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Duty to Warn of the Risk of HIV/AIDS Infection in Africa: An Appropriate Legal Response?

Dr. Obiajulu Nnamuchi* & Dr. Remigius N. Nwabueze**

I. INTRODUCTION

At an international colloquium on building local jurisprudence and expertise for health law in Nigeria,[1] one of the authors chaired a group session composed of health law experts in Nigerian universities, in which an issue arose as to the existence of a physician's duty of disclosure with respect to HIV/AIDS infection in Africa. Starkly presented, the question was whether a physician who competently diagnosed an African female patient of HIV/AIDS infection is legally bound to disclose the test result to the patient's husband or partner. Quite unsurprisingly, most of the participants passionately argued against disclosure. But that did not end the debate that is increasingly assuming center stage in the legal, medical and bioethical communities of sub-Saharan African countries.[2] Concern amongst scholars in these fields about a female patient suffering from HIV/AIDS infection reflects the gender inequality and general disempowerment of women in most African countries.[3] In most cases, the disclosure of HIV status carries untoward consequences for an African woman, including violence resulting in death or serious injury, abandonment, and ostracism.[4] This means that female victims of HIV/AIDS are the ones most likely to object to the disclosure of their seropositive status[5] to their husbands or partners.

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1. Colloquium, Building Local Jurisprudence and Expertise on Health Law and Reproductive Rights (2008).

2. See generally Francis Masiye & Robert Ssekubugu, Routine Third Party Disclosure of HIV Results to Identifiable Sexual Partners in Sub-Saharan Africa, 29 THEORETICAL MED. & BIOETHICS 341 (2008); Paul Ndebele et al. HIV/AIDS Reduces the Relevance of the Principle of Individual Medical Confidentiality among the Bantu People of Southern Africa, 29 THEORETICAL MED. & BIOETHICS 331 (2008).

3. See A. Dhai, HIV and AIDS in Africa: Social, Political and Economic Realities, 29 THEORETICAL MED. BIOETHICS 293, 293-94 (2008).

4. Id. at 294–95.

5. The term "seropositive status" refers to a state of being positive in a test for the

The concern as to whether physicians have a mandatory duty of disclosure in HIV/AIDS cases may seem trite and unimaginative, considering that several western legal systems have generally settled in favor of a physician's duty or power to disclose a patient's sero-status to identifiable sexual or needle-sharing partners.[6] Nonetheless, the gender and cultural rationales that animated the opposition against disclosure demonstrates that the disclosure regime in most western legal systems cannot be easily transplanted to Africa without significant reflection and analysis. Special and critical policy factors in Africa warrant a contextual analysis of whether a duty of disclosure to third parties should be imposed on a physician whose patient suffers from HIV/AIDS.

This article examines the issue of involuntary sero-status disclosure in Africa by analyzing the relevant statutory regime and the potential response of the law of negligence in common law African countries, including the imposition of a duty on physicians to warn of the risk of HIV infection. We conclude that while Africa presents an interesting mix of regimes on partner notification obligations, policy considerations deriving from the potential for violence against an HIV positive African woman are likely to militate against the development of a judicial "duty to warn."

In framing the discussion and concluding as we did, we are not in any way unmindful of the fact that there could possibly be issues, such as the tort liability of physicians and other health professionals for unauthorized disclosure of HIV positive status or the liability (civil and/or criminal) of an infected individual for deliberately or negligently infecting others,[7] which some might consider relevant to this subject. While not denying the relatedness of these issues, we deem them somewhat tangential and, for brevity reasons, outside the purview of this discourse.

II. STATUTORY DUTY TO WARN IN CONNECTION WITH HIV/AIDS IN AFRICA

Pearshouse trenchantly remarked that the region of West Africa is "one

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presence of an antibody to HIV.

6. See generally JAMES CHALMERS, LEGAL RESPONSES TO HIV AND AIDS 53-78 (2008) (summarizing confidentiality and duties to warn in the case of HIV patients); Roger S. Magnusson, A Decade of HIV Testing in Australia Part 2: A Review of Some Current Debates, 18 UNSW L.J. 364, 391-407 (1995) (discussing Australia's approach to dilemmas between confidentiality and HIV care); Donald G. Casswell, Disclosure by a Physician of AIDS-Related Patient Information: An Ethical and Legal Dilemma, 68 CAN. B. REV. 225 passim (1989) (discussing the ethical and legal obligations of physicians regarding disclosure of sero-positive tests); Mylène Beaupré, Confidentiality, HIV/AIDS and Prison Health Care Services, 2 MED. L. REV. 149 passim (1994) (discussing the United Kingdom's legal approach to balancing the need of disclosure and the interest of confidentiality).

7. See Z v. Finland, 25 Eur. Ct. H.R. 371, ¶ 16, ¶ 108 (1997).

of the most 'legislated' regions in the world (if not the most legislated) when it comes to HIV."[8] This is equally true for the southern African region where member states of the Southern African Development Community (SADC) are in various stages of adapting and adopting model HIV/AIDS laws, initiated by the Southern African Development Community Parliamentary Forum (SADC PF) and approved at its 24th Plenary Assembly Session in Arusha, Tanzania, 2008.[9] HIV/AIDS specific legislation has been promulgated in African countries of Benin,[10] Guinea,[11] Mali,[12] Guinea-Bissau,[13] Niger,[14] Togo,[15] Sierra Leone,[16] Kenya,[17] and Mauritius.[18] Other African countries in the process of developing similar legislation include Cameroon, Chad, Senegal, Côte d'Ivoire, Cabo Verde, Angola, the Democratic Republic of Congo, Malawi, Madagascar, Tanzania and Uganda.[19] HIV/AIDS specific legislation in the West and Central African regions is based on a model HIV/AIDS law developed by the Action for West African Region – HIV/AIDS (AWARE-HIV/AIDS) and approved in a regional workshop held in N'djamena, Chad in 2004.[20] While the national laws above provide for various issues and activities relating to HIV/AIDS, the focus of this article is on the provisions relating to the duty to warn of the risk of HIV/AIDS infection.

The SADC PF model law, for instance, does not embody a mandatory disclosure requirement. Rather, section 15(4) permits the notification of a

8. Richard Pearshouse, Legislation Contagion: the Spread of Problematic New HIV Laws in Western Africa, 12 HIV/AIDS POL'Y & L. REV. 5, 5 (2007).

