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Compulsory HIV testing of alleged sexual offenders – a human rights violation

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Chapter 5 of the Sexual Offences Amendment Act strives to achieve two objectives. It makes post-exposure prophylaxis (PEP) accessible to victims of sexual assault, whether a charge is laid or not. In addition, it allows for the victim or the investigating officer to make application for the forcible disclosure of the HIV status of the accused, within 90 days of the assault. It is argued that the provision of PEP to victims of sexual assault is required by section 27(1) of the Constitution, and is an obligation that the state should assume and discharge efficiently and ably. However, it is considered that the provisions compelling the accused to disclose his HIV status to the victim and investigating officer serve no medical purpose, and seriously infringe a number of important constitutional rights. The authors go on to argue that a magistrate has to be satisfied that a *prima facie* case has been made that the accused sexually assaulted the victim before compelling disclosure. Given the seriousness of this finding, it is very likely to be robustly contested by the accused and consequently victims may have to testify twice, initially at these proceedings and subsequently at the criminal proceedings. They argue that the medical, legal and support services provided to the victim should be upgraded and improved. The authors identify some clinics that are operating with reasonable efficiency. They argue that the simplistic solution of compelling the accused to disclose his HIV status is aimed at making up for the inadequacies of policing and the inability to prosecute effectively. They also submit that the test results may bring false hope and result in poor choices being made regarding treatment. They submit that the testing provisions may not be in the medical best interests of the patient and the provisions are not reasonable and justifiable in an open and democratic society and consequently unconstitutional.

Recently there has been mounting public concern and pressure on the authorities to take appropriate action with regard to the deliberate transmission of HIV infection.¹ This has to be seen against the backdrop of the alarmingly high levels of sexual crimes against women and children in South Africa.^{2,3} The high HIV seroprevalence in the country further compounds the problem. In 2009, the SAPS recorded 68 332 rape victims reporting rape,² and the general consensus is that large numbers of rape cases go unreported.⁴ In 2009 approximately 5.6 million people were estimated to be living with HIV infection,³ with 17.3% of the adult population affected, 25% (1.1 - 1.6 million people) with symptomatic HIV infection, and 7% (360 000) with full-blown AIDS.³ The inability to deal with the scourge of sexual violence against women and the high levels of HIV seroprevalence in the country mean that women who are raped are at risk of contracting HIV. The issue, however, is how do we deal with this reality? Parliament sought to address the issue by including a number of measures in Chapter 5 of the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007 (the Act).⁵ In lieu of this, the purpose of this article is to assess the efficacy of these measures from a medical perspective, and to determine their constitutionality from a legal perspective.

The South African Law Commission (SALC), at the request of the Justice and Constitutional Affairs Portfolio Committee, was

tasked with investigating the creation of a statutory offence aimed at harmful HIV-related behaviour, and the compulsory testing of sexual offenders for HIV.⁵ The SALC prepared two discussion papers. *Discussion Paper 80* dealt with the issue of harmful behaviour by persons with HIV/AIDS.⁶ Further to this, *Discussion Paper 84*⁷ dealt with the question of compulsory HIV testing of persons arrested on a charge or on suspicion of having committed a sexual offence, and the right of the alleged victims of such offences to be informed of the HIV test result.⁷ In general, the debates have focused on the following issues:⁵

- the high prevalence of HIV, coupled with the high prevalence of rape and other sexual offences in the country
- the utility and limitations of HIV testing
- women's international and constitutional rights, and
- the arrested person's constitutional rights.

The preliminary conclusion of the Project Committee on HIV/AIDS is that there was a need for statutory intervention⁵ in the light of the vulnerability of women and children to widespread sexual violence in South Africa.^{2,4} This occurs in the context of the increasing prevalence of a nationwide epidemic of HIV infection,³ and in the absence of adequate institutional or other victim-support measures.^{6,7}

In these circumstances, the Project Committee concluded that there was a compelling argument for curtailing an accused person's rights of privacy and bodily integrity to a limited extent to enable his/her accuser to know whether he/she has HIV or any other life-threatening sexually transmissible infection (STI). The Project Committee concluded that knowledge of the accused's HIV status enables the victim to make life decisions and choices for him/herself and the people around him/her. Furthermore, this information would be profoundly beneficial to his/her psychological state, as it provides a degree of certainty regarding his/her exposure to a life-threatening disease.⁵ This, according to the Project Committee, justified the infringement of the rights of the accused.⁵

