HIV/AIDS AND THE LAW IN KENYA
Preliminary Observations

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ABSTRACT

This paper discusses the legal implications of the HIV/AIDS epidemic in Kenya. It provides a general overview of the legal problems that have arisen due to the HIV/Aids epidemic. The paper discusses the nexus between policy and law and suggests a reform agenda within the context of a comprehensive law on HIV/AIDS issues.

HIV/AIDS AND THE LAW IN KENYA: PRELIMINARY OBSERVATIONS*

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INTRODUCTION

AIDS is an acronym for Acquired Immune Deficiency Syndrome. It is so named because it is acquired through the transmission of blood, blood products, semen or vaginal juices between two individuals as opposed to occurring randomly through genetic or environmental factors. It is an immune deficiency disorder in that the immune systems of affected individuals are gradually weakened over time and are thereby rendered deficient in their ability to protect the person from infection. It is precisely because the weakened immune systems of affected individuals makes them susceptible to a variety of opportunistic diseases that ordinarily would cause neither illness nor death in unaffected persons, as opposed to a single disorder, that it is designated a syndrome.

HIV is an acronym for Human Immune-deficiency Virus. It has been identified as the cause for AIDS. There is, at the present time, no test for HIV itself. Instead, current teSts detect merely whether

the infected person has produced antibodies to HIV. Since there is usually a delay between the time of exposure and a positive HIV antibody result, a person who may be infectious can produce a negative test result for the disorder. Furthermore, since the test reveals only that a person has been exposed to HIV, a positive result does not necessarily mean that the person is contagious. In addition, although almost all persons who test positive eventually develop AIDS, this period may take ten years, and during this period the individual may manifest no signs of the disorder. Indeed, there are persons from a 1979 San Franscisco study who, even today, have manifested no signs of the disorder. Finally, in addition to those who are HIV positive but who manifest no signs of the disorder and these who have full-blown AIDS, there is a third category of persons who manifest some but not all of the United States Centre for Disease Control's criteria for AIDS (reduced white blood cell T-lymphocyte count/manifestation of one or more of the opportunistic infections associated with the disorder) who are deemed to have AIDS-Related Complex or "ARC".

The number of new AIDS cases in Kenya has increased from about 843 in 1985 to about 33,902 in 1991, and yet, no plateau for the disorder is in sight. Although that was expected to occur in 1991.[1] Accordingly, the potential for HIV/AIDS epidemic to cause extensive havoc in society is indisputable. And yet, only recently have African governments begun to show sensitivity regarding the scourge and to take important steps to arrest its spread.[2] Critically, in my view, neither the law nor lawmakers have begun to respond to the crisis; indeed, hardly any discussion is heard on the issue of "AIDS and Law" in many African countries. This article therefore attempts

to outline the relationship between HIV/AIDS and the law in Kenya through five parts as follows:

I. Government intervention and the law;

II. The individual and the law;

III. Spouses and the law;

IV. The response of the criminal law to HIV/AIDS; and

V. General observations on legal issues and the HIV/AIDS epidemic.

We shall see that a specific law(s) is/are yet to be developed to address this epidemic and, therefore, only earlier public health standards, general tort law, some criminal sanctions and constitutional principles are available as legal instruments which can be canvassed to respond to the epidemic before a comprehensive legal regime is instituted.

1. GOVERNMENT INTERVENTION AND THE LAW

a. The Right of the Community to Know the Magnitude of the Epidemic.

Since, to date, no cure has been developed for HIV/AIDS, adequate information on the nature, extent and effects of the epidemic, aimed at introducing or enhancing citizens' degree of responsibility in their social behaviour, is critical. For example, since we know that HIV/AIDS can be transmitted through semen and vaginal fluids, and since we know that condoms, although not foolproof, can dramatically reduce the risk of transmission in heterosexual and male homosexual intercourse, all individuals need to know and internalise the fact that every act of reckless sexual activity, and permissiveness in general, is, consciously or not, suicidal. Similarly, since we know that the disorder can be

transmitted through blood, and now further that intravenous drug users who share and re-use hypodermic syringes (because of purchase of new sterile syringes is illegal in many countries) can virtually eliminate the risk of HIV/AIDS transmission by sterilising their syringes in boiling water or washing them in chlorine, failure to take these precautions is suicidal.

Up through the present time, the government has issued general policy statements on AIDS. Regarding the right to information, it has said:

> The people have a right to all relevant knowledge about AIDS and related infections and problems:
>
> That through information, education and communication, people will be helped to make informed decisions in adopting life styles that do not favour transmission and spread of AIDS.[3]

Sections 79 of the Constitution, which guarantees, inter ilia, freedom to receive ideas and information from prior restraint by the government (absent Official Secrets Act prohibitions) and permits citizens to communicate with other citizens without interference from the government (whether the communications is to the public generally or to any person or class of persons in particular) buttresses the above policy position.

It is crucial for the community to possess extensive information on HIV/AIDS so that behaviour can be moulded and remoulded consistent with such knowledge. Presently, much of the reckless behaviour stems from ignorance or inadequate knowledge.[4]

Currently, then, there exists a dearth of information in the country on the spread of the epidemic.[5] In learned conferences in the country, little has been developed by way of comprehensive and

accurate data. The Ministry of Health@s Sentinel Surveillance for HIV Infection and Sexually Transmitted Diseases has just completed the task of compiling HIV/AIDS frequency data.[6] On the whole, then, general information as gleaned from the media suggests the spread is alarming without always making the information more concrete. Due to the above situation, citizens and politicians, especially, normally feel health officials are merely exaggerating the situation. And yet, some of the studies undertaken have painted a bleak state of affairs. For example, among low income prostitutes -- a high risk group -- in Pumwani and Majengo in 1981, 4% were HIV positive; in 1986 60% were HIV positive; and by 1991 90% were HIV positive.[7] A study of recently delivered mothers in Pumwani Maternity Hospital showed that of the 1,507 respondents, 94 (or 6.2%) were HIV positive.[8] This sample as considered representative of HIV infection among the general population of that community. Other information about the magnitude of the epidemic originates from international and regional (especially health) bodies, Non-Governmental Organisations (NGOs) and outside researchers.