9. MODEL LAW ON HIV IN S. AFRICA (S. Afr. Dev. Cmty. Parliamentary Forum 2008).

10. The Law on Prevention, Care and Control of HIV/AIDS, 2006, No. 2005-31 (Benin).

11. Law on Prevention, Care and Control of HIV/AIDS, No. 2005-25 (Guinea).

12. Law Establishing Rules Relating to the Prevention, Care and Control of HIV/AIDS, 2006, No. 06-28 (Mali).

13. Framework Law Relating to the Prevention, Treatment and Control of HIV/AIDS (Guinea-Bissau).

14. Law Relating to the Prevention, Care and Control of Human Immunodeficiency Virus (HIV), 2007, No. 2007-08 (Niger).

15. Law on the Protection of People with respect to HIV/AIDS, No. 2005-012 (Togo).

16. The Prevention and Control of HIV and AIDS Act, 2007 (Act No. 8/2007) (Sierra Leone) [hereinafter Sierra Leone].

17. HIV and AIDS Prevention and Control Act (2006) (Kenya) [hereinafter Kenya].

18. HIV and AIDS Act 2006 (Act No. 31/2006) (Mauritius) [hereinafter Mauritius].

19. Edwin J. Bernard, Criminal HIV Transmission and Exposure Laws Spreading around the Word 'Like a Virus,' AIDSMAP NEWS (August 7, 2008), http://www.aidsmap.com/en/news/B250DD99-C534-4C29-A078-EDF602EFB615.AS.; see also Pearshouse, supra note 8, at 5.

20. FAMILY HEALTH INTERNATIONAL (Sep 2004), AWARE Holds Regional Workshop on a Model Law on STI/HIV/AIDS available at http://www.FHI.org/en/CountryProfiles/West Africa/res_modellaw.htm; see also Pearshouse, supra note 8, at 5.

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patient's HIV/AIDS status to a third party subject to certain conditions: (a) the intended recipient of the information is at immediate risk of HIV transmission, (b) the person living with HIV refused to inform the third party at risk of HIV transmission after appropriate counseling, (c) the person living with HIV was informed of the intention to communicate his or her HIV status to the third party, and (d) the disclosure must not expose the person living with HIV to physical violence.[21] Section 15(4)(c) of the SADC PF model law further provides that involuntary disclosure of HIV status might be permitted where the HIV-infected person is dead, incompetent or unlikely to regain consciousness and "there is or was a significant risk of transmission of HIV by the person living with HIV to the sexual partner(s)."[22]

In contrast, Article 26 of AWARE-HIV/AIDS's model law, which inspired similar provisions in West and Central African regions, "requires a person diagnosed with HIV to disclose his or her HIV status to a 'spouse or regular sexual partner' as soon as possible and at most within six weeks of the diagnosis.[23] The testing centre shall be required to disclose to spouses or sexual partners after six weeks."[24] Surprisingly, Uganda, a member state of SADC, has proposed HIV/AIDS legislation that not only embraces the broad partner notification provision above but goes farther in authorizing disclosures of HIV status to any "third party with whom an HIV infected person is in close and continuous contact including but not limited to a spouse."[25] Pearshouse noted that HIV/AIDS legislation in Niger, Mali and Togo faithfully reproduced the AWARE-HIV/AIDS model law's provision on the "duty to warn".[26]

But not all African countries embraced the mandatory disclosure requirement above. HIV/AIDS legislation in Sierra Leone, for instance, empowers, but does not compel, physicians to disclose HIV test results.[27] The Sierra Leonean statute provides strict confidentiality of HIV test results in sections 15 and 18.[28] The statute stipulates that where a person fails to "take all reasonable measures and precautions to prevent the transmission of HIV to others"[29] and neither informed, in advance, "any sexual contact or

21. SADC PF MODEL LAW, supra note 9, §15(4).
22. SADC PF MODEL LAW, supra note 9, § 15(4), at 16.
23. Pearshouse, supra note 8, at 6.
24. Id. at 7.
25. Human Immunodeficiency Virus Control Bill (2008), at § 14 (Uganda).
26. Pearshouse, supra note 8, at 9.
27. See Sierra Leone, supra note 16, § 18.
28. See id. at § 21(1)(a).
29. See id.

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person with whom needles are shared, of that fact,"[30] nor required "any medical practitioner. . . to inform and counsel a sexual partner of the HIV status,"[31] then a medical practitioner responsible for the treatment of that person "may inform any sexual partner of that person, of the HIV status of that person."[32]

The Sierra Leonean approach resonates with the cautious and measured disclosure requirement under the SADC PF model law. Yet a few African countries, like Mauritius, impose a strict ban on the disclosure of "any information concerning the result of an HIV test or related medical assessments to any other person".[33] Exceptions are made, however, for voluntary disclosures of HIV status and disclosures ordered by a court or made to a treating heath care worker or for purposes of epidemiological study, research and compilation of statistical data.[34] Otherwise, the Mauritian legislation simply requires that a person who tested positive to HIV should be counseled on "the importance [of disclosing] his status to his spouse, sexual partner or children."[35] Kenyan HIV/AIDS legislation substantially mirrors the Mauritian legislation on the issue of disclosure.[36] Nigeria, on the other hand, has no HIV/AIDS specific legislation, but a pending bill – National Health Act 2008 (passed by both Houses of the legislature and awaiting Presidential assent) – containing a general provision for the confidentiality of all health information, including HIV/AIDS status, with exceptions for voluntary disclosures and disclosures made in the interests of public health or ordered by the court.[37] As the analysis above shows, it may be surmised that while Africa presents an interesting mix of disclosure regimes, the legislative trend, especially in the West and Central African regions, generally favors a duty to warn of the risk of HIV/AIDS infection.

III. COMMON LAW DUTY TO WARN

Absent statutory regulation, as highlighted above, whether or not there exists a duty to warn of the risk of HIV/AIDS infection ultimately depends on the dynamics of common law, particularly the law of negligence. Where

30. See id. at § 21(1)(b).
31. See id. at § 21(4).
32. See id. at § 21(7)-(8).
33. Mauritius, supra note 18, at § 13(4).
34. See id. at § 13(4)(a)-(d) and (5).
35. See id. at § 11(2)(b)(iii).
36. Kenya, supra note 17, at § 22.
37. An Act to Provide a Framework for the Regulation, Development and Management of a National Health Systemand Set Standards for Rendering Health Services in the Federation, and Other Matters Connected Therewith (2008) § 26 (Uganda).

such duty exists, failure to discharge its burden would expose a physician to negligent liability. For most commentators,[38] Tarasoff v. The Regents of the University of California is the foundational case for the existence of a duty to warn in the analogical context of HIV/AIDS.[39] There, in the course of treatment, a mental health patient confided to his psychotherapist his intention to kill a woman who had rebuffed his advances.[40] Acting upon a report by the therapist, the campus police promptly detained the patient.[41] The therapist did not inform the woman about the threat. Following his release from detention, the patient murdered the woman.[42] One of the central questions the Supreme Court of California addressed was whether the therapist had a duty to warn the deceased about the threat on her life.[43] The court held that a therapist who knows or ought to know that "a patient poses a serious danger of violence to others . . . bears a duty to exercise reasonable care to protect the foreseeable victim of that danger," and since the therapist failed in this duty, he was liable to plaintiffs.[44]

