissible level (U=U). Increased awareness of HIV due to U=U should also lead to an increase in HIV testing, and more people with HIV will become aware of their status and still may face HIV-related stigma. Thus, increased awareness of HIV due to U=U will lead to an increase in HIV testing, and more people with HIV will become aware of their status but this alone may not work as PLWH may still face HIV-related stigma. Additional interventions that complement U=U will be needed to reduce and remove the stigma and discrimination that remain critical barriers to HIV care, treatment, and prevention.45

43 *(Now 2019).*
44 *id*
45 *Id*

There is need to address negative and judgmental attitudes of health care providers about HIV-negative people seeking pre-exposure prophylaxis (PrEP) and other HIV prevention services.46

Dr. Greenwood was of the informed opinion that there is need for better understanding of intersectionality because HIV is highly concentrated in socially disadvantaged communities affected by issues such as poverty, hunger, lack of s/table housing, and uneven access to care. Hence note has to be taken of intersecting forms of disadvantage and discrimination which compound the negative effects of stigma for PLWH. In respect of a way forward strategy, Dr. Rausch opinionated that HIV stigma can be mediated or accelerated by depression, alcohol and substance use disorder, and social isolation. Therefore, the need for intervention to reduce social isolation or support recovery from substance use disorder, is crucial. This could improve depression, which could then decrease internalized HIV stigma.[47]

Overall, the brunt of stigmatization is most felt by women. Concerning criminalization, the term "HIV Criminalization" is a term used to describe laws that criminalize otherwise legal conduct or increase penalties for criminal conduct based on a person's HIV-positive status. [48] In many countries around the world, criminal laws have been introduced that punish the transmission of HIV, potential or perceived exposure to HIV, and even non-disclosure of HIV status.[49] Laws often fail to recognise that HIV is no longer a death sentence, that effective treatment eliminates the risk of transmission (U=U) and that, regardless of treatment, the possibility of HIV transmission from a single act of exposure is extremely low.[50] Cases of people living with HIV intentionally transmitting HIV to others are extremely rare, as are cases of medical negligence by health-workers. Such cases can be prosecuted under existing law, rendering additional legislation that singles out HIV redundant such as in South Africa.[51]

Sub-Saharan Africa is the region with the most countries that have enacted HIV criminalisation laws, although in most countries, the number of reported cases is not high compared with the number of people living with HIV.[52] Romania and Latvia have also enacted HIV-specific criminal laws, although here have been very few reported cases to date. Others are found in Latin America and the Caribbean, for instance a recently enacted law in El Salvador (2016). In Mexico, laws in several states were proposed and then withdrawn in 2017/2018. In Colombia, the Constitutional Court of Colombia found their HIV-specific criminal law unconstitutional in 2019. In the Asia-Pacific region, there also countries with HIV criminalisation laws, including Vietnam and a recently enacted law in Nepal (2018). In China, national regulations state that a person living with HIV must inform a prospective sexual partner of their HIV status and take necessary precautions to prevent HIV transmission, although those precautions are not defined.[53] Types of HIV criminalization: criminalizing HIV transmission for PLHV; exposure or non-disclosure of HIV status. Some countries criminalize all of them. In some countries around the world, you are legally obliged to inform your partner of your HIV-positive status before you have any sexual contact. A few HIV-specific criminal laws are written in such a way that they assume guilt on your part even if you have not been diagnosed but think you might have HIV. [54]

Some countries criminalize potential or perceived HIV exposure. 'HIV exposure' refers to an act which may have put another person at risk of HIV infection, even if that person did not acquire HIV. The criminal law often assumes that HIV exposure always takes place when someone has any kind of sexual contact, or spits or bites or breastfeeds, disregarding up-to-date science. In some countries you can be prosecuted for HIV 'exposure' even if one was effective treatment, performed oral sex, or spat on

46 *id*
47 *id*
48 *Amira Hasenbush, Jim Kepner Law & Policy Fellow, Former, REPORT on HIV Criminalization in Georgia Penal implications for people living with HIV/AIDS, January 2018*
49 *(Webb 2020).*
50 *id*
51 *id*
52 *id*
53 *id*
54 *(Webb 2020).*

someone. For example, the Nigeria, Australia-in some states, the police may forcibly test anyone they think might have exposed to them HIV via spitting or biting, even though scientific research is to the opposite. This violates the rights of the people forcibly tested.55

4.2.1.1. Criminalization of HIV transmission

Many laws around the world appear to criminalize HIV transmission but they overly broad or so vague as to actually criminalize non-disclosure or HIV 'exposure'. It is not unusual for courts faced with allegations of actual HIV transmission to erroneously assume that the person diagnosed first passed it on and disregard progress in scientific research56. As the *Expert Consensus Statement on the Science of HIV in the Context of Criminal Law* states, it is extremely difficult to conclusively prove HIV transmission directly from one person to another.57 In Uganda, the *H*IV and AIDS Prevention and Control Act of 2014 criminalizes both intentional and attempted transmission of HIV. However, courts have made assumptions about what is intentional and assume that the person on trial, who was diagnosed first, must have passed it to the complainant.[58]

4.2.2. Incidence of HIV AND AIDS & Gender-Based Violence

HIV prevalence is almost four times higher among young women aged 15 to 24 than young men of the same age59 where the incidence of HIV AIDs is due to gender- based violence. Young Ugandan women who have experienced intimate partner violence are 50% more likely to have acquired HIV than women who had not experienced violence.60 A sizeable literature now links GBV and HIV infection. Sexual violence can lead to HIV infection directly, as trauma increases the risk of transmission.61