In our context, government may feel that HIV/AIDS information should/will be kept secret for the following reasons:

1. To avoid undue alarm;
2. To prevent economic dislocation (due, for example, to deleterious effects on tourism and investment);
3. To prevent indiscriminate or incorrect information from being disseminated;
4. To present dysfunctional behaviour due to hopelessness produced by dissemination of unrelentingly pessimistic information;

5. To remain within its proper role of not preventing people from receiving information (as opposed to actively providing information;

6. To uphold the public interest by withholding information under the Official Secrets Act;[9]

7. To conform its activities to the meagre health research resources available to it within the expansive health sector.[10]

Be that as it may, Section 79 of the Constitution requires, generally, that government provide full information on any matter. Such information would include the extent of HIV/AIDS spread. Indeed, a citizen could, in court, endeavour to compel the government to gather more information, conduct more research, and disseminate the same, a.though the court may qualify such a right consistently with the argument of non-availability of research resources.

b. Mandatory HIV Testing

Mandatory testing for any individual or group (done as a legal requirement) is against policy in Kenya.[11] Individuals are therefore left to determine if and when they with to be tested. The above government policy position recognise the fact that any benefits to be derived from mandatory testing are far outweighed by the ensuing disadvantages due to the following reasons:

1. Mandatory testing is extremely expensive since each of the available tests developed thus far cost about $75.00 (2,100 Kenya Shillings) per test. Who would bear this expense, particularly for indigent low income persons?

2. Mandatory testing can open an avalanche of discriminatory

practices because even the mere fact that people are categorised as eligible for mandatory testing is enough to cause them to be treated by society as suspect.

3. Mandatory testing may give a false sense of security since the existing tests are not foolproof. One can test negative and yet be positive and vice-versa. If two tests are done with the result that one is positive and the other negative, those who deal with the tested person may not be satisfied that she/he is actually HIV/AIDS free.

4. During the "window period", HIV testing may not yield any useful results since detectable antibodies are as yet to develop.

5. To the extent that the avenues of getting infected with HIV/AIDS are known and can be avoided by individuals, the HIV/AIDS disease may not therefore require the extreme measure of mandatory testing.

HIV testing can take several forms. Voluntary testing occurs with the consent of the person tested. Mandatory/compulsory testing is done as a legal requirement irrespective of the subject's consent. Unlinked testing occurs if a blood sample is not labelled with the name of the person from whom it is taken. Anonymous testing occurs when the identity of the person from whom the blood is drawn is not obtained and she/he is identified instead only by a numbered code known only by her/him.

Several legal questions have arisen regarding mandatory testing. Some of the key ones are:

i. Should couples preparing to marry or re-marry be tested? Obviously such a requirement introduces prudence on the part of

the parties. If one party tests positive, the other could reconsider the marriage. Some churches have been requesting intended spouses to be tested. The argument of the churches is that marriage requires freedom from diseases which could hinder legitimate sexual intercourse and procreation, which are central to the institution. Moreover, if the majority in a church favour mandatory testing before marriage, any dissenting minority would compromise the freedom of worship and association of the majority were its minority position upheld. The churches argue further that any person denied the sacrament of marriage would be free to receive the same from another church (or denomination) or have the union blessed in a civil ceremony.

Individuals who do not favour testing before marriage argue that churches have no legal right to demand testing on pain of refusing to celebrate the marriage since that would compromise the right of worship of the individual who does not want to move to another church or denomination or temporal authority to solemnise her/his marriage. Moreover, if the church were allowed to insist on testing for HIV/AIDS, the church could soon demand mandatory testing for other less threatening diseases or even any disease. Also, given present social behaviour patterns, testing may be superfluous at the marriage stage.

Up to this moment, no person has filed a court challenge against any church's request for mandatory testing. Perhaps not many churches require such testing and the few that do merely recommend rather than require it. In my view, the courts would most probably approve a church's injunction regarding mandatory testing because courts do not normally question a church's internal rules. In my

view, the courts would even be more sympathetic to a church which calls for mandatory testing for widows and widowers, and especially if the deceased spouse's death involved an AIDS-related disorder.

ii. Should Pre-and Post-Employment Screening by Employers be Allowed?[12]

In keeping with classical contract law, some employers have argued that mandatory testing before employment is legally sound since both parties are free to bargain for contractual terms, and therefore the employer can have as the requirement of employment that testing be done. So long as all potential employees are treated similarly so that no prospective employee can allege discrimination, it is argued the employer can insist on pre-employment screening as part of the threshold interview conditions.

However, any potential employee including a HIV/AIDS infected person can counter the above argument thus: pre-employment screening is discriminatory in that it seeks to exclude the potential employee from employment for reasons which do not bear on his/her ability to perform the job. HIV/AIDS infected persons can and do perform their respective jobs as well as other persons. Moreover, employees can lose their job if it is shown that any disease affects their ability to perform the job satisfactorily. Also there is no risk either to customers or co-workers by the HIV/AIDS infected person unless the job requires her/him to come into contact with their blood, e.g., health care workers, and they may be dealt with separately. Therefore, mandatory pre-employment screening, in general is discriminatory and illegal.[13] However, such testing, in my view, is sound and should be legal in employment where an employee can infect

others, e.g. surgeons, dentists and other health care providers. For this category of employees, the potential for causing harm to others in high and therefore testing them potentially benefits the public. The Medical and Dentists Practitioners Board should mover more emphatically in this direction.[14]

After employment, mandatory testing is illegal.[15] An HIV/AIDS infected employee's employment can be terminated if they can no longer perform the job, not because they have HIV/AIDS.

iii. International visitors could be subjected to mandatory testing and especially those who: (1) will stay in the country for a long period of time; (2) come from high risk countries; (3) belong to high risk groups; or (4) are from states where such testing is required for entry.