The decision has been widely adopted in some American jurisdictions[45] but explicitly rejected in others.[46] As to whether the reasoning is applicable in the context of HIV infection, there is no unanimity of opinion. Denying its applicability, some scholars point out that in Tarasoff, a direct physical violence against an identified individual was threatened, but such is not the

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38. See Lawrence O. Gostin & James G. Hodge, Piercing the Veil of Secrecy in HIV/AIDS and Other Sexually Transmitted Diseases: Theories of Privacy and Disclosure in Partner Notification – Contact Tracing, the 'Right to Know,' and the 'Duty to Warn', 5 DUKE J. GENDER L. & POL'Y 41, 43 (1998); Carrie Gene Pottker-Fishel, Improper Bedside Manner: Why State Partner Notification Laws are Ineffective in Controlling the Proliferation of HIV, 17 HEALTH Matrix 158, 159 (2007); Christine E. Stenger, Taking Tarasoff Where No One Has Gone Before: Looking at "Duty to Warn" under the AIDS Crisis, 15 ST. LOUIS U. PUB. L. REV. 471, 480-2 (1996); Richard O'Dair, Liability in Tort for the Transmission of A.I.D.S.: Some Lessons from Afar and the Prospects for the Future, CURRENT LEGAL PROBLEMS 236, 236 (1990).

39. See generally Tarasoff v. The Regents of the Univ. of California, 551 P.2d 334 (Cal. Sup. Ct. 1976). Compare with the Australian case of Harvey & 1 ors v. PD [2004] NSWCA 97 (Austl.) (held that a doctor has a duty to prevent onward transmission of HIV/AIDS as between two of his patients).

40. Id. at 341.

41. Id.

42. Id.

43. Id. at 342.

44. Id. at 345-6.

45. Turner v. Jordan, 957 S.W.2d 815, 819-21 (Tenn. 1997); People v. Sergio, 864 N.Y.S.2d 264, 266 (N.Y. Sup. Ct. 2008); Emerich v. Phila. Ctr. for Human Dev., 720 A.2d 1032, 1036-37 (Pa. 1998).

46. See Thapar v. Zezulka 994 S.W.2d 635, 638 (Tex. 1999) (holding that confidentiality statute governing mental health professionals in Texas trumps Tarasoff–type common law duty).

case with HIV-infected patients.[47] They admit that although an HIV-infected person poses a risk to others, there is generally a lack of intent to infect anyone.[48] The distinction, they note, is that in one the threat is active but passive in the other.[49] This argument seems persuasive, especially in terms of finding of culpability based on whether one actively pursued a course of action or vice versa. Nonetheless, no court in the U.S. has declined to apply the holding in Tarasoff on the basis of the distinction sought to be drawn. For instance, in Lemon v Stewart, in which appellants/family members of an HIV patient who took care of him sued his physician for failing to warn them of the patient's HIV seropositive status, the court showed no concern for this distinction.[50] As far as the Court was concerned, the crucial issue was whether appellants could show that they were "identifiable potential victims of non-disclosure and were in significant and foreseeable risk" of infection by the patient.[51] The Court went on to explain the transmission mode of HIV, noting distinctly that the virus is transmitted through exchange of bodily fluids such as blood, semen, vaginal fluids and breast milk.[52] One is infected by engaging in unprotected sex, needle-sharing and breastfeeding and not through casual contact.[53] None of the appellants fell within any of these relationships.[54] Had any of them been a sexual or needle-sharing partner of the patient, the Court concluded, the person might have been able to make a claim that he or she was a reasonable foreseeable victim of a breach of a duty to warn.[55]

Whether the holding in Tarasoff would sway common law courts outside the U.S. remains to be seen. But as O'Dair observed, Tarasoff evinces two characteristics that diminish its utility in England: First, it involves liability for an omission, contrary to the traditional view of English courts recognizing only a moral duty to act.[56] Second, Tarasoff imposes liability on a defendant for the deliberate wrongdoing of a third party (patient).[57] This traditional view seems to have been altered by the leading case of The

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47. E. J. Kermani & B. A. Weiss, AID and Confidentiality: Legal Concept and Its Application in Psychotherapy, 43 AM. J. PSYCHOTHERAPY 25, 29 (1989).

48. Id.

49. Id.

50. Lemon v. Stewart, 682 A.2d 1177, 1182 (Md. Ct. Spec. App. 1996).

51. Id.

52. Id.

53. Id. (quoting Faya v. Almaraz, 620 A.2d 327, 445 (1993).

54. Id. at 1182-83.

55. Id. at 1184.

56. O'Dair, supra note 38, at 236-37; Smith v. Littlewoods Organisation Ltd. [1987] AC 241, (H.L.) 271; MARGARET BRAZIER & EMMA CAVE, MEDICINE, PATIENTS AND THE LAW 86-87 (Penguin Books 4th ed. 2007); CHALMERS, supra note 6, at 71.

57. O'Dair, supra note 38, at 237-38.

Home Office v. Dorset Yacht Co Ltd.[58] In that case, the House of Lords reversed the Appeals Court, holding that the Home Office was liable for damage caused to the plaintiffs' yacht by escapees from its borstal home on the ground that borstal officers owe a duty to exercise reasonable care to prevent boys under their control from causing damage to private property.[59] On the strength of this reasoning, O'Dair concluded that an English court would impose a duty of disclosure on physicians, but only as to the "carrier's current partner and any child of that person infected in utero."[60]

Apart from Tarasoff, a duty to warn of the risk of HIV/AIDS infection could be deduced by analogy from a line of cases on contagious diseases in which such duty had been established.[61] In these cases, as in Tarasoff, the decisive factor was foreseeability of harm to a third party, rather than the existence of physician-patient relationship and confidentiality conundrum.[62] But care should be taken in the extrapolation of contagious diseases cases to HIV/AIDS scenario. In contrast to contagious diseases, HIV/AIDS is not transmitted by social contact, nor can a sufferer claim inability to act responsibly towards third parties in order to avoid the spread of the virus. This is unlike a person suffering from a contagious disease whose responsible individual efforts might not necessarily translate to protection for others. Hence, O'Dair observed that the "contagious disease case . . . do not go so far as to make the doctor liable for the socially irresponsible behaviour of his patient. . . they cannot be decisive in the A.I.D.S. context".[63] Therefore, since neither Tarasoff nor the jurisprudence on contagious diseases provides a convincing analogy for the existence of a duty to warn in the context of HIV/AIDS, the issue ought to be considered from a principled standpoint that is, the mechanics for determining the

58. See The Home Office v. The Dorset Yacht Co. Ltd. [1970] A.C. 1004 (H.L.) (held that the Home Office was liable for damage caused to the plaintiffs' yacht by escapees from its borstal home on the ground that borstal officers owe a duty to exercise such care as is reasonable to prevent boys under their control from causing damage to private property).