Gender-based violence is one of the most widespread human rights abuses and public health problems in the world today, affecting as many as one out of every three women. It takes many forms-- physical, emotional, or sex abuse.62

In that regard, section 13(b) of the *HIV/AIDS Act* subjecting pregnant women to routine testing, unwillingly places women at the forefront of HIV-status determination. In the context of HCT and RCT in pre-natal settings, women will certainly be the first to know their HIV+ status which can have several ramifications. Firstly, this creates conditions for initial blameworthiness for a HIV+ diagnosis, this will be the case whether the women disclose this diagnosis to her husband or intimate partner or, as provided under section 18(2)(e) of the Act, it is disclosed by a medical practitioner. In *Pitty Mpofu & Another v. The State*,63 the wife was prosecuted for HIV transmission at behest of the husband since she was 'first to know' when she tested HIV+ as a result of routine antenatal HIV testing when she fell pregnant.

Disclosure of HIV+ status often leaves women susceptible to stigma, ostracism and, in numerous instances, gender-based violence. These concerns were raised in *AIDS Law Project v. Attorney General & 3 Others*64 in respect of the HIV testing policy in Kenya that compelled pregnant women to undergo HIV tests but they were not addressed by the High Court of Kenya.

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55 *id*
56 *id*
57 *Barre-Sinoussi F et al. Journal of the International AIDS Society 2018, 21:e25161.*
58 *(Uganda 2014), Ss. 43&41 respectively.*
59 *Arise Uganda HIV Network Strategic Plan 2019-2023.*
60 *id*
61 *Andersson, Neil et al. "Gender-based violence and HIV: relevance for HIV prevention in hyperendemic countries of southern Africa." AIDS (London, England) vol. 22 Suppl 4 (2008): S73-86. doi:10.1097/01.aids.0000341778.73038.86.*
62 *Onyejekwe, Chineze J. (2004). The Interrelationship Between Gender-based Violence and HIV/AIDS in South Africa. Journal of International Women's Studies, 6(1), 34-40.*
Available at: <https://vc.bridgew.edu/jiws/vol6/iss1/3>.

63 *Pitty Mpofu (2) Samukelisiwe Mlilo v. The State, Judgment No eez 5/2016\1, Const. Application No CCZ08/13.*
64 *Aids Law Project v Attorney General & 3 others [2015] eKLR .*

Rights: Equality and Gender-Based Discrimination

Sexual Assault and Domestic Violence

As noted, HIV testing places women at forefront of getting to know of an HIV+ status and renders them vulnerable to sexual and gender-based violence (SGBV).

Rights with respect to Family and Property

The dilemma of an HIV+ status for many women is underscored by the fact that, as the consequence of stigma, those infected with HIV are shunned by the families of deceased husbands and women infected with HIV are usually not allowed to inherit property. Many women die of stigma of HIV and not of anything related to HIV. Of note is the fact that courts have sought to condemn any actions that deprive women of rights to property, treating such actions as tantamount to discrimination. In *Midwa v. Midwa*,65 where the husband petitioned for divorce after his wife tested HIV+ and brought proceedings to have his wife vacate their jointly-owned matrimonial home where they were living with their two children on the grounds that she posed a grave risk to his life and the life of the children and she had been ordered to move to the servant's quarters. On appeal, the Kenya Court of Appeal considered the law of custody and the fact that the wife was still strong and healthy despite being HIV+ for some five years and ordered that the wife be reinstated in the matrimonial home.

We have no hesitation in holding that the intended appeal is arguable and not frivolous. The ruling of the learned Judge, on its face, smacks of insensitivity and total inconsideration of the facts presented before her. It is not denied that the wife is 50% holder of the entire property and that her salary services the mortgage. It is traumatising and dehumanising to order her to live in the servant's quarter of her own house. We agree … that in such conditions her health is likely to be adversely affected.

It is trite law that, prima facie, other things being equal, children of tender age should be with their mother, and where a court gives the custody of a child of tender age to the father it is incumbent on it to make sure that there really are sufficient reasons to exclude the prima facie rule … The learned Judge, in our view, did not correctly direct herself on the principle that in cases of custody of the children the paramount consideration is their welfare. Moreover, as the record shows, there were no exceptional circumstances shown to justify depriving the mother of her natural right to have her children with her.

The husband in countering the application maintains that he cannot live together with his wife under the same roof as she poses a grave risk to his life. We sympathise. The wife is still working and servicing the mortgage. She avers that she is still strong and healthy despite the fact that she was diagnosed HIV positive about five years ago. Until the Court decrees otherwise the husband should not desert his wife. Presently it would be morally wrong.

If anything is done to upset and alter the state of health of the wife, substantial harm may be occasioned and the intended appeal will be rendered nugatory. We allow the application and grant a stay of execution. We order that the wife be put back in the matrimonial home forthwith.

Midwa v. Midwa [2000] 2 EA 453 (Kenya CA), paras 8-12.

