Theor Med Bioeth (2008) 29:341–348
DOI 10.1007/s11017-008-9085-x

Routine third party disclosure of HIV results to identifiable sexual partners in Sub-Saharan Africa

Francis Masiye · Robert Ssekubugu

Abstract The challenges of dealing with disclosure of HIV status cause frustration to health care providers and counselors. This frustration follows from the already known high risk to the third party on one hand and our ethical obligation to "respect persons" in terms of privacy and confidentiality on the other side. Given the stubbornly low rates of voluntary disclosure (partner notification) among couples, however, it is quite tempting to suggest a paradigm of routine third party disclosure to identifiable sexual partners by health care providers. This might be the lesser of the two evils and might give better public health outcomes in the fight against HIV/AIDS in Sub-Saharan Africa.

Keywords Third-party disclosure · HIV status · Identifiable sexual partners · Confidentiality · Sub-Saharan Africa

Introduction

The changing face of the HIV/AIDS epidemic has resulted in new opportunities as well as new imperatives. It is imperative to increase availability and access to HIV testing and counseling. It is also imperative for people to know their HIV status and for those who are HIV infected to receive care and treatment.

In recent years, scientists and health care providers have debated about regular practices in the contemporary HIV/AIDS care such as "should AIDS treatment programs be implemented in low income countries?" [1, p. 10]. Today, however,

F. Masiye (✉)
Center for Bioethics in Eastern and Southern Africa, University of Malawi College of Medicine, Blantyre, Malawi
e-mail: fmasiye@medcol.mw

R. Ssekubugu
Rakai Research Project, Kampala, Uganda

we are talking of universal access to anti-retroviral therapies (ARVS) and the "opt-out" strategy, which is also known as routine testing and counseling. The "opt-out" approach was a response to the ever frustrating and stubbornly too low Voluntary Counseling and Testing (VCT) uptake that would translate in unsuccessful initiatives to offer the now somewhat available Highly Active Antiretroviral Therapy (HAART) in the developing world [2]. The "opt-out" routine testing approach has been widely adopted, especially in antenatal care, and this has greatly bolstered VCT up-take and Prevention of Mother-to-Child Transmission (PMTCT) in Sub-Saharan Africa.

This "opt-out" strategy is perfectly consistent with the 3 by 5 target, which is the WHO scale-up strategy for antiretroviral therapy in resource-limited settings. The "opt out" strategy is also responsive to the universal accessibility of HAART programs and consistent with the United Nations' eight Millennium Development goals that range from halving extreme poverty and halting the spread of HIV/AIDS to providing universal primary education by the year 2015.

Bodies implementing HIV testing and counseling programs are highly cognizant of the human rights and ethics debates that have emerged and are still emerging in response to this "opt-out" initiative. One of the arguments is that women are disproportionately more likely to be targeted by these policies since they are more likely to come into contact with the health care system during pregnancy and/or childbirth, and their usual frequency in seeking health care. These are really healthy debates, considering the fact that similar debates would still emerge if there were no proactive initiatives like this one in high HIV-prevalent areas like Sub-Saharan Africa.

Disclosure of HIV results

One mind-boggling question in public health, especially in our struggle against the HIV epidemic today, is the issue of disclosure of HIV results to sexual partners. Both the scientific community and civil society have been long divided on how HIV results should be handled in the developing world. Bioethicists have extensively deliberated the question of whether confidentiality in health care should be qualified or unqualified. Hardly any consensus has been reached apart from a compromise to rely on empirical data when deciding to override the cardinal principle of confidentiality [3, p. 15]. A survey carried out in Nigeria illustrates the type of problems that physicians in developing countries (more specifically in Sub-Saharan Africa) face when critical decisions have to be made regarding confidentiality, or shared confidentiality, patient's rights, and third parties' right [4]. The physician in most cases faces the quandary of how to decide and take responsibility for his or her action. In the survey, it was revealed that a majority of respondents would want to know if their spouses had an HIV infection. In contrast, they would not allow their spouses to be told if they were infected. Seventy-six percent of the male respondents (almost the same percentage of those who would refuse to tell their wives if they had HIV infection) said they would wish to know or be told if their wives had HIV infections. A minority of women who tested sero-positive during their pregnancy disclosed their status to the male partners (eighteen percent). Unfortunately, condom use also remains stubbornly low and the incidence of pregnancy subsequent to HIV diagnosis is the same as amongst HIV negative couples. These and similar data and operational situations cannot be debated without a temptation to reflect on the need to keep HIV results confidential. From a spiritual perspective, more paternalistic approaches are taking shape day by day among certain Christian groups. For example, some churches are making HIV/AIDS testing a pre-condition for marriages. They do it "so that an innocent party does not enter into trouble unknowingly," says Rev. Oshodipe [5, p. 7].

Studies in developed and developing countries have revealed that sexual partners of HIV-infected persons continue to be at a significantly high risk of HIV transmission as a result of confidentiality. This implies that it is not very effective to leave partner notification to patients. The moral life often requires a lot more than *specified* general norms, which at times may not clearly apply.

More compelling evidence indicates that by the age of twenty-five, over ninety percent of women have had a child and more than eighty-five percent of the pregnant women are married. In Zambia's capital city, Lusaka, approximately one in five cohabiting couples has one HIV positive and one HIV negative partner. This state of affairs will not only spark debates among health care and public health professionals, but also among counselors, members of the legal profession, policy makers, academicians, and bio-medical researchers.