A policy of testing international visitors may discourage some visitors. e.g. tourists, although it is meant to safeguard the national population from further spread of HIV/AIDS. In some countries such as India and Canada foreign students must be tested before entry.[16]

iv. Periodic Mandatory Testing of high risk group populations

High risk population groups include (1) prostitutes and their clients; (2) barmaids; (3) truck drivers; (4) salesmen; (5) prisoners; (6) drug addicts; (7) those infected with sexually transmitted diseases; (8) homosexuals; and (9) promiscuous individuals. However, confining periodic mandatory testing to such persons might amount to discrimination under Section 82 of the Constitution which, inter ilia, provides:

> [N]o person shall be treated in a discriminatory manner by a person acting by virtue of any written law or in performance of the functions of a public office or a public authority.

Therefore, isolating high risk groups and then treating them differently from the rest of the population in such a manner that their members suffer harm, can amount to negative discrimination which is disapproved by the Constitution. Furthermore, it is difficult to identify many of the persons who come within these categories. In addition, even if a positive test were revealed, what could be done vis a vis such persons in light of the previously discussed protection against discrimination?

v. Periodic mandatory testing for sexually active persons.

However, this is alarmist (perhaps verging on paranoia) and is exceedingly expensive.

vi. Periodic mandatory testing for those manifesting symptoms of HIV infection

vii. Periodic mandatory testing upon request of a spouse or sexual partner.

The idea here is to assist a spouse or sexual partner in determining whether they have contracted HIV/AIDS where they have strong reasons to believe that their partner is engaging in risky behaviour or have reasons to believe the partner is infected. However, a better way of determining an individual's HIV status, is simply to be tested instead of requiring testing for the spouse/partner. If mandatory testing is allowed under these circumstances, a large potential for abuse by an angry spouse/sexual partner, or by someone who wants to humiliate others exists.

ix. Mandatory testing of alleged rapist upon victim's request.

As has been stated earlier, mandatory testing is against government policy. The constitution would bar it as discriminatory, constituting inhuman treatment (Section 74) and infringing personal liberty (Section 72). Section 74(1) provides:

> No person shall be subject to torture or to inhuman or degrading punishment or other treatment.

Section 72(1) provides:

> No person shall be deprived of his personal liberty save as may be authorised by law.

Arguably mandatory testing is inhuman and degrading punishment. It also amounts to torture to the extent that the person who is being tested is exposed to a lot of anxiety from the time testing starts until its conclusion. Moreover, if the results are negative, the person is exposed to torture presumably for the rest of her/his life.

To achieve mandatory testing, coercion may be necessary where the individual prefers not to be tested. Here, personal liberty and privacy of the individual would be compromised.

However, absence of mandatory testing can potentially violate the rights of others, e.g. right to life (Section 71) where infected persons continue to relate with others in ignorance. Obviously, if infected persons know of his/her status and abstains from conduct which can spread the disease, then they would not endanger the lives of others, e.g., if HIV positive person is not having sex/sharing blood with others or

she/he discloses her/his status to her/his sexual partners and uses a condom.

Although a rapist could, when required, to subject himself to mandatory testing allege infringement of Sections 72 and 74 as outlined above, provisions contained din those sections allow

mandatory testing in favour of the victim since her health is implicated pursuant to the criminal activity of the rapist. It would also be advisable for the victim to subject herself to testing.

To conclude this segment, it is important to point out that future developments in policy and law in this area should ensure a balancing of individual rights and the state's duty to protect the public. As the epidemic grows without the prospect of a cure, more persistent demands and acceptance of mandatory testing in certain limited situations, which we have alluded to above, is likely to occur.

c. Who can be told the results?

Upon testing, confidentiality of results is critical. This is meant to encourage people to volunteer for testing. It has been observed:

> Intentional or unintentional breaches of confidentially destroy the trust that is essential between the testing programme staff and individuals/groups involved and may have a serious and sometimes irreversible effect on the programme. Handling and storage of records must be such as can make it impossible for any undesired person to obtain results of and (sic) individual tested.[17]

Confidentiality then should be the rule for results as well as counselling. If seropositive people are known within the community then they can be discriminated against in practice although the law bars discrimination. Also, the doctor-patient relationship is privileged; what is discussed between both should not be divulged. However, under the Public Health Act,[18] reports of infectious diseases are communicated to the Ministry of Health. These are general results and need not divulge identities of subjects. There are some legal issues relating to the question of confidentiality.

These are:

i. If an individual says she/he does not want to be told her/his results and she/he is positive, should she/he be told or not? Presently she/he has the right not to be informed although her/his subsequent behaviour may hurt others.

ii. Does a spouse or even an intimate friend have the right to know the results of her/his partner? According to the present policy, the answer is no. Not even if the spouse/friend is HIV positive.

iii. If, during blood transfusion or other medical treatment, it is discovered that an individual is HIV positive, there is no legal requirement to inform her/him.

iv. An employer or relative has no right to be told of an individual's results.

v. In the process of contact tracing, an individual is usually asked to identify previous sexual partners. This, strictly speaking, compromises the confidentiality of those who are identified. However, it is felt that community protection requires contact tracing by health personnel who keep the information confidential.