4.3 HIV/AIDs in the Workplace

4.3.1. HIV Status, Testing and Recruitment

The implications of HIV/AIDS have been most felt in the employment sector more than any other sphere of life. Employment discrimination against people living with HIV may take the form of bias in hiring, refusal to grant workplace modifications to accommodate medical conditions, or unjustified termination.66 The

65 *Midwa v. Midwa [2000] 2 EA 453 (Kenya CA), [2000] 2 EA 453.*
66 *The Centre for HIV Law and Policy, <https://www.hivlawandpolicy.org/about/our-work >.*

courts have been vigilant in protecting employees within the context of HIV/AIDS in the workplace. Two critical areas arise in employment that have posed questions for the courts, especially resulting from HIV testing, that is, firstly, requiring HIV testing as a basis for hiring or recruitment for a job and, secondly, on-job HIV testing while in employment. In both instances, the courts have been vigilant to protect prospective and on-job employees from what they have deemed unjustified *discrimination* on basis of HIV status. It is also crucial to understand the types of testing and the time it takes before one gets infected because ignorance about the procedure also breeds discrimination which will eventually culminate in one being stigmatised.

There are three types of tests available: nucleic acid tests (NAT), antigen/antibody tests, and antibody tests. HIV tests are typically performed on blood or oral fluid. They may also be performed on urine. The industrial Court of Botswana in *Diau v. Botswana building Society*, Case No IC 50/2003, made a determination that an employee cannot be dismissed for refusing to have a compulsory HIV anti body test because it is with in his right to privacy to refuse such.

The right to equal opportunity in employment is illustrated in the case of ***Hoffman v. South African Airways,67*** in which the appellant applied as a cabin attendant with the South African Airways. At the end of the selection, he was found to be a suitable candidate for employment, but he was later denied employment because he tested HIV+. The South African court declared that PLHIV 'must be treated with compassion and understanding' and they 'must not be condemned to 'economic death' by the denial of equal opportunity in employment', and it held that the refusal of the defendant to employ the appellant as a cabin attendant because he was HIV+ violated his right to equality. Notably, the court held that the right to *freedom from discrimination* was intricately linked to the *right to dignity*, using the test of dignity as a way to read HIV status into the list of prohibited grounds in the Constitution.

> At the heart of the prohibition of unfair discrimination is the recognition that under our Constitution all human beings, regardless of their position in society, must be accorded equal dignity. That dignity is impaired when a person is unfairly discriminated against. The determining factor regarding the unfairness of the discrimination is its impact on the person discriminated against. Relevant considerations in this regard include the position of the victim of the discrimination in society, the purpose sought to be achieved by the discrimination, the extent to which the rights or interests of the victim of the discrimination have been affected, and whether the discrimination has impaired the human dignity of the victim.
>
> 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

67 *Hoffman v. South Africa Airways [2000] ZACC 17 (South Africa CC), paras 27-8, 32.*

> 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.
>
> The fact that some people who are HIV positive may, under certain circumstances, be unsuitable for employment as cabin attendants does not justify the exclusion from employment as cabin attendants of all people who are living with HIV. Were this to be the case, people who are HIV positive would never have the opportunity to have their medical condition evaluated in the light of current medical knowledge for a determination to be made as to whether they are suitable for employment as cabin attendants. On the contrary, they would be vulnerable to discrimination on the basis of prejudice and unfounded assumptions – precisely the type of injury our Constitution seeks to prevent. This is manifestly unfair.

Hoffman v. South Africa Airways [2000] ZACC 17 (South Africa CC), paras 27-8, 32.

4.3.2. HIV Status and Dismissal from Employment

The other instance in which HIV status has come to play in employment is where an HIV+ status, once known or discovered, is the basis or reason for dismissal. The courts have held such dismissals unlawful, wrongful and discriminatory.68

In ***Lundy v. Phillips Staffing***,[69] Lundy brought suit against his former employer alleging discrimination under the Americans with Disabilities Act (42 U.S.C. § 12101) (ADA) when he was fired after his employer Phillips learned of Lundy's positive HIV status. In 2011, Phillips Staffing offered Lundy a position at Hubbell Lighting. As a new hire, Lundy was required to fill out a medical questionnaire. Lundy failed to disclose his HIV status, believing he was only required to disclose medical information that would impair his ability to safely perform the job. Later in his employment, in a routine physical exam, Lundy disclosed he was diagnosed with HIV in 2003 and was taking HIV medications. After this disclosure, Lundy was terminated from his employment.

In consonance with the existing law, a pre-Trial was conducted by a local Magistrate who prepared a Report. The Magistrate Judge submitted a Report and a Recommendation ("Report"), recommending that the court deny Phillips's motion. (ECF No. 41). Phillips had filed timely objections to the Report (ECF No. 43) and Lundy hadresponded to those objections (ECF No. 44). The matter came up for Review before a South Carolina District Court. In order to survive summary judgment, Lundy must first establish a prima facie case of discrimination by showing: "(1) he 'was a qualified individual with a disability'; (2) he 'was discharged'; (3) he 'was fulfilling h[is] employer's legitimate expectations at the time of discharge'; and (4) 'the circumstances of h[is] discharge raise a reasonable inference of unlawful discrimination.' Summary judgment is appropriate if, after reviewing the entire record in a case, the court is satisfied that no genuine issues of material fact exist and that the movant is entitled to judgment as a matter of law. Fed.R.Civ.P. 56(a). An issue of fact is "genuine" if the evidence is such that a reasonable jury could return a verdict for the plaintiff. The Report established that there was a question of fact as to whether Phillips reasonably concluded that Lundy lied on the questionnaire because (1) Lundy's understanding that the form was asking for conditions that would affect his job performance may be reasonable. The Report found that Lundy's HIV satisfied the first definition.