A description of chapter 5 of the Act⁸

Chapter 5 of the Act has two distinct objectives. It provides that the victims may receive post-exposure prophylaxis (PEP)¹, and it allows for compulsory HIV testing of the alleged sex offenders. Various safeguards are built into the process, and the test results may only be used for purposes stipulated in the Act. Section 28 of the Act provides that a victim who has been exposed to the risk of being infected with HIV as a result of a sexual offence having been committed against him or her may receive PEP to prevent HIV infection, at state expense.⁹ These free services are only provided to victims who either lay a charge with the SAPS, or report the incident to a designated health establishment (i.e. rape trauma rooms or crisis centres) within 72 hours of the alleged sexual offence having occurred.¹⁰ It is important to note that a victim who presents to a designated health institution is not obliged to lay a charge in order to obtain PEP, provided they present within 72 hours and baseline rapid-test HIV testing is negative.⁹ This is a positive measure, which will have the effect of curbing the transmission of the virus where a sexual offence has been committed.¹¹

Much more controversially, the chapter goes on to provide for applications to be made, either by the victim¹² or by the investigating officer, for compulsory HIV testing of the alleged offender.¹³ Either the victim, or someone on behalf of the victim, may within 90 days apply to a magistrate for the alleged offender to be tested for HIV, and for the results to be disclosed to the victim or the interested person. The application must be made after a charge has been laid. The victim must state that a sexual offence has been committed against him or her by the offender, that it has been reported, and that the victim is exposed to the risk of being infected with HIV. The magistrate is required to consider the application in chambers, and may consider evidence on behalf of the accused, if to do so would not give rise to a substantial delay. If the magistrate is satisfied that there is *prima facie* evidence that a sexual offence has been committed by the alleged offender against the victim, that the victim has been exposed to bodily fluids and that not more than 90 days has elapsed since the date of the alleged offence,¹⁴ the magistrate may make an order for the alleged offender to be tested. The results can then be disclosed to the victim and to the alleged offender.

Section 34 of the Act provides that the results may be used to enable the victim to make informed medical choices, and in civil proceedings that may be instituted against the alleged offender. Furthermore, the results can be used by the investigating officer to gather information, in order to build a case against the accused in criminal proceedings. Finally, section 37 seeks to protect the

confidentiality of the information and section 38 makes it an offence for any person to lay a charge with the objective of ascertaining a person's HIV status.

The issue, then, is whether the proverbial baby is thrown out with the bathwater as a consequence of these processes. We submit that the Act contains provisions that may be unconstitutional, and may be contrary to the medical best interests of the victim. The HIV status of the alleged perpetrator has no material consequence to the medical or legal outcomes for the victim, and could in fact further traumatise the victim. An acquittal in the subsequent trial could open the possibility of charges being laid in terms of the Act by the accused person, alleging that the information was obtained with malicious intent.¹⁵

The constitutional right of access to health care services¹⁶

Section 27(1) of the Constitution provides that everyone has the right of access to health care services, and there is an obligation on the state to take reasonable legislative and other measures within available resources to achieve the progressive realisation of these rights.¹⁷ This is the formula that the Constitution uses in respect of the cluster of socio-economic rights that are protected in the Constitution. As the jurisprudence has developed, the key issue is how the courts enforce socio-economic rights such as the right of access to health care, without unconstitutionally trespassing on the policy-making and implementation responsibilities of the executive.