59. See id.

60. O'Dair, supra note 38, at 239.

61. See Bradshaw v. Daniel, 854 S.W.2d 865, 872 (Tenn. 1993) (held that a physician who treated a woman's husband for Rocky Mountain Spotted Fever owed a duty to warn the woman of the risk of contracting the disease, regardless of non-existence of a physician-patient relationship with her); Skillings v. Allen, 173 NW 663, 664 (Minn. 1919) (a physician who failed to advise parents that they were in danger of contracting scarlet fever from their daughter, patient of the physician, was found liable for negligence); Jones v. Stanko, 160 N.E. 456, 458 (Ohio 1928) (held that a physician who treated a patient afflicted with smallpox - a contagious disease- had a duty to give notice of the existence of the disease to other persons who are known by the physician to be in dangerous proximity to the patient).

62. Tarasoff, 551 P.2d at 342.

63. O'Dair, supra note 38, at 235.

existence of a duty of care in negligence.

IV. DUTY OF CARE

As a conceptual framework, "duty of care" in negligence aims to limit the liability of a wrongdoer based on the existence of a legally specified relationship with a claimant; otherwise, a wrongdoer would be liable to everybody injured by his or her tortious act.[64] Thus, the duty concept is relational in nature.[65] Prosser and Keeton famously declared "duty of care" is "not sacrosanct in itself, but is only an expression of the sum total of those considerations of policy which lead the law to say that the plaintiff is entitled to protection."[66] Therefore, a determination as to whether a duty exists in any situation is mainly a policy decision with full legal coloration. This view accords with the opinion of scholars and the jurisprudence in most common law countries.[67] In Vu v. Singer Co., for instance, the court opined that a duty of care is determined by balancing certain policy factors including the foreseeability of harm to claimant, the degree of certainty that clamant suffered injury, the closeness of connection between defendant's conduct and injury suffered, the moral blame attached to defendant's conduct, the policy of preventing future harm, the extent of burden to defendant and the consequences to the community of imposing a duty to exercise care with resulting liability and the availability, cost, and prevalence of insurance for the risk involved.[68]

In contrast to the U.S., Canada and England adopt a more methodical and layered approach to finding a duty of care in negligence. In Cooper v Hobart, the Supreme Court of Canada set out a tripartite framework for evaluating the duty of care.[69] Under this framework, a claimant must first establish the defendant's foreseeability of harm and proximity of relationship. Successful discharge of this burden means that a prima facie duty of care has been established. Consequently, the burden shifts to the defendant to establish any policy factor that ought to limit or negate the duty established by the claimant. This last stage of duty analysis is laden with policy considerations and invites the evaluation of policy factors

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64. See Generally Percy H. Winfield, The History of Negligence in the Law of Torts, 42 L.Q.R. 184 (1926).

65. W. PAGE ET AL. (EDS.) PROSSER AND KEETON ON THE LAW OF TORTS § 53, at 356-58 (West 5th ed. 1984).

66. Id. at 358.

67. See Lewis N. Klar, Judicial Activism in Private Law, 80 CAN. B. REV. 215, 221 (2001); W.H.V. ROGERS, WINFIELD AND JOLOWICZ ON TORT 128 (2002).

68. Vu v. Singer Co., 538 F. Supp. 26, 29 (N.D. Cal. 1981) (citing Tarasoff, 551 P.2d at 344).

69. Cooper v. Hobart, [2001] 206 D.L.R. 193 (Can.).

outside the relationship between the parties, such as the impact of the potential duty of care on other legal obligations, the legal system and the society generally. The observation of Lord Bridge in the leading English case of Caparo Industries PLC v. Dickman shows that there is not much difference between the Canadian and English approach to analysis of the duty of care.[70] For historical reasons, Nigeria and other common law African countries, whose law of negligence is relatively embryonic, are likely to follow the Cooper / Caparo framework above.[71]

A. Foreseeability

Applying the duty frameworks above to the context of HIV/AIDS, it is relatively easy to establish the foreseeability of harm. It is reasonable to expect that a physician, sure of his or her patient's HIV/AIDS diagnosis, would enquire about the patient's sexual or needle sharing partner and, where known, would inform that partner of the patient's HIV/AIDS infection. In other words, a physician could reasonably foresee that non-disclosure of a patient's HIV/AIDS status might harm the patient's partner. A physician would have a hard time proving that an HIV/AIDS patient's partner's risk of infection was not foreseeable. As Reisner v. Regents of University of California made clear, it is immaterial whether the partner is both unknown and unidentifiable.[72] In that case, the appellant, who became infected with HIV virus as a result of sexual intimacy with his girlfriend, sued her doctor for not disclosing to her that she had received tainted blood during a blood transfusion and was HIV positive.[73] Appellant did not claim that the physician owed him a duty to be warned.[74] Instead, he argued that had his girlfriend been warned about her HIV status, she could have taken precautions against transmitting the disease to him or given him notice so he could protect himself.[75] Because appellant's risk of exposure to HIV through sexual intimacy with his girlfriend was foreseeable, the court held the doctor liable because his duty extends to appellant notwithstanding the

70. Caparo Indus. Plc. v. Dickman, [1990] 2 A.C. 605 (appeal taken from H.L.) ("What emerges is that, in addition to the foreseeability of damage, necessary ingredients in any situation giving rise to a duty of care are that there should exist between the party owing the duty and the party to whom it is owed a relationship characterized by the law as one of "proximity" or "neighbourhood" and that the situation should be one in which the court considers it fair, just and reasonable that the law should impose a duty of a given scope upon the one party for the benefit of the other.").