In his holding, the District Judge, Timothy M. Cain agreed with the Finding of the Report. He also noted that while Phillips was correct that the Fourth Circuit had not, at that point, definitively held that asymptomatic HIV is a per se disability, the court found that based on the evidence before it, Lundy's asymptomatic HIV meets the Americans with Disabilities Act ("ADA"), 42 U.S.C.ADA's definition of disability. He held that

68 *Zungu v ET Security Services, J1916/1999, the South African Commission for Reconciliation, mediation and Arbitration declined to consider that there was discrimination following the dismissal of the complainant a security guard who had full-blown AIDs. The Commission found that this was done in good faith and consideration of the complainant's delicate health.*

69 *Lundy v. Phillips Staffing, WL 811544 (D.S.C. 2014.*

Lundy had shown that he had HIV, which is a physical impairment that has a "constant and detrimental effect on the infected person's hemic and lymphatic systems from the moment of infection." Concerning the legitimate job expectations, the Judge agreed with Phillips that the legitimate expectations prong encompasses compliance with company rules, along with general job performance. However, while "on summary judgment[,] an employer is free to assert that the job expectation prong has not been met, nothing prohibits the employee from countering this assertion with evidence that demonstrates (or at least creates a question of fact) that the proffered 'expectation' is not, in fact, legitimate at all."70 In this context, 'legitimate' means that the employer's expectations cannot be a "sham designed to hide the employer's discriminatory purpose."71 Pertaining to the reasonable inference of discrimination, the court agreed with Phillips that the temporal connection could go either way the moment Phillips discovered that Lundy was HIV-positive and the same moment it discovered that Lundy's medical questionnaire did not indicate that he was HIV-positive. In fact, Phillips challenged Lundy's testimony about being discriminated whilst Lundy stated otherwise. So, the court is left with Lundy's testimony that Phillips employees made comments about his HIV status at his termination meeting. Consequently, the court is left with two different sets of facts and a credibility dispute. The court had to determine whether there is a reasonable inference of discrimination, or at least a disputed issue of material fact. The court found that Lundy's testimony regarding statements made at his termination meeting plausible and material. After a thorough review of the record in this case, the court endorsed the Report's apt analysis and the Report was incorporated in the proceedings. As such, Phillips's motion for summary judgment (ECF No. 24) it was denied.

The case of ***X v. The Commonwealth*72**concerned a soldier who had enlisted in the Australian Defence Force (ADF). After his enlistment, a pathology test showed that he had been infected with HIV, the virus that causes AIDS. He was immediately discharged pursuant to a policy of the ADF applicable to all new recruits requiring the termination of their employment if they tested positive to HIV. The ex-soldier complained about his discharge to the Australian Human Rights and Equal Opportunity Commission. The ADF admitted that there was discrimination against him otherwise contrary to the Disability Discrimination Act 1992 (Cth). However, it asserted that the discrimination was lawful in his case because, within one of the exceptions recognized by the Act, the soldier was unable to perform the "inherent requirements" of the particular employment. It was contended that one of the "inherent requirements" of a soldier was a capability to (as it was vividly put) "bleed safely", if bleeding arose in circumstances of combat or training. The Commissioner, who held an inquiry for the Commission, held that the relevant exemption applied only where there was "a clear and definite relationship between the inherent or intrinsic characteristics of the employment and the disability in question". At first instance in the Federal Court of Australia, the judge reviewing this decision declined to disturb it for error or law but the Full Court of the Federal Court of Australia set the decision aside and ordered a rehearing. It held that the Inquiry Commissioner had misdirected himself in adopting a construction of the exception under the Act which was too narrow and restrictive.

On further appeal by special leave to the High Court of Australia, the Court, by majority, upheld the Full Court decision. It directed that the matter be returned to the Human Rights Commission for redetermination without adopting the "narrow and restrictive construction" which the majority felt had originally been taken. **Hon. Justice Michael Kirby AC CMG dissented** from this opinion, concluding that there was no error of law in the approach of the Inquiry Commissioner. It was Justice Michael Kirby`s opinion that the Act that was being applied should

70 *Warch v. Ohio Casualty Insurance Company, 435 F.3d 517 (4th Cir.2006).*
71 *Id, p. 518.*
72 *(1999) 200 CLR 177.*

be given a beneficial construction to secure its objectives, namely the elimination of decisions against people with disabilities on the basis of attributes ascribed to their disabilities by stereotyping. Justice Michael Kirby suggested that the imposition of a universal "policy" requiring the dismissal of all recruits in a large employment area within the federal government defied the particularity required of employers in decisions affecting employees necessitated by the Act. This view did not prevail.

This case illustrates the way in which HIV/AIDS is no longer a remote, exotic far-away problem for judges. It is becoming a regular visitor to the courts whether in Fiji, Australia or elsewhere. He observed that in common law countries which personally derive their legal systems largely from England, the judge enjoys an especially important place in the exposition, development and application of the law. This gives lawyers a creative role which role in developing the common law gives the lawyers of our tradition opportunities and responsibilities of law-making, which are probably greater than in most countries of the civil law tradition. Thus, a judge of the final appellate court will have an enormously important role in applying the Constitution, in expounding basic human rights, in sometimes striking down legislation as unconstitutional, and in keeping the other branches of government in check.

In ***Lemo v. Northern Air Maintenance (Pty) Ltd.,*73** an ill employee who was absent from work for extended periods of time was dismissed when the employer became aware of his HIV status. The Botswana High Court held that the employee could not be dismissed purely on the basis of his HIV status without adequate procedures being followed to determine his incapacity. Additionally, the court addressed an employer's legal responsibilities in situations where an HIV+ employee is ill. It further emphasised the importance of treating HIV+ employees as it would all other employees, noting how the nature of HIV and the existence of ART allowed employees to work for many decades.