However, infected persons have not co-operated in divulging their HIV/AIDS status and their contacts primarily because they have no tangible incentive to do so. The benefits to them are next to nil (no cure for the disorder), the risk of discrimination is high (even if laws against this exists in the books), employer and others can discriminate by using a legal reason to mask illegal discrimination, most persons in high risk groups have never been favoured by society and thus do not trust society, etc. Contact tracing will be

strengthened where HIV/AIDS patients feel they are genuinely protected against discrimination.

vi. "Going Public" by a spouse or partner without the consent of the other spouse or partner infringes that other person's confidentiality. People who might wish to go public have a responsibility to consult their partners since they are exposing them as well. "Going Public" in this context, means revealing one's HIV-positive status so that the subject can counsel and educate members of the public.

d. making drugs available

There has been pressure the world over for governments to approve drugs which are in an experimental stage and/or their curative potential is undetermined or dubious. Even individuals take governments to court wishing to pressure for release of such drugs, the main argument being that certifiably HIV- positive persons would in any event die irrespective of any harm which may be caused by the experimental drug. Already such a case is in Kenya courts.[19] The above tug of war did exist for AZT, MMI, Kemron, etc. In Kenya, laws exist which have the aim, inter ilia of ensuring drugs are properly developed, tested and found to be medically valuable before being allowed onto the market[20]. This ensures patients are not exposed to ineffective drugs. If an open door policy vis a vis new drugs existed, quacks would be encouraged to originate miracles cures. Although such "cures" may offer psychological succour as a supplement to counselling, they give patients unfounded hope and should, therefore, be discouraged.

A counter argument to the above runs thus: the law in Kenya may

not adequately balance between protecting the public and protesting drug companies and the medical establishment to the extent that there exists an expensive and drawn out process to approve new drugs through the agency of the Pharmacy and Poisons Board. Indeed, Kenya seems to wait until drugs are approved abroad in their country of origin before approval for sale in this country is granted. New drugs, particularly those manufactured by small companies, may take longer to be approved internationally and in Kenya.

In my view, AIDS drugs should be sufficiently scrutinised to ensure that their medical value is established without making the process too long and drawn out since there is great demand for drugs in this area.

e. experimentation

Medical science heavily relies on research and experimentation. It is accepted that new drugs and procedure can be tried on human beings, particularly after protracted successful trials on animals. However, it is illegal to use human beings as "guinea pigs" for experimental purposes by exposing them to unquantifiable and unpredictable harm. Such exposure is inhuman treatment in contravention of Section 74 of the Constitution to the extent that the individual's life and health are exposed to major risk without any scientific benefit necessarily accruing from the experiment. As a result, such experimentation is barred absolutely or undertaken only where;

i. Volunteers are consenting after full disclose of the risks involved:

ii. the risks of harm to the volunteer is minimal in light of results from animal experimentation.

iii. the volunteers are already infected and, therefore, exposure to infection is not a factor.[21]

HIV/AID experimentation, e.g. vis a vis development of vaccines on human beings, given present knowledge regarding the disease, can be a very risky affair. Therefore, such experimentation must be undertaken in the context of maximum precaution.

f. Quarantine.[22]

This public health control measure is not generally allowed for HIV/AIDS patients under the law although it could assist in controlling spread of the disease. Quarantine would constitute discrimination under Section 82 of the Constitution since a group of persons would be excluded from the rest of the community for no sufficient medical or other reason except fear and prejudice. It is a fact that the HIV/AIDS condition is not necessarily highly infectious since the reckless behaviour that is its principal cause can be avoided by individuals.

Usually, home care and counselling are favoured, particularly during the advanced stages of the disease. In excluding the possibility of quarantine, society shows that the epidemic is not overwhelming society but it is manageable. And after all, it is not easy to identify infected persons even if quarantine measures were approved.

Where, however, an individual becomes a direct danger to others by, for example, executing deliberate acts which are likely to infect others, such individual can be quarantined so as to remove or immunise such danger. However, even in such circumstances, there must still exist effective measures to prevent discrimination. For

example, an infected person may desist from using condoms because she/he is worried that spouse/sexual partner will then infer s/he is HIV positive and tell all. Such a person may end up spreading the disease in order not to risk exposure and the ensuring discrimination.

g. Denial of rights to procreation for HIV/AIDS infected persons.

The right to procreate and raise a family is safeguarded under religious law, domestic family law,[24] and international instruments [24]An unborn child, however, subject to laws permitting abortion, has a right to be born healthy.[25] It has therefore been argued that HIV infected persons should not be allowed to procreate. However, not all children of HIV positive mothers became infected with the disorder. If denial of rights to procreation are exercised here. society embarks on a slippery slope; demands for similar denial of rights to procreation for imbeciles and others may be urged. Those who favour limiting of rights to procreation for infected persons urge that infected men and women can be surgically operated on to ensure cessation of reproductive ability, or their procreation can be criminalised.

h. Explicit a advertisement in Mass Media:

An end to "beating around the bush"

Before the AIDS scourge, communities all over the world were very sensitive to sexually explicit advertising in the mass media. Today, relevant knowledge on HIV/AIDS demands advertisements which explain the situation explicitly. For example, advertisements on condom are now regular. Indeed, the HIV/AIDS epidemic is transforming cultural norms relating to sexual behaviour so that, for

example, more discussion on sex between parents and children is now acceptable.

i. Revision of customary las and practices

Another area where government intervention is urgently required to stem the possible spread of the epidemic is revision of some customary laws and practices which encourage spread of the disease. These are:-

i. scarification and traditional circumcision in which unsterilised instruments are used:
ii. ritual sexual intercourse with a diseased brother's wife;
iii. polygamy;
iv. early marriage under customary law in which the bride may not have the freedom to refuse a partner who may be infected, or the bride is too young to make an evaluation:
v. widow or widower inheritance:

Although it is obvious these changes need to occur, it is always difficult to effect attitudinal change even where the law is changed. Counselling and the provision of an endless flow of information will aid in changing the above habits.