The test as far as justiciability of socio-economic rights is concerned, is one of reasonableness.¹⁷ The advantage of this test is that it requires a clear exposition and justification by government for its policy choices, without being unduly rigid and prescriptive. The Constitutional Court (CC) in *Grootboom*, indicated that in determining whether governmental action is reasonable in terms of section 26(2) of the Constitution, a court will not enquire into whether different and more favourable measures could have been adopted. The reasonableness enquiry recognises that a wide range of options may be adopted by the state to meet its objectives.¹⁷ One of the recurring themes in the judgments of the CC is that if governmental measures are to be deemed reasonable, they must cater for those most in need and whose rights are most in peril.¹⁸ There must be a demonstration that the most marginalised and vulnerable in the society are being assisted by the government measure. A comprehensive housing policy was therefore held to be unreasonable in *Grootboom*, because no provision was made to alleviate the plight and conditions of those in great need and who were on waiting lists for formal housing. They were simply left to their own devices, with no assistance from the state, and this was untenable. Similarly, in the *Treatment Action Campaign* case,¹⁹ the court held that the government policy of restricting the use of nevirapine to prevent mother-to-child transmission to certain test sites was unreasonable. The net effect of the policy was that those who were entirely dependent on the state for health care were being denied access to the drug that could potentially prevent mother-to-child transmission if they attended public hospitals outside the test sites. The drug was being offered free of charge to the state for a certain period, and the court concluded that the reasons for not making the drug available in all state hospitals when its use was sanctioned by the attending physician was unreasonable. Once

again, the most marginalised and disempowered in society were worst affected by the policy. The state was ordered to change its policy and bring it into line with the Constitution.

In both *Grootboom* and the *TAC* cases, the court set aside the policies, and taking cognisance of the separation of powers allowed government to reformulate the policies in a manner that complied with its constitutional obligations. Finally, the CC in *Mazibuko*²⁰ provided further guidance on how to evaluate the reasonableness or otherwise of measures adopted by government. The court declined to grant an order obliging government to provide a minimum of 50 litres of free water per person per day in the Phiri area of Soweto. Such an order would, in the opinion of the court, have been unduly prescriptive and may have had the effect of hampering government in the proper and systematic realisation of all socio-economic rights. The court²¹ held that government policies would be unreasonable if they made no provision for those desperately in need, if government adopted a policy with unreasonable limitations and exclusions, and if government did not continually review its policy to ensure that the achievement of rights was being progressively realised. In this case, the court held that the policy of providing 25 litres of free water, together with various other options including installing prepaid water meters, was not unreasonable. A factor that weighed heavily with the court was that indigent persons could apply for a further and additional supply of free water. Importantly, government provided a full and comprehensive explanation for its policy choices.

As a consequence of the jurisprudence on the socio-economic rights, government is required to progressively realise the right of access to health care. In terms of section 4(3) of the National Health Care Act 2003, the state, clinics and community health centres funded by the state must provide free health care services to pregnant and lactating women and children below the age of 6 years, who are not members or beneficiaries of medical aid schemes. Further free primary health care must be provided to all persons, except members of medical aid schemes and their dependants and persons receiving compensation for compensable occupational diseases. In addition, women must be provided with free termination of pregnancy services, subject to the Choice on Termination of Pregnancy Act, No 92 of 1996. To this list must now be added free PEP to the victims of sexual assaults.

Given the high prevalence of HIV in our society, the alarming number of sexual offences being committed, the efficacy of preventing transmission if victims are put on PEP treatment immediately, the long-term cost savings and cost-effectiveness of this treatment, and the low numbers of people on private medical insurance, the government would have been acting unreasonably had PEP not been made available free of charge in state hospitals and clinics – to victims. The issue is whether, having made this treatment available to all victims, is it reasonable and justifiable to compel the alleged offender to reveal his status?

Impact on the survivor

We acknowledge that the forced disclosure provisions in the Act may have the effect of reducing trauma and empowering some victims to make informed medical and other personal decisions. The term 'victim' is used, as this is the terminology of the Act. However, it is preferable to refer to survivors, as it is a more empowering and affirming term. It may also have negative

implications for other victims. At the moment, emergency medical services, including PEP, antiretroviral drugs, and ongoing counselling are available in terms of the National Department of Health Protocols on Management of a Rape Survivor/Child Sex Abuse.²² There are a number of 'one-stop' crisis centres operating on a 24-hour basis. These are staffed by trained clinical forensic officers and clinical forensic nurses, and in addition a SAPS desk is present at these facilities. In KwaZulu-Natal (KZN) this model is working well at Addington, Mahatma Gandhi (MGH), and Prince Mshyeni (PMMH) hospitals. However, the service needs to be expanded into the peri-urban and rural areas of KZN.