In the case of ***Canada (A.G) v. Thwaites*** **(1994) 3 FC 38,** the Federal Court of Canada held that the discharge of a soldier for having HIV was discriminatory and contrary to the law. In another case, the Labour Court in Namibia in *Haindongo Nghidipohamba Nanditume v. Minister of defence,* case no. LC 24/98, held that the non-consideration of the plaintiff's application for enlistment in the defence force on the basis of him being HIV positive was discriminatory. In the case MX v ZY, AIR 19$^{97\ BO}$M 406, High Court of Judicature, the High Court in India held that the employment policy of refusing to hire people with HIV was a discriminative one.

4.3.2.1. J.A.O. v. Homepark Caterers Ltd & 2 Others

In *J.A.O. v. Homepark Caterers Ltd & 2 Others*,74 the Kenya High Court upheld the right to work, non-discrimination, autonomy, privacy and confidentiality by way of a consent judgment, in a case of a widow who was wrongfully dismissed from employment on the basis of her HIV status after she was tested without her consent and the results of her HIV status shared with her employer by the doctor without her consent.

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73 *Lemo v. Northern Air Maintenance (Pty) Ltd [2004] 2 BLR 317 (Botswana HC), p 17 Accessible at* <http://www.elaws.gov.bw/desplaylrpage.php?id=1199&dsp=2>.

74 *J.A.O. v. Homepark Caterers LTD & 2 Others Civil Case No. 38 of 2003 (decided in 2004).*
Kenya, High Court Accessible at <http://kenyalaw.org/caselaw/cases/view/12744>.

4.3.3. HIV/AIDs and Access to Healthcare and Treatment

A critical part of HIV/AIDS control is *treatment*, especially in terms of antiretroviral therapy or treatment (ART). The *HIV/AIDS Act* sets out State responsibilities such as ensuring equitable distribution of health facilities including essential medicines and universal HIV treatment on non-discriminatory basis as well as establishment of an HIV/AIDS Trust Fund to support HIV response. In the early years of the HIV/AIDS pandemic, there were concerns about access to treatment. A pertinent decision was made in *Minister of Health & Others v. Treatment Action Campaign*,75 in which the South African Constitutional Court interpreted the right to access to health care as provided for under the Constitution and ordered the government to modify its programme for the PMTCT measures in order to ensure that *Nevirapine* is available to the public health sector. The Court's decision was very progressive and sought to comply with international guidelines on HIV/AIDS.

4.3.3.1. Patricia Asero Ochieng & 2 Others v. Attorney General & Another

In ***Patricia Asero Ochieng & 2 Others v. Attorney General & Another,76*** the petitioner challenged the constitutionality of Kenya's 2008 Anti-Counterfeit Act due to its negative impact on accessing generic anti-retroviral medications for people living with HIV/AIDS and as a violation of the rights to life, health and human dignity. The Kenya High Court ruled for the petitioners and declared Sections 2, 32 and 34 of the Act unconstitutional, holding that the definition of 'counterfeit' in the law would likely be read as including generic medication and was therefore likely to adversely affect the manufacture, sale and distribution of generic drugs and, in turn, this would hamper the availability of the generic drugs and pose a threat to the petitioners' right to life, dignity and health under the Constitution. The judgment of the High Court extensively discussed the issue of the right to health in the context of access to medicines.

4.3.3.2. Luis Guillermo Murillo Rodríguez et al. v. Caja Costarricense de Seguro Social

In the case of *Luis Guillermo Murillo Rodríguez et al. v. Caja Costarricense de Seguro Social*, Constitutional Chamber of the Supreme Court of Justice, Decision No. 6096-97 (1997), the Court ordered the Costa Rican Social Security Fund to immediately begin supplying the plaintiffs with the necessary antiretroviral medicines combination therapies appropriate to their clinical condition, as prescribed by their responsible physicians.77

In *Jorge Odir Miranda Cortez et al. v. El Salvador*, Inter-American Commission on Human Rights, Report No. 29/01, the IACHR) received a petition filed by Carlos Rafael Urquilla Bonilla of the Foundation for Studies for the Application of Law, FESPAD ("the petitioners"), alleging international liability on the part of the Republic of El Salvador ("the State") with respect to Jorge Odir Miranda Cortez and 26 other persons who are carriers of the Human Immunodeficiency Virus/Acquired Immunodeficiency Virus ("HIV/AIDS") and are members of the Atlacatl Association. The petitioners allege that the acts reported constituted a violation of several provisions of the American Convention on Human Rights (hereinafter "the American Convention"): the right to life (Article 4); humane treatment (Article 5); equal protection before the law (Article 24); judicial protection (Article 25); and economic, social, and cultural rights (Article 26), in accordance with the general obligation set forth in Article 1(1) and the duty set forth in Article 2 of the aforementioned international instrument. They also allege violation of Article 10 of the Additional Protocol to the American Convention on Human Rights in the area of Economic, Social, and Cultural Rights ("Protocol of San Salvador"),

75 *Minister of Health and Others v. Treatment Action Campaign and Others, (No 2) (CCT8/02) [2002] ZACC 15; 2002 (5) SA 721;*
76 *Patricia Asero Ochieng & 2 Others v. Attorney General &Another, Petition No. 409 of 2008: [2012] eKLR.*
77 *(Luis Guillermo Murillo Rodríguez et al. v. Caja Costarricense de 1997)*

> as well as other provisions consistent with the American Declaration on the Rights and Duties of Man ("the American Declaration") and other human rights instruments. In light of the gravity and urgency of the situation, the petitioners requested precautionary measures on behalf of the 27 persons mentioned above, which were granted by the IACHR when it began processing of the case.78

Given that a vast majority of people living with HIV/AIDS in Uganda and most Third World countries rely on generic drugs for their survival, the decision in the case is a major victory for millions of PLHIVs who depend upon generic medicine for ART treatment.