II. THE INDIVIDUAL AND THE LAW RELATING TO HIV/AIDS.

We have already discussed some of the points regarding the above. For example, we have seen:

i. Testing must be confidential and cannot be mandatory:
ii. An individual's employment may not be terminated due to infection;[26]

iii. HIV infection is not transmitted via ordinary social contact;

iv. HIV/AIDS patients and individuals have to be treated as normal people because any other treatment amounts to discrimination. For example, they may not be legitimately excluded from public facilities or ordered to quit rented premises, etc.

Other areas where the individual is affected by laws relating to HIV/AIDS are:

a. Minimum age for consensual sex

This should be raised from the present 14 years[27] to 18 years. After majority age, individuals are better placed to take decisions on sexual behaviour knowing the consequences.

b. Insurance

Currently, lifeinsurance companies require to know the HIV/AIDS status of their potential clients. They can legitimately refuse to assure life if a potential client refuses to test or tests positive. If a person gives incorrect information on HIV/AIDS status, the insurance company can ultimately refuse to pay. However, during the "window period" when a test will be negative since no antibodies detectable by laboratory testing exist (that is within 5 weeks after contact with infected agent) a potential assurer cannot be held liable for giving information discounting infection. It is permissible for doctors to complete insurance forms disclosing a person's HIV status without breaching confidentiality since the individual seeking insurance is deemed to have consented to disclosure of the information. In the U.S.A. this is widespread.

Gerald M. Oppenheimer, et al., have commented on the above phenomenon that:

> In summary, health insurance as it has developed in the United States is very conservative. it requires a high degree of knowledge of utilisation patterns and risk, and it is not entirely adequate for unusual epidemic or very expensive diseases or groups of persons believed to be higher than average health care users. It is precisely on these grounds that AIDS threatens the private health insurance system.[28]

Kenya's health insurance system is still very small and will tend to exclude HIV/AIDS patients. Insurers requires ab initio testing so that they can exclude some individuals from the schemes.

III. SPOUSES AND THE LAW.

We have already seen that "going public" must accommodate the confidentiality of the other spouse. Hence, consent from the other spouse is necessary. A right of one spouse to inform the other of infection should exist. However, fear of divorce dissuades passing this information from one spouse to the other.[29]

Upon knowledge of infection, a spouse can and should refuse exercise of conjugal rights by the other. Even where both spouses are infected, protected sex with use of condoms is advocated to minimise re-infection with the virus and other organisms. Lack of re-infection may prolong the life of the spouses or one of them with all the advantages that has.

An interesting issue is whether HIV/AIDS infection should be a ground for divorce or separation. It must be acknowledged that sexual activity is only one possible- although the most notable -- cause of infection. Thus, one has to prove that HIV/AIDS is a function of adultery so that adultery is the primary ground of

divorce or separation. It may be possible for a non - infected spouse to argue that continued marital association with an infected spouse amounts to cruelty for which separation can be granted. In jurisdictions where marriages can be dissolved due to irretrievable breakdown, it may be argued that HIV/AIDS infection of one spouse constitutes irretrievable breakdown of marriage especially since some of the basic functions of marriage cannot be accomplished within the context of infection.

IV. THE RESPONSE OF THE CRIMINAL LAW TO HIV/AIDS

The HIV/AIDS epidemic may trigger an expansion of the criminal law arena. Since HIV/AIDS infected persons can potentially expose non-infected members of society to extremely high risk, particularly in a scenario where no cure exists, there is likely going to be demands that criminal law should address any deliberate life threatening activities. Several areas come to mind in the sphere of criminal law. In this segment, I admittedly pose more questions than propose solutions. Nevertheless, the areas for inquiry are:

a. Should a person who knowingly and wilfully infects another with HIV virus be accused of attempted murder or (where the victim dies) manslaughter?

b. Should rape be a capital offence particularly if the rapist;

   i. knows that he is infected,

   ii. is infected but does not know, or

   iii. in all cases of rape (whatever the HIV/AIDS status of the rapist)?

c. Should criminal sanctions for knowingly spreading a venereal disease be strengthened with respect to sexual and other activities known to transmit AIDS engaged in by HIV positive persons?

d. Should criminal sanctions against homosexual activity be more strongly enforced or perhaps strengthened?

e. Should criminal sanctions against illegal drug peddling and use be more strongly enforced or perhaps strengthened?

f. Should criminal sanctions against owning and managing brothels more strongly enforced or perhaps strengthened?

g. Should criminal sanctions against living off the earnings of prostitution be more strongly enforced or perhaps strengthened?

h. Should present criminal sanctions against attempted suicide be modified for persons with HIV/AIDS?

i. Should euthanasia be decriminalised for persons with HIV/AIDS?

j. Should abortion be decriminalised for persons with HIV/AID?

k. Should criminal sanctions against medical personnel from endangering patients (through negligent use of unsterilised syringes and/or other equipment, for example be more strongly enforced rf perhaps strengthened?.

A necessary prelude to a discussion of the above questions is that HIV/AIDS infected persons may not easily control activities which may enhance spread of the epidemic. For example, drug addicts are often sick individuals who need medical care rather than criminal sanctions. Prostitutes are driven by economic considerations rather than a love for prostitution per se. Even if they were addicted to the practice of prostitution, this would constitute psychiatric condition needing medical attention. In the above instances or similar ones, criminal law sanctions may not, therefore, help much in assisting the infected individuals and in arresting the epidemic.

a. There are some instances where persons upon learning that they are HIV/AIDS infected have proceeded to engage indiscriminately in activities calculated to spread the disease. Such persons show an utter disregard to the health and life of others. Although such initial behaviour and reaction may be triggered by fright, this may be one area where criminal law may wish to intervene more forcefully. Currently, such persons may be charged with the offence of spreading an infectious disease. However, the acts undertaken by them can constitute attempted murder.[30] Where the innocent party dies as a consequence of the wilful infection, a manslaughter charge may be appropriate. Some difficulties in this area are:

i. proving conclusively the source of infection.

ii. proving that the disease which causes death can be directly linked to prior HIV infection.