Addington, MGH and PMMH are 24-hour walk-in crisis centres. They are staffed by trained clinical forensic nurses and district medical officers (previously known as district surgeons). A rape victim can walk into these centres, which afford privacy, confidentiality and professionalism in terms of trained staff conducting a medical examination, evidentiary collection using the Sexual Assault Collection Kit, medico-legal documentation, and PEP inclusive of counselling. The patient, after discussion with the professional staff, may elect to report or not report the case. The patient's autonomy is respected. If the victim wants to report the case, then either the on-site police desk or the nearest police station is contacted to come to the crisis centre to register the case, and to take charge of the documentation and evidence collection kits. In terms of National Department of Health (DOH) policy, no patient is turned away from a crisis centre, irrespective of whether they choose to report the case or not. A full medical and medico-legal examination is done with evidentiary collection, and PEP is provided in all cases, and as per standard DOH protocol.

Rape is a high-risk exposure for STI, including HIV and pregnancy. A standard DOH protocol is followed, and entails baseline blood testing (hepatitis, syphilis) and HIV testing. Analysis takes place in a laboratory, and results take up to 3 weeks to process. A urine pregnancy test is also performed and, if negative, post-coital contraceptives are given, with an appointment for repeat pregnancy testing at 2- and 4-week intervals. Should the patient become pregnant, she will be offered termination in terms of the Choice of Termination of Pregnancy Act of 1996. Two HIV rapid tests are also done, with pre- and post-test counselling. This includes a buccal smear and a finger-prick blood-test strip for HIV. If the victim presents within 72 hours^{11,23,24} and both tests are negative, the victim is counselled, given antiretroviral treatment (ART) for 28 days, and is then given an appointment for HIV testing at 3 weeks, 6 weeks, 3 months and 6 months, as per DOH protocol.⁹ Should the patient test positive at presentation, the patient is counselled and given an appointment to visit the HIV clinic for initiation of ART. ART is generally well tolerated by patients, and most patients complete the 28-day course of tablets. All patients are given syndromic treatment, comprising antibiotics for STI. Ongoing counselling is ensured by an appointment with the psychology department of the hospital.

From the perspective of the victims, the primary concern relates to medical as opposed to legal issues. The alleged perpetrator could be in the 'window period', which could be as long as 3 weeks; a false-negative HIV result could influence the survivor's choice and result in him or her declining ART, and this would have serious consequences for his/her health outcomes.

Telephonic conversation with staff at Addington Hospital Crisis Centre revealed that only 3 requests were received under the Act in the first 8 months of this year. In all 3 cases, a formal HIV blood test was done and sent to Inkosi Albert Luthuli Central Hospital (IALCH), bearing an Addington Hospital case number – resulting in Addington Hospital bearing the costs of the test. Owing to the large amount of enzymatic HIV blood testing done at IALCH, the HIV results would only be available some 3 weeks after blood testing. This 3-week time delay would render such result irrelevant as far as the medical treatment of the victim is concerned. The staff at Addington Hospital Crisis Centre also stated that in all 3 instances the HIV results were negative, and that these results were collected by the SAPS. The staff further stated that they were uncertain about how they would handle a positive result, as the provisions of the Act created an ethical dilemma for them in respect of the accused. There is an ethical duty for medical practitioners to provide post-test counselling, to enable the accused to access the ARV programme, and to further advise him or her on lifestyle changes.²⁵ The accused under the Act do not enjoy the same standards of care as other patients.

In addition, a positive HIV test result of the accused at day 90 is not scientifically compelling evidence that he was HIV positive at the time the offence was committed, or that he infected the victim. The victim could have tested negative immediately after the offence, but she could also have been in the window period having already been infected prior to the assault. The other variable is that she could have seroconverted by contact with other HIV-positive partners during unprotected sex, after the assault. Even if the accused is found to be HIV positive, it will be very difficult to prove beyond reasonable doubt that he infected the victim.

In addition, present constraints in the criminal justice system and public health system would create a logistical nightmare in giving effect to this Act, and would devour already scarce human and financial resources in an exercise that would not influence the medical outcomes for the victim. IALCH has a 3-week turn-around time for HIV results, as it processes HIV blood samples from the entire province. There are acute resource constraints in respect of HIV testing. Would this Act be allowed to circumvent the processing of HIV results of acutely ill patients, who need urgent medical intervention, or will the applicants be obliged to take their place in the queue? If there are to be delays in accessing the HIV status of the accused, then one of the main objectives of the Act – affording the victim certainty relatively quickly – will be undermined.