78 *Jorge Odir Miranda Cortez et al v. El Salvador, Case 12.249, Report No. 29/01, OEA/Ser.L/V/II.111 Doc. 20 rev. en 284 (2000).*

Part V: Judging and Adjudicating HIV-Things to consider

5.1 Introduction

This Part provides a guidance and checklist for judges and judicial officers in dealing with HIV/AIDS issues that might come up with cases either criminal or civil that may come up before them.[79]

5.2 Judges must act scrupulously as impartial adjudicators

They must keep open minds and they must refrain from doing anything that could create the impression that they are biased or partisan in their approach. Judges owe it to their own self-esteem; to the dignity of their office; to the credibility of the legal system; and most of all, to those who attend their judgment, to comport themselves in such a way as persuades all before them that a fair hearing was afforded and an honest and considered decision was handed down. Audience that is fairly given to both contending parties is most likely to result in a decision that not only commends itself as even-handed but is also just. An appearance of disfavor in the proceedings, conversely, is calculated to result in a decision that fails to command confidence and which is the more likely to be wrong.[80]

In order to achieve this, there are **Key Considerations in Judging and Adjudicating HIV/AIDS,** Judges may borrow a leaf from the Hon. Justice Michael Kirby AC CMG. While discussing HIV/AIDS-Implications of the Law and the Judiciary.

The 6 Cs[81], which include;

Contemporaneity

This involves issues such as consent for testing; counseling of those at risk and those who are infected with HIV; issues of confidentiality and discrimination; the special problems of vulnerable groups, some of them subject to discrimination which is reinforced by the law; issues of the safety of the blood supply and of the work environment.

Consciousness

The first responsibility of the legal profession is consciousness about HIV/AIDS. All lawyers today, in every country, should have more than a layman's understanding of HIV/AIDS.[2] Each judicial officer should have a basic knowledge about AIDS and HIV infection, with rudimentary information on what AIDS such as when it first appeared; how HIV is transmitted; how many people in; which groups of people have been particularly infected; what the life expectancy of a person with HIV or AIDS is; how it is diagnosed; what are its symptoms; whether health care workers and other professionals are at risk of HIV infection; and what risk still exists in donated blood, blood products or human tissue.

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79 *See Paul Mukiibi, HIV/AIDS, TB and the Law: Experience from the Bar. A Paper presented to the Judicial officers in a judicial dialogue on HIV/AIDS, TB, Human Rights and the Law at Protea Hotel-Entebbe. December, 2020. Available at* https://uganet.org/wp-content/uploads/2020/12/HIV_AIDS_TB-AND-THE-LAW_-EXPERIENCE-FROM-THE-BAR.pdf *accessed on 3 December 2021.*

80 ***Musindo* 1997 (1) ZLR 395 (H)**

81 *HIV-AIDS-Implications for the Law and the Judiciary. A paper presented to the Fiji Law Society on the 15th Anniversary Convention, Figatoka, Fiji Islands on 27th May 2006.*

Judicial officers have a duty to their communities to inform themselves about the basic facts. They should not rely solely upon the general media, for it is often guilty of misinformation and extravagant reporting on this topic. It must be assisted by informed and unbiased help from a skilled legal profession. That is why the first step in the role of the legal profession in this area is consciousness about HIV/AIDS. It is the function of professional bodies to supply information to practicing lawyers. If this is not done, conscientious legal professionals must inform themselves.

Courts

When it comes to the courtroom, there are various medical conditions that can gather elements of prejudice and stigma, but HIV/AIDS in the courtroom is especially sensitive. In part, this is because of its significant association with death. In part, it is also because the modes of transmission are frequently by sexual intercourse and the use of drugs. Communities do over react when dealing with groups which have often been (and sometimes still are) the subject of stigma and even criminalization (homosexuals, drug-addicted persons, sex workers etc.). As such, Lawyers cannot separate themselves from their communities. They are likely to have tints of the same, the attitudes, fears and prejudices of the societies they live in. They should try to treat PLHIVs well. Judicial officers should not permit court process to be distorted, invariably to the disadvantage of the litigant, by generally unnecessary isolation, or disadvantageous treatment[3]:

Judicial officers should carry out their work without fear or favour. Ensuring the right to an attorney, the right to have one's case heard.

Judicial officers must be prepared for sensitive questions that can arise in cases involving HIV/AIDS, and must ensure that they and the legal practitioners guarantee a measure of confidentiality to the persons involved since trials should be public as much as possible.