A. person who behaves as described above may not be guilty of murder because it may not be possible to prove malice aforethought, and secondly, the law as it exists requires that death

occurs within a year and a day after the act which contributes to the death.[31]

b. If a rapist commits rape knowing he is infected and that he is likely to spread the disease which, in turn, will kill the victim, such rape should be treated as extra-ordinary rape amounting to both rape and attempted murder for the reasons discussed in section (a), above. Where the raped person subsequently dies from causes traceable to the HIV infection, the rapist should be tried for manslaughter. Although rape is and should be treated seriously by the courts, it is particularly appropriate due to the HIV/AIDS scourge to treat this offence as an extremely serious offence, and particularly so with respect to sentencing. Presently, courts, in my view, often hand down non-deterrent sentences for rape.

c. The Penal Code and the Public Health Act criminalise spread of venereal and communicable disease. Section 28 (1) of the Public Health Act states:

> Any person who, suffering from a venereal disease, or having reasonable cause to know, exposes others to the risk of infection, shall be liable to a fine not exceeding four thousand shillings or not more than six month's imprisonment or both.

To the extent that HIV is transmitted sexually, the above provision may be applicable.[32]

Section 186 of the Penal Code provides:

> Any person who unlawfully or negligently does any act which is, and which he knows or has reason to believe to be, likely to spread the infection of any disease dangerous to life is guilty of a misdemeanour.

The general punishment for misdemeanours is imprisonment for a term not exceeding two years or a fine or both.[33]

In my view, legislators, as I have stated above, should more

pointedly criminalise sexual or other activities known to transmit HIV/AIDS by a person who knows she/he is infected.

d. In Kenya homosexuality is already criminalised.[34] Serious debates have not really raged on the propriety of legalising homosexual conduct between consenting adults in private. Given that homosexual activity is a key factor in the incidence of infection, calls for effective detection and presecutions for it, as required by existing law, are likely to be made. However, it should be noted that homosexuality has existed from time immemorial and criminalisation has not vanquished or deterred it. Furthermore, there is no evidence that decriminalisation or non-enforcement of present law in other jurisdictions promotes homosexuality. The reason is obvious, issues as basic to one's own identity as one's sexual orientation are not affected by the law (except to the extent that such activity is simply buried further and further underground). In light of the nature of HIV transmission it is doubtful whether forcing people to have "quickie" homosexual sex in dark alleys, or the back seats of cars (to avoid detection) will encourage safe sex. It is likely to do just the opposite. Furthermore. increased criminal sanctions will reduce the chances that those infected will come forward or tell their partners (or anyone else).

Because of the above reasons, criminal law may as in (a) (b), above, intervene more pointedly where deliberate and wilful activity is carried out whose effect is to spread the infection.

e. Detection and treatment for drug related offences need to be improved upon. Existing criminal sanctions per se may not deter the activities. Indeed, increasod criminal sanctions for drug use will only decrease the likelihood that addicts will sterilise syringes

(instead, they will "shoot" drugs as quickly as possible to reduce the risk of detection). However, criminal law may target more pointedly those engaged in illegal distribution of drugs.

f. The punishment for owning and managing brothels for economic gain under Section 156 of the Penal Code is not stiff enough. Brothels are breeding grounds for infection. Punishment should be enhanced.

g. Prostitution is not a criminal offence in Kenya. It is, however, an offence to live on the earnings of prostitution.[35] The criminal law may not, therefore, be able to reach prostitutes and their clients in a bid to the spread of the infection except through Section 182 of the Penal Code which provides:

> The following persons.
>
> (a) every common prostitute behaving in a disorderly or indecent manner in any public place;
>
> (e) every person who without lawful excuse publicly does any indecent act;
>
> (f) every person who in any public place solicits for immoral purposes....
>
> are guilty of a misdemeanour.

As indicated earlier on, criminal law may not easily suppress prostitution if its underlying economic causes are not removed as well as the reasons which make clients seek prostitutes. Perhaps a regulatory regime through which prostitutes are checked regularly for infection and instructed on safer sex will provide a lower risk of harm to themselves, their customers, and the public generally.

h. Attempted suicide is a criminal offence in Kenya.[36] AIDS patients are subject to immense societal and personal pressures.

Suicide attempts by them should therefore be understood in that light. Many AIDS patients seem to reason thus: since death will surely come, it is better to hasten it and thereby exclude pain for self and relatives and unnecessary economic expenses. Although such reasoning is not necessarily right, its logic can be appreciated. In my view, where HIV/AIDS infected persons attempt suicide, more sympathy and understanding should be demonstrated by the courts just as in other cases where the patients have terminal diseases, e.g. terminal cancer. This should be much more so for those in the terminal stages of the disorder as opposed to those who are merely HIV-positive (and may live for years and benefit from a future cure).

i. Perhaps the question of euthanasia will be seriously revisited due to the HIV/AIDS epidemic. In the past, it has been stressed that human life must be allowed to continue until a natural end. The HIV/AIDS epidemic is likely to revive the euthanasia debate as patients with advanced manifestations of the disease in the absence of a cure ask for a right to die.

j. Abortion law [27] should be more liberal, particularly where the expectant mother has HIV/AIDS since the risk of foetal infection is high and if the child is borne s/he is likely to die at a tender age after living a non-productive, unhealthy life. Obviously, changes in abortion law would address all other diseases which ensure the child does and cannot survive long after birth.

k. Section 218 of the Penal Code enjoins all medical personnel to take reasonable precautions in the practice of medicine to ensure that the life and health of patients are not endangered during surgical and medical treatment. Negligent use of unsterilised syringes and other equipment, transfusion of blood products prior to

testing, etc. fall under this category because they can cause spread of HIV/AIDS and thereby endanger life and health.