Infringements on the rights of the alleged perpetrator

It is common cause that the forced disclosure provisions infringe a number of fundamental rights of the person accused. The nature of these rights is now analysed and it is determined whether infringements of such rights can be justified in terms of the limitation clause. While a number of rights may be indirectly affected, the rights most egregiously impacted upon are the rights to privacy,²⁶ the right to freedom and security of person, and the right to remain silent and not to give incriminating evidence.²⁷

One of the cardinal aspects of the right to privacy is what has been referred to as the right of 'informational self-determination'.²⁸ This aspect of the right refers to restricting the collection and disclosure of private or personal information. Clearly, the disclosure of personal

information would also adversely affect the right to human dignity. In *C v Minister of Correctional Services*,²⁹ the court held that drawing a blood sample from a prisoner for an HIV test without following the informed consent policy amounted to a violation of the right to privacy. Importantly, the court recognised that a positive test result may have devastating consequences for the person, and hence the absolute imperative for proper pre- and post-test counselling.²⁹ The coerced disclosure provisions of the Act abrogate the necessity for informed consent, before testing is conducted. In addition, no provision is made in the Act for either pre- or post-test counselling. The net effect is that the state may be informing an accused person that he is HIV positive, without providing any further assistance, even though prevailing medical opinion is that counselling intervention in these circumstances is imperative.

In *Mistry*,³⁰ the CC had to consider whether the right to privacy was breached by a communication from one official to another. The court indicated that the following factors relating to the breach were relevant:

- Was the information obtained in an intrusive manner?
- Was it about intimate aspects of the applicant's personal life?
- Did it involve data provided by the applicant for one purpose, but which were used for another purpose?
- Was it disclosed to persons from whom the applicant could reasonably expect the information to be withheld?

Chapter 5 of the Act allows for the forced testing, irrespective of whether the alleged perpetrator consents to the testing. The taking of bodily specimens may not be excessively intrusive, but is nonetheless a violation of section 12(2) of the Constitution, which guarantees everyone the right to bodily and psychological integrity. From a practical perspective, it will be virtually impossible for the confidentiality of the report to be maintained once the information is disclosed to the victim, particularly if the finding is that the person accused is HIV positive. If the victim perceives that he or she has been infected with a life-threatening disease, it will be wholly unreasonable for the law to expect the victim in these circumstances to respect the right of privacy and confidentiality of the person accused. In effect, this law could make the HIV status of the accused, public knowledge. The intrusion is therefore significant and far reaching.³¹

A further objective of the forced disclosure is to enable the investigating officer to gather information with a view to using it as evidence in criminal proceedings. In effect, the person accused may, against their wishes, be ordered to allow two specimens to be taken which can subsequently lead to evidence that may be used against him or her.

The application of the limitation clause

If the forced disclosure provisions of the Act are challenged, the focus no doubt will be on whether the infringement of the rights of the accused is reasonable and justifiable in accordance with section 36 of the Constitution.

Section 36 of the Constitution provides for the limitation of rights in the Bill of Rights, therefore no right is absolute.

S 36 states:

'The rights in the Bill of Rights may be limited only in terms of law of general application to the extent that the limitation is reasonable, and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including:

- a) the nature of the right;
- b) the importance of the purpose of the limitation;
- c) the nature and extent of the limitation;
- d) the relation between the limitation and its purpose; and
- e) less restrictive means to achieve the purpose.'

As the forced disclosure provisions of the Act infringe a number of rights of the accused, the disclosure will be unconstitutional unless the legislature can satisfy the requirements of the limitation clause. The Act is clearly a law of general application, and the question will be whether it is reasonable and justifiable in an open and democratic society based on dignity, equality and freedom. As the CC pointed out in *S v Makwanyane*,³² the limitation of constitutional rights for a purpose that is reasonable and necessary in an open and democratic society, involves the weighing up of competing values, and ultimately an assessment based on proportionality. Unlike the enquiry in respect of whether government is acting reasonably when progressively realising socio-economic rights, the courts assess whether the option chosen by government is proportionate and whether there are less restrictive options available.