71. See GILBERT KODILINYE, THE NIGERIAN LAW OF TORTS 38-89 (1982) (a chapter discussing negligence).

72. Reisner v. Regents of Univ. of California, 31 Cal.App.4th 1195, 1197 (1995).

73. Id. at 1195.

74. Id. at 1199.

75. Id.

absence of a special relationship between the two.[76] Thus, establishing foreseeability for the purpose of a duty to warn in connection with HIV/AIDS does not pose a significant problem. Klar even suggested that there is no known case where a claimant failed on foreseeability grounds.[77]

B. Proximity

Proximity is a much more difficult hurdle. The term itself is conclusory in nature and amounts in "effect to little more than convenient label[s] to attach to the features of different specific situations which, on a detailed examination of all the circumstances, the law recognizes pragmatically as giving rise to a duty of care of a given scope."[78] This renders proximity a double-edged sword capable of utilization by both the claimant and defendant. A claimant might establish proximity on the basis of a physician's knowledge that his or her patient's HIV/AIDS infection poses a serious risk of injury to the claimant and other identifiable partners of the patient. To succeed, the claimant must be able to establish the existence of a relationship from which it is clear that she is at risk of infection. As Lemon amply demonstrates, casual contact would not suffice.[79]

V. POLICY CONSIDERATIONS RELATING TO DUTY OF CARE

As mentioned above, residual policy analysis is the last stage of the tripartite duty frameworks. In the context of HIV/AIDS, relevant policy considerations include the impact of a potential duty to warn on a physician's already existing obligations of privacy and confidentiality towards his or her patient, the need to avoid undermining the physician-patient relationship, and a physician's suitability for the performance of notification duties. Others include the enforcement of coercive notification laws, success of notification laws in reducing the spread of other sexually transmitted disease, prevention of HIV infection, and accentuation of the plight of already vulnerable populations.

A. Impact on Other Legal Obligations: Privacy and Confidentiality

A major policy consideration is the impact of a potential duty to warn on

76. Id. at 1195; But see N.O.L. v. Dist. of Columbia, 674 A.2d 498, 499 (D.C. 1995). (The D.C. Court of appeal came to a contrary conclusion, that no duty to warn was owed to appellant whose wife tested positive for HIV. The law in force does not permit such disclosure without the written consent of the wife or a court order and since no such consent or order was issued, no duty was owed to appellant).

77. Klar, supra note 67, at 215.

78. Caparo, 2 A.C. at 618.

79. Lemon, 682 A.2d at 1182.

other legal obligations of a defendant-physician, such as the obligations of privacy and confidentiality imposed on a physician for the benefit of a patient. In evaluating the existence of a duty of care, courts are usually conscious of the correlation between the alleged duty and an existing legal obligation. For instance, in C.B.S. Songs Ltd. v Amstrad Consumer Electric PLC, the House of Lords refused to recognize a duty of care on the part of a manufacturer of tape-to-tape domestic audio system, which could facilitate copyright infringement, on the ground that to do so would subvert the statutory regime on copyright.[80] Similarly, it is arguable that imposing on a physician the duty to warn third parties of the risk of HIV/AIDS infection would infringe the physician's obligation of privacy and confidentiality toward the patient.

The dual obligation of respecting the privacy of patients and maintaining confidentiality of their medical information has long been recognized as central to the practice of medicine. Although privacy and confidentiality are sometimes used interchangeably, the two concepts are not synonymous.[81] Privacy refers to the right of everyone to "control access to and/or distribution of personal information, property, and or knowledge of personal behaviors."[82] As Warren and Brandeis tersely, but famously, put it, it is the "right to be let alone."[83] Each of us is entitled to a "zone of privacy" upon which no one may intrude save with our permission. Our eating habits, sexual preferences or choice of dressing are considered private matters that may not be interfered with in the absence of a justifiable cause.[84]

Confidentiality, on the other hand, simply means keeping intimate information about a person secret.[85] There is a legal as well as an ethical obligation to keep secret information revealed to another in circumstances

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80. C.B.S. Songs Ltd. v. Amstrad Consumer Electric Plc., [1988] 2 A.C 605 (H.L.).

81. In England, however, privacy is not yet recognized as giving rise to an independent tort: Kaye v. Robertson, [1991] F.S.R. 62; R v. Khan, [1997] A.C. 558; Wainright v. Home Office, [2004] 2 A.C. 406 (H.L.). But following the introduction of the Human Rights Act of 1998, incorporating Article 8 (privacy) of the European Convention on Human Rights, English law now recognizes the values of privacy through the equitable cause of action for breach of confidence. See Gavin Phillipson & Helen Fenwick, Breach of Confidence as a Privacy Remedy in the Human Rights Act Era 63 M.L.R. 660, 661 (2000). See also Douglas v. Hello [2008] 1 A.C. 1 (H.L.).

82. Evan G. DeRenzo, Privacy and Confidentiality, in FLETCHER'S INTRODUCTION TO CLINICAL ETHICS 87-88 (John C. Fletcher, Paul A. Lombardo & Edward M. Spencer eds., University Publishing Group, Inc., 3rd ed. 2005).

83. Samuel D. Warren & Louis D. Brandeis, The Right to Privacy, 4 HARV. L. REV. 193, 195 (1890).

84. See DeRenzo, supra note 82.

85. For a detailed judicial analysis of the cause of action for breach of confidence see Attorney-General v. Guardian Newspapers Ltd., (No. 2) [1990] 1 A.C 109 (H.L.).

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warranting such expectation. In clinical practice, information which a physician acquires by virtue of the existence of a physician-patient relationship may not be divulged to a third party without the consent of the patient or his duly authorized representative.[86] Commentators trace the origin of this duty to Hippocrates, the father of modern medicine.[87] From physicians, the Hippocratic Oath – the oldest ethical code and upon which most modern medical codes of ethical conduct are based – explicitly requires: "What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself, holding such things shameful to be spoken about."[88] Authoritative today as in ancient Greece, this principle is definitive of the environment that guides physician-patient relationship from initial consultation until cessation of the relationship.

Several rationales undergird the principle. First, an understanding that what is said in the course of a therapeutic relationship is to be used solely for the benefit of the patient creates an environment that facilitates frank and open discussion of the totality of the patient's circumstances. Without this protection and the comfort zone it creates, patients would be on constant guard as to the kind of information they share about themselves. This sometimes leads to less candid relationship, with detrimental consequences for the patient. The assurance that patient information is secure with the physician is crucial to the healing process. The more information a patient is willing to disclose, the better informed the physician is about his or her condition, placing the physician in a better position to provide appropriate therapy.

The second justification for confidentiality is prevention of harm that might result to the patient should his or her medical history fall into wrong hands. There are numerous conditions that people suffer from which they would like to be kept secret out of concern about adverse consequences that might befall them should the condition become known. This is particularly

86. Doe v. City of New York, 15 F. 3d 264, 267 (2nd Cir. 1994); Campbell v. MGN Ltd., [2004] 2 A.C. 457 (H.L.) (The House of Lords accepted that medical information is confidential in nature).