It is all easy , as I have done in some instances, to require criminalisation and stiff penalties for conduct that can potentially spread the infection. However, it has to be remembered that victims need sympathy and often may not be able to easily control their conduct. Criminal law has to develop a response cautiously in this area.

V. GENERAL OBSERVATIONS ON LEGAL ISSUES AND THE HIV/AIDS EPIDEMIC

Where a person is infected by another, it is possible to sue in tort. For example, if "A" infects "B" can sue in tort. "A" could be a simple individual or a health services provider, e.g. a dentist. Health personnel may, in the future, be exposed to such suits. Also, health personnel can sue their employer if they are exposed to infection during the course of their employment and the employer did not take sufficient precaution to prevent infection.[38] Other persons, such as those who perform circumcisions in traditional societies, may also be affected. Additional legal issues would arise for those:

a. given an infected blood product if testing is overlooked or inadequate,

b. whose confidentiality is breached,

c. defamed, particularly by innuendo, as suffering from HIV/AIDS when they in fact, are not.

Many areas for potential law suits in this area are likely to grow .

Secondly, adoption law [39] will need to be re-examined to

provide for relatively easy adoption. Many children will be orphaned after losing their parents to AIDS [40]

Thirdly, those who discovered drugs and processes or improve on drugs and processes related to HIV/AIDS will need adequate protection. Kenya's present patent law [41] offers such protection, particularly where originators of drugs competently secure their interest vis a vis collaborating foreign scientists.

Fourthly, mortgage law, just like insurance laws, will have to adjust to the HIV/AIDS reality because, when death occurs subsequent to taking a mortgage, the outstanding amount is not charged to the deceased's estate. Before entering into the above risk, mortgage companies may specially need to determine the HIV/AIDS status of their clients.

Fifthly. succession law may need to be changed so as to, inter ilia:

i. offer greater protection for orphans in light of HIV/AIDS epidemic,

ii. make it easier for terminally will persons to finally arrange their affairs,

iii. prevent succession from A to B if A wilfully infected B with HIV.

In the near future, it will become necessary to derive a comprehensive law on HIV/AIDS and related conditions. Such a law would assist in ensuring a frontal attack on the disease. This comprehensive law could, inter ilia:

i. further sensitive people on the problem,

ii. tie all the legal questions arising of the epidemic and which are currently tackled in various statutes.

iii. create concrete institutional infrastructures to deal with the epidemic. For example, it will be critical to enhance infrastructures for counselling and home care.

CONCLUSION

Although I have addressed legal issues relating to the HIV/AIDS epidemic, it is necessary to emphasise that measures to combat the epidemic must ensure:

i. Mobilisation of immense resources to the health information and education sectors. Economically, the epidemic which is affecting the most productive section of the population is going to cost the country a lot. The country should prepare for this;

ii. Fear is removed and replaced with knowledge so that people don't act from panic. Therefore, more research is necessary so that accurate findings are arrived at and disseminated;

iii. Counselling and home care are continuously strengthened since they will be critical until a cure is found;

iv. Intolerance against infected persons is reduced. Some of the approach to combating the epidemic may ensure that liberalism takes a back seat. This has to be continuously fought against if society is to stay level headed;

v. A continuous balancing of individual rights and state responsibility to protect non-infected individuals and the public in general.

Law can and is likely to play an important role in controlling the epidemic , especially in the context of developing comprehensive legislation to address it. The law, like society itself, must be human in dealing with HIV/AIDS infected individuals.[42]

END NOTES

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1. See Ministry of Health, Sentinel Surveillance for HIV and Sexually Transmitted Diseases in Kenya. Provisional Projections, September, 1991 (Mimeo). The cumulative AIDS cases were approximately 1080 in 1985 and 89,566 in 1991.

2. See Sam Gonza, "Death Calls the Tune," Executive, September 1991 at 14, col. 1, where it is noted:
Even as the disease threatens to reverse the gains of past decades in health care and development, leaders dither over recognising, let alone tackling, the crisis.

3. See Sobbie A. Z. Mulindi, Wajibu, Vol.6, No.2 (1991) at 4.

4. Of course, there are those who, even in the context of adequate knowledge, prefer to bury their heads in the sand like the proverbial ostrich.

5. Recently, a controversy arose as to the number of HIV carriers in the country. The Deputy Director of Medical Services reported that about 700,000 persons were HIV positive, with 40,000 of them having been confirmed as being AIDS infected. Such figures did not include undetected and unreported cases especially in rural areas. See The Standard, October 16, 1991 at 1, col. 1. Subsequently, the correctness of such figures was challenged by politicians in Parliament. See the Daily Nation, October 17, 1991, at 1, col. 2. Upon this challenge, the then Director of Medical Health stated that the cumulative number of persons with AIDS since 1984 was 19,000 and the projected number untested carriers was 200,000.

6. Report on the Proceedings of the Update Workshop on HIV Sentinel Surveillance, November 1990 - Compiled by Muia, E> G. & Muthamia, L. N. for AIDS Programme Secretariat ("APS").

7. Curriculum for training of trainers for improved management of Sexually Transmitted Diseases: Epidemiology Section, University of Nairobi and CIDA, April 1990.

8. M. Temmerman, et al., "Impact of Single session post-partum counselling of HIV infected women on their subsequent reproductive behaviour", AIDS Care, Vol.2, No.3, 1990 at 249.