Judicial officers should guard about unnecessary closed court sessions because a person suffers from HIV/AIDS, or is a PLHIVs. However, in deserved cases closed sessions may be held.[4]

Cases

The stereotyping views about dangers to the public should be expelled by the judge, who should confine his or her decision to the actual known conduct of the applicant.[5] An appellate court in New York held that it was an abuse of discretion to impose a condition of a negative HIV/AIDS test prior to release on bail, in so far as this was not mentioned in the statutes, and could involve an injustice to the particular applicant.[6] In the criminal area, the main questions which have come before judges involve issues such as sentencing persons who are known to be infected with HIV, and ordering parole release of such persons. King CJ in the ***South Australian Court of Criminal Appeal in R v Smith[7] noted that "the state of health of an offender is always relevant to the consideration of the appropriate sentence for the offender."***[8]

Many other, cases call forth understanding by the lawyers involved. In such cases especially, judges need to ground all decisions upon sound data resting on the evidence not on prejudice, stereotypes, myths or pre-judgment.

Colleagues

HIV/AIDS penetrates more societies and every branch of society, the legal profession and judiciary will become aware of colleagues as PLHIVs either in the judiciary, or in the legal profession. They also deserve fair treatment. In South Africa, Justice Edwin Cameron, a Judge of the Supreme Court of Appeal, is a PLHIVs and is open and forthright about it. He speaks up for the millions who are silent and ashamed. His book, Witness to AIDS is a brilliant description for judges and lawyers of what HIV/AIDS is really like. This is a textbook commendable for reading to have some understanding about this subject[9].

Community

Many of the features of HIV/AIDS are relevant to the professional duties of judges and other lawyers. Typically, laws stigmatize, and sometimes criminalize conduct which is relevant, e.g., the sexual activities outside marriage; prostitution; homosexual activities; and injecting drug use. It is therefore the duty of judicial officers to reflect upon the effectiveness of current laws, in so far as they are relevant to the epidemic. Where law has become part of the problem, legal practitioners (being better informed and usually more powerful) have a responsibility to add their voices to the discussion of law reform. In default of a cure for, or vaccine against, HIV/AIDS, the only readily-available weapon in society's armoury is behaviour modification. It is the lesson which lawyers can tell society that strong criminal sanctions are only of limited use in securing and reinforcing behaviour modification in such basic activities as sex and drug use.[10]

The AIDS paradox teaches that criminalization and stigmatization make it more difficult to reach the minds of those affected. The first step on the path to effective behaviour modification will often be decriminalization, and the provision of educational messages. It is in this sense that informed judges can contribute to AIDS prevention by participating in discussion of legal reform. The same message is relevant to the re-evaluation of laws on homosexual conduct and drug use.[11]

5.3 HIV in the Courtroom—Role of a Judicial Officer

As judicial officers, there are matters to be considered in the courtroom when handling HIV/AIDS cases.

1. The sanctity or decency of the courtroom should be maintained82 and there should not be any necessity of changing courtroom procedures because parties to the case are HIV+ or the case is HIV/AIDS-related, unless the parties request a change.83 This is a common practice here in Uganda, for example, in defilement cases.84

2. The presumption of innocence until one is proven or pleads guilty provided under Article 28(3) (a) should not cease to exist when an accused or offender is found to be HIV+.

3. Judges (and assessors) should require a proof that HIV was transmitted by the accused in order to secure a conviction in HIV transmission cases.

4. Judges (and assessors) must note that available scientific techniques including phylogenetic analysis and Recent Infection Testing Algorithm (RITA) testing have significant limitations and alone cannot definitively prove the source or timing of an HIV infection.85

5. The best practices should be adopted by Judges hence the necessity to sensitize them on such practices whilst handling HIV/AIDS cases. For instance, they should be encouraged to take into consideration the fact that if a party to the case or a witness has a disability, including living with HIV, the party concerned should be given the option of conducting the hearing in a different manner. They may inquire from the party whether there is anything that the court can do differently to allow them to participate fully.86

6. Judicial officers must at all times maintain control of the proceedings. For instance, the judicial officers need to be sensitized on being alert to HIV-related threats, breaches of privacy and other abuses of process, which they should handle in the same way as any other potentially inflammatory issue in the Court. Some parties have tried to use the other party's HIV-positive status to their advantage, such as by revealing their HIV-positive status in open court or by

82 *UNAIDS, Judging the Epidemic: A Judicial Handbook on HIV, Human Rights and the Law (2013).*

83 Ibid.

84 *Although the Judges tend to be rather biased, just as the law is, towards young girls who are defiled by an HIV/Aids Accused Person*

85 UNAIDS, *Judging the Epidemic: A Judicial Handbook on HIV, Human Rights and the Law* (2013).

86 *Ibid.*

delaying proceedings knowing that the person living with HIV is ill. Such conduct should not be tolerated.

5.4 Case Notes

Bragdon v Abbott, US Supreme Court, (97-156) 107 F.3d 934,

Discrimination, Stigmatization, disclosure

In this case, Bangor, Maine resident Sidney Abbott went to Randon Bragdon, D.M.D. to have a cavity filled. Citing his fears of HIV transmission from a patient, Dr. Bragdon refused to fill her cavity in his office solely because Ms. Abbott disclosed on a medical questionnaire that she has HIV. Dr. Bragdon claimed that people with HIV who were not yet manifestly ill did not meet the ADA 's definition of "disability." The ADA defines a disability as a health condition that

The United States Supreme Court ruled 5-4 in Bragdon v. Abbott that the federal Americans with Disabilities Act (ADA) prohibits discrimination against people living with HIV, whether or not they show any visible symptoms or have an AIDS diagnosis. The Court's 1998 decision is a critical victory for people living with HIV because the ADA and similar state disability discrimination statutes are the only legal bases to fight HIV-related discrimination in jobs, housing and health care. The Court's language and reasoning, however, go far beyond the facts of Sidney Abbott's case and ensures that all people with HIV will be covered by the ADA. In a lengthy analysis, the Court endorsed long-standing interpretations of the ADA by the U.S. Department of Justice and the Equal Employment Opportunity Commission, which found that the ADA protects symptomatic and asymptomatic HIV-infected individuals from discrimination, in part because HIV limits both procreation and sexual relations. The Supreme Court directed the nation's lower courts to follow these agency interpretations. The Supreme Court's broad definition of "disability" and its endorsement of these administrative interpretations of the ADA mean that Bragdon v. Abbott is an enormous victory, not only for Sidney Abbott, but for all people living with a disability.