In *S v Manamela*, the court held that as a general rule, the more serious the impact of the measure on the right, the more persuasive or more compelling the justification must be. Further, it was held that the essence of the enquiry is to determine the proportionality 'between the extent of the limitation of the right considering the nature and extent of the limitation of the infringed right on the one hand, and the purpose, importance and effect of the infringing provision, taking into account the availability of less restrictive means available to achieve that purpose'.³³

The right in issue is a central aspect of the right to privacy, and includes the right not to have blood taken without consent, and the right not to have his or her HIV status made known to others. Weighed against this, is the right of the victim to know the HIV status of the accused. This knowledge will, no doubt, affect his or her physical and psychological health in various ways. However, the sanguine words of the CC in *Dlamini*³⁴ are apposite here:

'One must be careful to ensure that the alarming level of crime is not used to justify extensive and inappropriate invasions of individual rights. It is well established that s 36 requires a court to counterpoise the purpose, effects and importance of the infringing legislation on the one hand against the nature and importance of the right limited on the other.'

The question, therefore, is whether the purpose the law seeks to achieve, justifies the infringement of the right not, for example, to have confidential medical information such as HIV status disclosed without consent.

In assessing this, the following three questions will be analysed:³⁵

1. How invasive is the infringement of the rights of the accused?
2. How persuasive is the justification for the infringement?

3. Are less restrictive means available to promote the rights of the victim?

The infringement on bodily integrity is limited, as blood taking for alcohol testing is routinely done under the Criminal Procedures Act, for the purposes of criminal prosecutions.³⁶

It is submitted that the HIV status of the alleged perpetrator bears no practical relevance to the treatment of the survivor. Rape is a high-risk situation with regard to HIV, and current protocols state that a survivor must be given PEP within 72 hours of the incident, unless he or she tests HIV positive. The medical intervention makes provision for first-contact counselling and ongoing counselling by designated health and allied agencies.²²

The argument of empowering the survivor with knowledge of the accused's HIV status is an emotionally charged one, and does not have any meaningful effect on therapeutic outcomes for the victim. The following is a useful analogy. If a rapist wore a condom at the time of the assault, would this information have any influence on the treatment of, or psychological outcomes for, the victim? The answer is a resounding NO. This use of a condom could provide a false sense of security, as the condom could have punctured during the rape. Save for evidentiary purposes, doctors disregard whether a condom was used or not, for therapeutic and treatment purposes.

The over-riding fact is that rape is a high-risk situation, and ART must be provided to the victim within 72 hours of the assault. Any time delay, even for the futile exercise of waiting for the HIV results of the accused by the victim, could have life-threatening consequences for the victim.

Clearly, society must provide redress to victims. Providing PEP and effective counselling for victims, empathetic treatment by medical personnel and law enforcement officials in their hour of need, competent investigation by the police, and effective and efficient prosecutions, will bring a greater measure of relief to the victim than by forcing the accused to reveal his HIV status. It is submitted that the radical infringement of the accused's rights is being used to make up for the shortcomings in the treatment of victims, and for the failures of the policing and prosecutorial services. It is highly unlikely that the forced disclosure provisions would be deemed to be a proportionate response, and it will, in our submission, be deemed unconstitutional.

In their submissions to the Portfolio Committee, the AIDS Law Project (ALP) emphasised that a small percentage of survivors will benefit from this law.³⁷ They argued that more vulnerable groups of women and other victims of sexual assault are unlikely to benefit from this law, and identified the following groups who will not benefit:

- women who do not report rape and other forms of sexual assault, including women in coercive and abusive relationships who, for various reasons, do not define their experiences as rape
- women whose assailants are either not arrested, or are arrested outside of the statutory period
- women who are already HIV positive
- women who have been subjected to gang or group rape, where not all the perpetrators are in custody.

Furthermore, the ALP noted that it is unlikely that such legislation will benefit large numbers of male survivors of sexual assault. Most men who survive sexual assault do not report their experiences because of the high level of shame and stigma attached to these crimes, and will thus be unable to access the provisions of such legislation. It is also not clear whether such legislation will benefit men in prisons who are subject to repeated sexual violence, unless it is linked to measures to protect victims of sexual violence in prisons from further assault and they are able to access PEP and related services.³⁷