9. Chapter 187, Laws of Kenya

10. Already concern is being expressed that HIV/AIDS research is taking away research funds from some of the traditionally more fatal diseases, e.g. malaria.

11. Ministry of Health (Kenya), National Guidelines for HIV Testing and Serosurveillance, December, 1988 at 3.

12. On the subject of AIDS and the workplace, see generally, Haron Wachira, "AIDS in the Workplace", Executive, September 1991 at 13, col. 1.

13. See generally, American Civil Liberties Union, EPIDEMIC OF FEAR: A SURVEY OF AIDS DISCRIMINATION IN THE 1980's AND POLICY RECOMMENDATIONS FOR THE 1990's: A REPORT OF THE ACLU AIDS PROJECT at 22-23 and passim (1990); see also, Cap. 226, Laws of Kenya.

14. This is the board which, inter alia, licenses doctors and dentists for purposes of practice under Cap.253, Laws of Kenya.
I wish to point out that surgeons, dentists, etc., are likely to view mandatory testing as discriminatory and an harassment, particularly since they ar enot allowed to demand mandatory testing for their prospective patients who could also infect them and indeed pose a greater danger of infecting the doctors than vice versa. Moreover, if the doctors refuse to be tested, then the health delivery system could be seriously compromised.
The main reason why I recommend mandatory testing for the above special class of health workers is that one infected individual can potentially expose all prospective patients to harm whereas the patients will expose only one peson to danger.

15. Ministry of Health (Kenya), December 1988, National Guidelines (sic) on Couselling for HIV Infection at 3, where it is stated:
Confirmation of HIV infection or AIDS in an employee provides no grounds for refusal of employment or dismissal.

16. As a result of this requirement, a scandal developed in this country when some unscrupulous employees at Kenyatta National Hospital started selling HIV/AIDS free certificates to untested persons whose HIV/AIDS status was, of course, unknown.

17. See supra n. 11 at 3 and supra n. 6 at 38-39. See also Ministry of Health, Sentinel Surveillance for HIV and Sexually Transmitted Diseases in Kenya (Mimeo) at 6. But see also supra n. 15 at 16 where it is observed:

> strict confidentiality is a constraint because it contradicts the Kenyan cultural set up where all is shared by the community .... Strict individual confidentiality could jeopardize the community support

required in counselling and incrase the myths surrounding AIDS.

18. Cap. 242, Laws of Kenya.

19. See Joe Muriuki v. Attorney General and Medikem International, Ltd., discussed in Daily Nation, August 9, 1991, at 5, col. 1, Daily Nation, August 28, 1991, at 3, col.5, and The Standard, August 28, 1991, at 2 in which Muriuki, the Chairman of the Know AIDS Society, has sued the Ministry of Health and Medikem, seeking a court order allowing the sale of Immunex.

20. See the food, Drugs and Chemical Substances Act, Cap. 254 ibid.

21. See Kivutha Kibwana. Fundamental Rights and Freedoms, Nairobi, Oxford University Press. 1990, at 33-34.

22. Fora discussion of this aspect of the law, see, Moses M. S. Kakoi, "AIDS and the Law: A Jurisprudential Analysis of the Implications of a Public Health Crisis", an unpublished LL.B. dissertation submitted to the University of Nairobi, April 1990, at 13-21.

23. All Kenya"s marriage laws, that is, African, Islamic, Hindu, and Western-type Christian family law system safeguard this right.

24. See e.g., Articles 12 and 16, Convention on the Elimination of All Forms of Discrimination Against Women.

25. Attempting to procure an abortion by a subject or another person is a criminal offence in Kenya. See Sections 158, 1259 and 160 of Cap. 63. Limited abortion rights are allowed only where the health of the mother is seriously endangered upon such certification by a medical doctor. But see Daily Nation, October 30, 1991, at 28, col.3, "Task Force Urged to Erase Abortion Laws".

26. But see Barbara Gerbert, et al., "Physicians and Acquired Immunodeficiency Syndrome," JAMA, October 13, 1989, at 1969 col. 1, in which, from a sample of 2,000 respondents (response rate 75%), 45% believed that physicians with HIV should not practice and 60% of surgeons should not operate.

27. See 145, Penal Code, Cap.63

28. AIDS and Health Insurance; Social and Ethical Issues, 2 AIDS AND PUBLIC POLICY J. 11, 12 (Winter 1987).

29. See M. Temmerman, et al., supra n. 7, at 249.

30. Section 220, Cap. 63.

31. Section 215(1), Cap. 63 provides:
A person is not deemed to have killed another if the death of that person does not take place within a year and a day of the cause of death.

32. The provision may be inapplicable for non-sexually transmitted HIV cases unless all HIVB cases are redefined as diseases encompassed by the section.

33. Sec. 36, Cap. 63

34. Sec. 162, 163, 164 and 165 id.

35. See. 153 and 154, id.

36. See 226, id.

37. Secs. 158 and 159, id.

38. Incidentally, health personnel, especially doctors, cannot legally refuse to treat patients with HIV/AIDS. As consequence, their employers must provide adequate protection for them.

39. Cap. 143, Laws of Kenya.

40. See Susan S. Hunter, Orphans as a Window on the AIDS Epidemic in Sub-Saharan Africa; Initial Results and implications of a Study in Uganda, SOCIAL SCIENCE AND MEDICINE, Vol.31, No. 6, 1990, AT 681-690.

41. Industrial Property Act No. 19 of 1989. See also J. B. Ojwang, The Protection of innovations and Inventions: The Patent System. A Public Debate, Kenyatta International Conference Centre, Room 5 & 6, December 9, 1988.

42. See Moses m. S. Kakoi, "AIDS and the Law, etc.," supra n. 22, at 72-73.