John Conner III Case [87]

HIV criminalization, Non disclosure of HIV status

Johnn Conner III a dance teacher in Tennessee met the 16-year-old student on social media in 2015. The teen joined Conner's dance team, the Infamous Dancerettes. The two then had sex several times and exchanged nude photos over text messages, according to WREG. Prosecutors said Conner did not tell the teen he was diagnosed with HIV in 2012. The teen later also tested positive for HIV after having sex with Conner. Conner pleaded guilty in November to charges of criminal exposure to HIV, statutory rape by an authority figure, and solicitation of a minor. He was Sentenced to nine(9) months in prison and four(4) years of probation.

Kemigisha Adrine vs Uganda HCCA No. 97 of 2019, High Court of Uganda at Mbarara delivered on 24th January 2020; Hon. Mr. J. Musa Ssekaana considered the severity of the Applicant`s HIV status in addition to other conditions to grant the applicant bail pending her trial.

Uganda vs No. 19515 Sgt. Driver Nkojo Solomon HCT-00-CR-SC-0036-2016, High Court of Uganda at Kampala (then Criminal Division)) delivered on 16th January 2018; Hon. Mr. J. Wilson Masalu Musene found the accused guilty with the offence of murder but considered his HIV/AIDS positive status as a mitigating factor and did not sentence him to a maximum punishment rather imprisonment for 18 years.

Rosemary Namubiru vs Uganda HCT-00-CR-CN-0050-2014, High Court of Uganda at Kampala (Criminal Division); Hon. Mr. J. Rugadya Atwoki upheld the conviction by the lower court that the appellant was negligent since she knew her HIV positive status and the consequence of her actions but reduced the

87 <https://www.oxygen.com/crime-news/john-conner-iii-of-lifetimes-bring-it-gave-teen-hiv >

sentence of 3 years imprisonment five months which is the period she had so far served in prison. It is however important to note that the court observed that;

A. The appellant was an elderly person aged 64 years, thus a mother and grandmother to the toddler;

B. That she was "sickly" and "HIV positive";

C. The toddler remained HIV-free;

D. The appellant had no intention of harming the toddler and

E. The court also noted that the sentence was manifestly excessive.

It argued that "medical practitioners need some degree of protection." It noted that 3 years was an excessive sentence and accordingly reduced it to five months.

Komuhangi Silvia vs Uganda HCCA No. 0019 of 2019, High Court of Uganda at Gulu delivered on 29th August 2019; Hon. Mr. J. Stephen Mubiru made quite a number of important observations concerning HIV/AIDS prosecution in relation to sec. 171 of the Penal Code Act cap. 120. His Lordship observed the following;

A. In order prosecution to succeed under this offence, it must establish that the act was committed with intent to cause the contact which causes infection of a disease.

B. Criminal negligence refers to a mental state of disregarding known or obvious risks to human life and safety.

C. Likelihood connotes a significant possibility as contrasted with a remote possibility, that a certain result may occur or that infection in such circumstance may exist. There should be evidence led before court showing that infection in such circumstances is not merely fanciful, remote or plausible but rather that it is statically significant and almost certain. It should be one whose occurrence is almost certain to materialize, unless preventive steps are taken.

D. Evidence must show the presence of "significant risk" and the circumstances must have presented a realistic possibility of transmission.

The Richard Dalley case (New Zealand)-No Need to disclose if the steps necessary to prevent the transmission of HIV can be met

Thirty-six year-old New Zealander Richard Dalley had faced two charges of criminal nuisance for having unprotected oral sex and protected vaginal sex with a woman he had met over the internet and did not tell about his HIV status. Earlier this year, Mr Dalley had been found guilty of "criminal nuisance" for having unprotected sex without disclosure with another sexual partner and was sentenced to 300 hours' community work. In her ruling, Wellington District Court Judge Susan Thomas wrote: "It seems to me that most people would want to be told that a potential sexual partner was HIV-positive. There may well be a moral duty to disclose that information. There is however a difference between a moral duty and a legal duty, the legal duty in this case being to take reasonable precautions against and use reasonable care to avoid transmitting the HIV virus. The evidence was that, as far as public health needs are concerned, the steps necessary to prevent the transmission of HIV can be met without the requirement for disclosure. In other words, the use of a condom for vaginal intercourse is considered sufficient."

She added that her ruling was based on testimony from some of New Zealand's top HIV experts, including Dr Richard Meech, author of the first government report on AIDS in New Zealand in 1985. In her ruling on unprotected oral sex she said that, "the risk of transmission of the virus as a result of oral intercourse without a condom is not zero because it is biologically possible, but it is so low it does not register as a risk. In any event Mr Dalley did not ejaculate. On the basis of those two factors I find that reasonable precautions against and reasonable care to avoid such danger were taken by Mr Dalley."[88]

88 *Ground-breaking New Zealand ruling finds condom use eliminates HIV disclosure requirement*

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