Even though the Act requires the decision of the magistrate to be made without undue delay, this is unlikely to occur. Prior to granting the order, the magistrate must be satisfied that there is *prima facie* evidence that a sexual offence had been committed against the victim by the alleged offender, that the victim may have been exposed to bodily fluids, and no more than 90 calendar days have lapsed since the date the alleged offence took place. It would be very difficult for the magistrate to come to this conclusion in an informal enquiry, in the face of a categorical denial by the accused. The magistrate would find it exceedingly difficult to determine conflicts of fact on affidavits, and may be obliged to resolve these disputes by allowing the parties to be cross-examined. The question that then arises is whether it is in the interests of the victim to be subject to a preliminary legal proceeding, and then again to the main criminal proceedings. Given the consequences of this order, it is very likely that the accused would vigorously resist these applications. The magistrate may therefore have to adopt an adversarial process to determine disputes of fact, and this could potentially be prejudicial to the victim and undermine important objectives of the Act.

Challenges associated with the practical implementation of the Act

In order for the legislation to be effectively implemented, members of court staff, police and medical and nursing staff will have to undergo extensive training. Survivors sometimes find that the police – usually the first point of contact with the criminal justice system for rape victims – are often uninformed and unsympathetic.⁶ Despite recent efforts to improve the system, a woman complaining of rape may have no choice but to give a statement to an untrained and unsympathetic male officer, within hearing of others waiting for attention. There is also a danger that the Act may overburden an already burdened police service.

Secondary traumatisation would be exacerbated if the alleged perpetrator of the rape is now acquitted and wishes to issue a counter-charge against the complainant for maliciously making an application to ascertain the HIV status of the accused.³⁸

The competence of staff who treat victims of sexual violence in the South African health sector has been questioned.^{6,7} Most of these health workers have little relevant training and see treatment for sexual violence as a minor part of their work, and so place little priority on learning from and discussing care with colleagues. They also inadequately manage clinical signs such as STIs. The provision of care has been largely developed in response to police and prosecutorial requirements, with the consequence that the physical and psychological health needs of the victim receive substantially less attention than medico-legal evidentiary issues.⁴

Hence, the health services should give precedence to the medical needs of the victim. This should include immediate and long-term psychological support, pregnancy prevention, STI treatment, and HIV counselling and treatment. Access to proficient medico-legal examinations to gather evidence for the prosecution of the accused should also be included.

In short, health workers in South Africa need specialised training in their management of victims of sexual assault.⁴

Section 7 of the National Health Act 61 of 2003³⁹ provides that health services may not be provided without the informed consent of the user, and section 14 demands confidentiality in respect of records.¹⁹ However, these sections are subject to the override of a court order. The dilemma that may confront medical practitioners is that the court order compelling forced disclosure may, from the perspective of their medical judgment, be unsound and unethical. Even if they are of this view, they will be obliged to implement the terms of the order of the court.

The Magistrates Court presently has a demanding workload and faces huge backlogs. The administration of the courts has budgetary and personnel constraints. The crime figures are daunting. In 2009/10, the SAPS had to deal with 815 280 reported cases of serious crime, including 68 332 reported rape cases.² Language barriers have also been cited as a factor needing attention, so as to give full effect to this Bill.⁴⁰

Conclusion

The Act aims to assist women who have been raped, as a vulnerable group, by enabling them to make decisions regarding their medical care, after having knowledge of the HIV status of the accused.

As argued, the forced disclosure provisions of the Act constitute a serious infringement of the various constitutional rights of the accused. The benefits that accrue to the victim are largely illusory, as the information plays no meaningful role in the treatment provided. Providing PEP and supportive measures within the prescribed time period of 72 hours occurs irrespective of knowledge of the HIV status of the accused. Ascertaining the status may in some instances induce a false sense of security, which could result in erroneous choices being made by the victim, which could then have dire health implications. The Act has the potential to burden an already overstretched public health care and justice system. Similarly, this law seeks to provide a simplistic solution that will not be in the long-term interests of Society. If we are genuinely concerned about the interests of the victims, then the solution lies in ensuring that state agencies serve them better.

What should ultimately be remembered is that HIV is an infectious disease. Every single person who is accused of sexually transmitting the virus by whatever means will at some point have been the victim of a 'transmitter' themselves. Replication and infection is the primary objective of any virus. The real criminal is perhaps not the human host, therefore, but HIV itself.

It is our submission that the law forcing disclosure of the accused's HIV status, is undesirable from a medical perspective, and the benefits do not outweigh the egregious infringements of constitutional rights. Furthermore, the forced disclosure of HIV status is disproportionate, unreasonable and inconsistent with the Constitution.