87. Martha Swartz, Is There a Duty To Warn?, 17 HUM. RTS. 40, 42 (1990).

88. Ludwig Edelstein, CROSS-CULTURAL PERSPECTIVES IN MEDICAL ETHICS 4 (Robert M. Veatch ed.,2nd ed. 2000). This quote could however be read as mere declaration against gossip, without developing a specific and clear ethical duty on confidence. CHALMERS, supra note 6, at 60. Modern ethical codes have, however, developed more lucidly defined ethical duties of confidence. AMERICAN MEDICAL ASSOCIATION, CODE OF MEDICAL ETHICS CURRENT OPINIONS WITH ANNOTATIONS §§ 5.00-5.09 (1997); See generally World Medical Association, International Code of Medical Ethics (2006), available at http://www.wma.net/en/30publications/10policies/c8/index.html.pdf?print-media-type&footer-right=[page]/[toPage].

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true of HIV/AIDS patients given their vulnerability to rejection, abandonment, violence and other forms of social stigmatization.[89] A powerful argument by gay rights groups and human rights campaigners is the fear that test results might be released to people that could stigmatize or in some other ways negatively treat the individual would hardly incentivize testing.[90] Without assurance of secrecy about their seropositive status, these patients would be unlikely to seek treatment. Finally, without confidentiality, some patients might decline treatment entirely, thereby threatening public health.

Despite its value, confidentiality obligation is not absolute but subject to the dictates of public health and individual security.[91] For example, the Court of Appeal in W v. Egdell held that the publication of a confidential medical report concerning a person suffering from mental illness was not in breach of confidence as it was necessary in the interest of public safety.[92] In other words, entitlement of patients to confidentiality and associated privacy interests are not sacrosanct and do not override other rights such as the right to be healthy.[93] At issue here is the legitimacy of prioritizing the privacy rights of the HIV patient over the pressing need to protect his partners or others at risk of infection. As previously stated, the duty to maintain confidentiality, while important, is not absolute.[94] Rather, it is what philosophers term a "prima facie duty," and therefore must yield to superior claims in appropriate circumstances.[95] A duty is considered prima facie when it is required to be performed unless a more important consideration dictates otherwise. As the Tarasoff court aptly noted: "The protective privilege ends where the public peril begins."[96] Put differently,

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89. See Jane M. Simoni & David W. Pantalone, Secrets and Safety in the Age of AIDS: Does HIV Disclosure Lead to Safer Sex? 12 TOPICS IN HIV MED. 109, 110 (2004).

90. Swartz, supra note 87, at 45.

91. See Schering Chemicals LTD. v. Falkman LTD. [1981] 2 W.L.R 848 (Civ) 869 (Eng.); see also Beloff v. Pressdram, [1973] 1 All E.R. 241 (Civ) 260 (Eng.).

92. W v. Egdell, [1989] 2 W.L.R 689 (Civ) 690 (Eng.). See also X v. Y, [1988] 2 All E.R. 648 (Civ) 649 (Eng.).

93. In this context, the term "right to life" recognizes that for the vast majority of HIV patients in resource poor countries, death is the inevitable result of infection and therefore the right to receive notice of a partner's HIV infection should be seen as a critical insurance against death. As of 2008, 33.4 million people were living with HIV/AIDS in different parts of the world, out of which sub-Sahara Africa accounted for 22.4 million, or 67 percent. See JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS, AIDS EPIDEMIC UPDATE 7, 21 (2009). Most of the infected in Africa would likely face untimely death due to unavailability of antiretroviral drugs in the region.

94. See Schering Chemicals, 2 W.L.R at 869.

95. See generally W.D. ROSS, THE RIGHT AND THE GOOD 18-20 (1930). This suggests that, while there is accepted that there is a duty to be truthful, ethically justifiable to be non-compliant where truth would unjustifiably result in someone's death. See Id.

96. Tarasoff, 551 P.2d at 347.

the autonomy of the infected person deserves respect as long as he does not endanger the autonomy of others. Denying proximate and foreseeable victims the knowledge of information that is critical for protecting themselves out of concern for maintaining the anonymity of infected individuals is difficult to justify. This difficulty has led some to conclude that the right of contacts to know, to be fully informed about the truth of the relationship presents a stronger claim.[97] Confidentiality and privacy do not, therefore, provide an overriding policy consideration against the potential duty to warn of the risk of HIV infection.

B. Enforcement of Coercive Notification Duties

Another policy consideration is that physicians are not suitably placed to perform notification duties. Notification involves locating and contacting named individuals, the number of whom may range from one (for monogamous couples) to several (in cases of gay men and intravenous drug users) – a time and resource consuming process. Especially in Africa, where health care resources and services are generally minimal, it would be unwise to divert physicians' services to the performance of notification duties. Moreover, with the shortage of physicians in some critical areas of practice such as family medicine, both in Africa and elsewhere,[98] time expended on tracking contacts should be more appropriately spent treating patients, the job for which physicians are most suited. Furthermore, breaking the news that an individual has contracted a deadly disease such as HIV is best handled by someone with appropriate training and expertise in dealing with the emotional and psychological distress that will result from the tragic news.[99] Physicians lack such training and are therefore ill-suited for the role. Having regard to these difficulties, it is arguable that the duty of physicians should be limited to counseling HIV patients on preventive measures, encouraging them to disclose their status to their partners and filing appropriate reports with the public health department.

Furthermore, the imposition of a duty to warn does not necessarily translate to compliance. How do you force a recalcitrant individual to

97. See Gostin & Hodge, supra note 38, at 66-7. See also Karolynn Siegel et al., Serostatus Disclosure to Sexual Partners by HIV-Infected Women Before and After the Advent of HAART, 41 WOMEN AND HEALTH 63, 65 (2005) (discussing potential reasons why women with HIV choose to disclose their serostatus).

98. See generally Shaheen E. Lakhan & Cyndi Laird, Addressing the Primary Care Physician Shortage in an Evolving Medical Workforce, 2 INT'L. ARCHIVES. OF MED 14 (2009); Amy Medley et al., Rates, Barriers and Outcomes of HIV Serostatus Disclosure among Women in Developing Countries: Implications for Prevention of Mother-to-Child Transmission Programmes 82 BULL. WHO 299, 304-05 (2004).

99. Swartz, supra note 87, at 54.

disclose the names of her contacts? How do you guard against disclosure of false names and other identifying information about sexual or drug-sharing partners of the individual? These are practical questions that admit of no simple solution, and works against the imposition of a duty to warn. Moreover, a significant number of those infected with HIV contracted the disease by engaging in illicit activities such as intravenous drug use or prostitution. Giving information about one's associates might lead to criminal prosecution, a situation these individuals desperately want to avoid. Even where there has been no breach of criminal law, some individuals might still be reluctant to be forthcoming with the names of their contacts. Avoidance of moral blame, shame, embarrassment and fear of abandonment are strong reasons for recalcitrance on the part of those in marital or otherwise committed relationships.

C. Success of Notification Laws in Reducing the Spread of other Sexually Transmitted Diseases

The push for a legal duty to warn of the risk of HIV infection is grounded on the assumption that existing voluntary notification laws with respect to sexually transmitted diseases were successful in reducing infection. As intuitively persuasive as this assumption seems, it lacks evidentiary support. Gonorrhea and syphilis, often cited as evidence of efficacy of voluntary notification programs have recently shown remarkable resurgence in different parts of the U.S.[100] For instance, the incidence of gonorrhea in the country that between 1975 and 1997 declined seventy-four percent has reversed course since 2005, increasing by 5.5 percent in 2006.[101] In New York City alone, more than twice as many cases of syphilis were diagnosed in the first three months of 2007 than during the same period the previous year.[102] This is not an isolated incident but reflects a much wider trend. Nationally, the number of newly diagnosed cases of syphilis steadily increased since an all time low in 2000, according to the U.S. Centers for Disease Control and Prevention (CDC).[103]

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100. U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION, 2006 SEXUALLY TRANSMITTED DISEASE SURVEILLANCE: GONORRHEA, available at http://www.cdc.gov/STD/stats06/gonorrhea.htm; See generally Sarah Kershaw, Syphilis Cases on the Increase in the City, N.Y. TIMES (Aug. 12, 2007), available at http://www.nytimes.com/2007/08/12/nyregion/12syphilis.html?_r=0.

101. U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION, 2006 SEXUALLY TRANSMITTED DISEASE SURVEILLANCE: GONORRHEA, available at http://www.cdc.gov/STD/stats06/gonorrhea.htm.

102. Kershaw, supra note 100.

103. U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION, New Data Reveal Seventh Consecutive Syphilis Increase in the U.S. and Opportunities to Improve STD Screening and Prevention for Gay and Bisexual Men, March 12, 2008, available at http://www.the

D. Protection against HIV Infection

A powerful policy consideration is that notification of HIV status would help to protect a (concerned) third party against the risk of infection. As with any other disease, preventive effort must start with knowledge of one's proximity to the source of possible infection. Knowing that one's partner is infected places the individual on notice to take preventive measures, such as condom use and abstinence from sexual or needle-sharing relationship with the HIV infected person. Shielding oneself from known sources of infection either by modifying sexual or other risky behavior, or establishing a relationship with a non-infected person, appears to be the most successful means of curtailing HIV transmission. Studies have shown that upon becoming aware of their seropositive status, twenty to eighty percent of HIV patients adopt less risky behavior.[104] Particularly for people with multiple partners, warning may serve to prevent chain infection. These preventive measures cannot be implemented unless one is apprised as to the person against whom precautionary measures should be directed.

Furthermore, early warning often means early treatment. Until the middle of last decade, the median survival after HIV seroconversion was approximately between 7.9 and 12.5 years, depending on the age of the patient.[105] The approval of highly active antiretroviral therapy (HAART) in 1995 by the U.S. Food and Drug Agency (FDA) and its widespread availability in that country is credited with a sharp decline in HIV related morbidity and mortality.[106] But the effectiveness of HAART or other treatment regimen depends on how early therapy is initiated, and this hinges on when the individual becomes aware of her infection. This is particularly important given the huge number of HIV infected people in Africa and other regions who are unaware of their status.[107] Even in industrialized countries, this population is not paltry. In the U.S., individuals unaware of

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body.com/content/art45536.html.

104. Donna L. Higgins et al, Evidence for the Effects of HIV Antibody Counseling and Testing on Risk Behaviors, 266 JAMA 2419, 2427 (1991); Niccie L. McKay & Kristen M. Philips, An Economic Evaluation of Mandatory Premarital Testing for HIV, 28 INQUIRY 236, 238 (1991).

105. Anne D. Walling, HAART and Patients with HIV Infection, 69 AM. FAM. PHYSICIAN 1797, 1797 (2004).

106. See generally John Henkel, Attacking AIDS With a 'Cocktail' Therapy, 33 FDA CONSUMER MAG. 12 (1999); See generally Robert S. Hogg, Life Expectancy of Individuals on Combination Antiretroviral Therapy in High Income Countries: A Collaborative Analysis of 14 Cohort Studies, 372 LANCET 293 (2008).

107. See Rebecca Bunnell, et al., HIV Transmission Risk Behavior among HIV-Infected Adults in Uganda: Results of a Nationally Representative Survey, 22 AIDS 617, 621 (2008) (finding that 79 percent of adults in Uganda were unaware of the HIV stats and 91 person had no knowledge of the status of their partners).

their status are estimated to number between 180,000 and 280,000 people.[108] Warning those at risk of infection in order to get tested affords them an opportunity to begin early treatment, thus avoiding the horror of full-blown disease.

VI. OVERRIDING POLICY CONSIDERATION IN AFRICA

While the policy considerations in the previous section both support and argue against the existence of a duty to warn, a major policy consideration in the particular circumstances of Africa is the impact of a mandatory disclosure requirement on vulnerable populations: forced warning may accentuate their vulnerability. This is especially true of people in unequal relationships and of lower socio-economic background – two characteristics that define the status of women in Africa. Analysis of this issue captures the objection of African scholars, noted in the introduction of this piece, against involuntary disclosure of HIV status.

In Africa, about sixty-one percent of people that tested HIV positive are women, and they are usually the first to know of their HIV status due to routine antenatal screening.[109] Being the first to know, African HIV positive women are often accused by their husbands of infecting them with the virus, even though such husbands were ignorant of their status and were probably the true source of infection.[110] Furthermore, the power-dependent relationship of most women in Africa means that they are generally unable to enforce the use of condoms by their husbands or partners, even when it exposes them to the risk of HIV infection.[111] Summarizing the socio-cultural plight of African women, which engenders their high rate of HIV infection, a UNAIDS report observed: "Often treated as legal minors, barred from owning or inheriting property, unable to make independent financial decisions, women are vulnerable to poverty, exploitation, violence – and ultimately to HIV infection, which lies at the end of this long causal chain of injustice."[112] HIV positive women in Africa are reluctant to disclose their sero-status to their husbands or sexual partners because of the potential for violence against them. IRIN PlusNews reported that at least

108. Rochelle P. Walensky et al., Effective HIV Case Identification Through Routine HIV Screening at Urgent Care Centers in Massachusetts, 95 AM. J. PUB. HEALTH 71, 71 (2005).

109. Bernard, supra note 19.

110. UNAIDS, FACING THE FUTURE TOGETHER: REPORT OF THE SECRETARY GENERAL'S TASK FORCE ON WOMEN, GIRLS AND HIV/AIDS IN SOUTHERN AFRICA 8, 16 (Advocacy ed. 2004) [hereinafter UNAIDS].