References

1. Artz L, Roehrs S. Criminal Law (Sexual and Related Matters) Amendment Act (No. 32 of 2007): emerging issues for the health sector.
2. Crime Situation in South Africa-SAPS stats. www.saps.gov.za/statistics/reports/crimestats/2010/crime_situation_sa.pdf. (accessed 14 December 2010).
3. Rape Statistics – South Africa & Worldwide 2011.
4. Jewkes R, Abrahams N. The epidemiology of rape and sexual coercion in South Africa: an overview. *Soc Sci Med* 2002;55:1231-1244.
5. South African Law Commission Discussion Paper 85 Sexual Offences: The Substantive Law (Project 107).
6. Human Rights Watch. South Africa: Violence against Women and the Medico-legal System (HRW report A904), 1997.
7. Suffla S, Seedat M, Nascimento A. Report: Evaluation of medico-legal services in Gauteng: Implications for the development of best practises in the after-care of rape survivors. Unisa Institute for Social and Health Sciences and Centre for Peace Action, 2001.
8. Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007.
9. Clinical Guidelines for the Management of HIV & AIDS in Adults and Adolescents. In: NDOH, ed. South Africa, 2010.
10. Section 28(2) of the Act.
11. AVERT.org. Post-exposure prophylaxis and pre-exposure prophylaxis, 2011.
12. Section 30(1) of the Act.
13. Section 32 of the Act.
14. Section 31 (3) of the Act.
15. Section 38(1) of the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007.
16. Constitution of Republic of South Africa Act 108 of 1996.
17. Government of the Republic of SA v Grootboom 2001 (1) SA 46 (CC) para 41.
18. Government of the Republic of SA v Grootboom 2001 (1) SA 46 (CC) para 52.
19. Minister of Health v Treatment Action Campaign (2) 2002v(5) SA 721 (CC).
20. Mazibuko v City of Johannesburg.
21. Mazibuko v City of Johannesburg, para 67.
22. The Primary Health Care Package for South Africa – a set of norms and standards. Victims of sexual abuse, domestic violence and gender violence. In: NDOH, ed. South Africa, 2000.
23. Meel BL. HIV/AIDS post-exposure prophylaxis (PEP) for victims of sexual assault in South Africa. *Med Sci Law* 2005;45:219-224.
24. Kim JC, Askew I, Muvhango L, et al. Comprehensive care and HIV prophylaxis after sexual assault in rural South Africa: the Refentse intervention study. *BMJ* 2009;338:b515.
25. HPCSA Ethical Rules, Booklet 11. Ethical Guidelines for Good Practice with regard to HIV; Booklet 12. Guidelines for the Management of Patients with HIV Infection or AIDS.
26. Section 14 of the Constitution.
27. Section 35(3) of the Constitution.
28. This expression comes from the decision of the German Constitutional Court in its Census decision, 65 BVerfGE 1(1983) as quoted in Currie and De Waal, *The Bill of Rights Handbook* (5th ed.) p. 322.
29. C v Minister of Correctional Services 1996 (4) SA 292 (TPD).
30. Mistry v Interim Medical and Dental Council of SA 1998 (4) SA 1127 at para 51.
31. Geoff Budlender has also expressed the view that the Act infringes the right to privacy and the right to bodily and psychological integrity in submissions made to the CGE workshop on the Constitutional perspectives of the bill.
32. S v Makwanyane 1995 (3) SA 391 (CC) para 104.
33. S v Manamela 2000 (3) SA 1 para 32.
34. S v Dlamini 1999 (4) SA 623 (CC) at para 220.
35. Geoff Budlender, Head of the Constitutional Litigation Department at the Legal Resources Centre, submission to the CGE workshop on the Constitutional perspective of this Bill .
36. Criminal Procedure Act 51 of 1977, Section 37.
37. AIDS Law Project: Submission on the Compulsory HIV Testing of Alleged Sexual Offenders Bill.
38. Section 38 of the Act makes it an offence for anyone to make an application with malicious intent to ascertain the status of any person.
39. National Health Act 61 of 2003.
40. Commission on Equality Gender: Submission to 'The Justice and Constitutional Affairs Portfolio Committee', 5 February 2003.