111. See Joseph-Mathew Mfutso-Bengo et al., Ethical Aspects of HIV/AIDS Prevention Strategies and Control in Malawi, 29 THEORETICAL MED. BIOETHICS. 349, 350 (2008).

112. UNAIDS, supra note 110, at 8.

three Uganda women were killed in 2008 by their husbands for testing HIV positive.[113] It is likely that similar killings occur, but go unreported, in other parts of the continent. Nonetheless, HIV/AIDS related violence against women is not restricted to Africa. In the U.S., for instance, North and Rothenberg acknowledged cases of "two women who were shot and many others who were injured or abandoned after revealing to their partners that they were infected with HIV".[114]

For most HIV positive women in Africa who were lucky enough to escape death or physical abuse following the disclosure of their HIV status to their partners, abandonment is a common fate.[115] UNAIDS found that "Women with AIDS are commonly sent back to their natal families to be looked after by female relatives."[116] Spousal abandonment, following disclosure of HIV status, carries enormous economic consequences for women in Africa, most of who lack independent means of economic existence. This consideration hardly incentivizes the voluntary disclosure of sero-status by such women. Medley, et al. pertinently observed that women's fear of abandonment was closely tied to the "fear of loss of economic support from a partner."[117] Medley, et al. further observed that "in these settings where. . . women's access to resources independent of their partner is uncommon, it is not surprising that fear of losing this instrumental support from a partner is a major consideration when deciding whether to share HIV test results or not."[118]

In anticipation of the twin evils of violence and abandonment potentially resulting from the involuntary disclosure of an African woman's sero-status, the SADC PF model law prohibits the disclosure of sero-status except "the person living with HIV is not at risk of physical violence

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113. Uganda: Draft HIV Bill's Good Intentions Could Backfire, IRIN PLUSNEWS (Nov. 24, 2008), http://www.plusnews.org/PrintReport.aspx?ReportId=81636.

114. Richard L. North & Karen H. Rothenberg, Partner Notification and the Threat of Domestic Violence Against Women with HIV Infection, 329 NEW ENG. J. MED. 1194, 1195 (1993). See generally Nabila El-Bassel et al., Intimate Partner Violence Prevalence and HIV Risks among Women Receiving Care in Emergency Departments: Implications for IPV and HIV Screening, 24 EMERGENCY MED. J. 255, 255 (2007); Linda J. Koenig et al., Violence during Pregnancy among Women with or at Risk for HIV Infection 92 AM. J. PUB. HEALTH 367, 367 (2002); Andrea Carlson Gielen et al., Women's Lives after an HIV-Positive Diagnosis: Disclosure and Violence, 4 MATERNAL & CHILD HEALTH J. 111,111 (2000).

115. The phenomenon is also evident in industrialized countries. In a 1995 study, 20 percent of the women surveyed reported being left by their partners following disclosure of their seropositive status. See Jane M. Simoni et al., Women's Self-Disclosure of HIV Infection: Rates, Reasons, and Reactions, 63 J. CONSULTING CLINICAL PSYCHOL. 474, 476 (1995).

116. UNAIDS, supra note 110, at 18.

117. Medley, supra note 98, at 300.

118. Id.

resulting from the notification."[119] Even in the U.S., where involuntary disclosure of sero-status is quite established, either on a mandatory or discretionary basis depending on the jurisdiction,[120] it has been suggested that physicians must weigh and balance the benefits of notification against the seriousness of potential harms.[121] Physicians must consider that "a high risk that an infected patient will be subject to immediate violence or death outweighs the risk that she will transmit HIV to her partner."[122] Finally, the foregoing analysis suggests that policy considerations deriving from the potentials for violence against an African victim of HIV are likely to militate against the finding of a duty to warn of HIV infection in African common law courts.

VI. CONCLUSION

Whether or not a physician has a duty to warn a third party of the risk of HIV infection remains a hotly debated issue in Africa. Africa, especially southern Africa, is the epicenter of HIV/AIDS.[123] An increasing number of African countries have sought to combat the pandemic (partly) by the promulgation of HIV/AIDS-specific legislation and policy. A good number of HIV/AIDS-specific legislation in the continent derives from sub-regional model laws, especially those developed by AWARE-HIV/AIDS and the SADC PF. Both model laws have contrasting provisions on partner notification, with the result that sub-Saharan African countries show an interesting mix of regimes on partner notification obligations.

While some countries favor mandatory partner notification and some merely empower the disclosure of sero-status, others maintain strict confidentiality of HIV test results except in narrowly defined circumstances. The general statutory trend, however, seems to be in the direction of mandatory notification of sero-status, especially in the West and Central African regions. Absent legislative regulation, however, the duty to warn depends on the legal systems of African countries. For common law African countries, this will depend on the law of negligence

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119. SADC PF MODEL LAW, supra note 9, at §15(4)(b)(iii)(bb).

120. The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990, Pub. L. No. 104-06, §8, 110 Stat. 1346, 1372 (codified at 42 U.S.C. § 300ff – 27a (2000)). Requires States, as a condition for receiving federal HIV prevention funds, to adopt legislative or administrative actions necessary for ensuring that "good faith effort" is made to notify current and former spouses of HIV infected patients that they may have been exposed to HIV and need to be tested. See generally Pottker-Fishel, supra note 38, at 166.

121. Nicole S. McKinney, A Legal and Ethical Analysis of Third Party Notification of HIV, 16 THE AM. ASS'N. OF BEHAV. & SOC. SCI. J., 46, 55 (2012).

122. North & Rothenberg, supra note 114, at 1195.

123. UNAIDS, supra note 110, at 18.

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and, for historical reasons, their law of negligence reflects the English common law which, as shown previously, adopts a tripartite framework for duty analysis. While foreseeability and proximity are important factors in determining the existence of a duty to warn, policy considerations would be determinative in the special context of Africa. As the analysis above shows, the potential for spousal violence against an African woman who tested HIV positive is one of the strongest policy considerations against the finding of a duty to warn of HIV infection.[124] For legal systems in Africa that have veered onto a contrary path, this is strong enough reason for policy makers in those countries to rethink their stand. What is good for the goose is not always good for the gander.

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124. Just as UNAIDS concluded, in relation to current trend toward criminalizing HIV transmission, that criminalization is counterproductive in that it achieves neither the ends of criminal justice nor prevents the transmission of the disease, we conclude that mandatory notification is equally counterproductive and "risks undermining public health and human rights." See UNAIDS, UNAIDS POLICY BRIEF: CRIMINALIZATION OF HIV TRANSMISSION 1, 7 (2008).

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