Disclosure of HIV status among sexual partners becomes even more pertinent a question today given the more successful counseling and testing campaigns that are a brainchild of programs like the "opt-out" strategy [6]. In spite of this, there is going to be more recognition of HIV positive couples: "We went to the villages encouraging people to come for HIV testing, we provided our members with home care support and counseling" [7, p. 27]. Likewise, interventions are more effective and sustainable if they are applied from the lowest level, right from the home, according to Rev. Jackson Muteeba.

Debates on the confidentiality of HIV results, ethics, and law were heated at the 1997 Dakar meeting that preceded the Dakar declaration. The main issue in the debates was the legal status of HIV/AIDS as a non-notifiable disease. This has created problems for the medical profession, the legal profession, and counselors. From ethical principles, medical information pertaining to a patient must be confined to professional colleagues only, as are communications between lawyers and their clients. The problem that arises is, when does it become a professional or a moral duty for a health worker to disclose information pertaining to the sero-status of a third person in order to save life and society? The 2007 Malawi HIV/AIDS draft legislation stipulates, "Any person who is infected with HIV has the right to confidentiality with regard to information concerning his or her state of health, if the conditions and characteristics of their life and work do not constitute a risk of infection to others" [8, p. 31]. This piece of legislation suggests that if a person knows his or her HIV positive status and poses a risk of infection to others but does not disclose his or her status to the others, confidentiality should be breached. However, the legislation itself does not legally mandate health providers to disclose the status of a patient's HIV status to third parties in cases where the first patient does not disclose his or her status to the third parties. The legislation further says “Any person who discloses the sero-status of another person without obtaining the consent of the other person shall be guilty of an offence and shall be liable to a fine of K1, 000,000.00 (approximately $14,280) and to imprisonment for five years” [8, p. 32]. In contrast, the 2003 Malawi National HIV/AIDS Policy talks of beneficial disclosure (routine disclosure) in exceptional cases, when a properly counseled HIV positive person refuses to disclose his or her status to his or her sexual partner [9]. It further stipulates that such beneficial disclosure should be subject to appropriate and explicit guidelines. However, like the above-mentioned legislation, the Malawi Government has not yet developed the guidelines for beneficial disclosure, and voluntary disclosure is the current norm. Of course, information about one’s HIV status cannot be communicated outside legal limits, and yet it might be essential for it to be leaked to a person who risks infection by association with an infected person.

It is imperative to note that despite the fact that the Dakar declaration and some national policies are highly cherished, some believe that most of the declarations, opinion papers and policies on ethics, human rights, law and HIV included in the declaration have offered only broad terms of guidelines and the tenets of ethics and HIV research, HIV in the workplace, discrimination, empowerment, confidentiality and privacy, commitment and responsibility. These policies and other declarations, however, fail to address pertinent and worrisome questions that many public health and health care providers encounter in their daily involvement in the care and management of people living with HIV/AIDS.

In Kenya, Dr. Ochieng was sued by her patient for disclosing the patient’s HIV results to her employer [10]. This event underscores the practical need to move personal morality, ethics and laws forward in tandem. The editor of the Nairobi *Daily Nation* states in part that the active discrimination resulting from failure to maintain confidentiality and disclosure of a patient’s status without first consulting with the patient presents clear need to ensure that standards are upheld in the medical community. This is particularly a crucial need in the ongoing move to encourage more individuals to undergo HIV Testing and Counseling (HTC). The editor asks, “Do members have any experiences or suggestions to share?” Based on this reflection, there is soundness in attempts that aim to bolster wide consultation (given the developments in medical science), and to re-examine and possibly gather empirical evidence to guide contemporary practice in HIV/AIDS care and public health.

It is imperative to note that Dr. Ochieng routinely disclosed his patients’ status to their employers and not to their spouses. It is not clear whether the consequences of routine third party disclosure may differ in circumstances of disclosure to spouses verses disclosure to employers and how. The possible harmful consequences of disclosure include discrimination, stigma, financial losses, and violence [11]. It is indisputable that these problems do occur after disclosure. Most are due to the apparent factors that frame HIV/AIDS within a moral web of blame and punishment contributing to fears about being tested, disclosure, and associating with HIV positive people. That correlation is sufficient to cause suspicions that lawsuits might emerge in the event of routine disclosure to spouses and third parties who are thought to be at a special risk.

Current public health policy and procedure in most countries encourages voluntary partner notification to protect those at risk of HIV infection. In some developed countries like the United States, this requirement is extended beyond voluntary disclosure to health provider providing information to the party believed to be at a special risk should there be information of insufficient will to voluntarily disclose. Health providers' experiences with partner notification, domestic violence, and women with HIV compel a reassessment of this strategy. In a survey of 136 health care providers in Baltimore, Maryland, substantial numbers reported that their HIV-infected patients had experienced with domestic violence before and after partner notification [12]. Health providers believed that fear of physical and emotional abuse, plus abandonment, were important reasons why many female patients resist partner notification. Health provider opposition to partner notification was strong in cases when they believed their female patients faced a risk of domestic violence. HIV-infected women fear (and experience) domestic violence, and this has broad implications (legal or otherwise) for health care practice. The authors recommend changes in health care provider practices to ensure that the risk of domestic violence is identified and addressed, and that partner notification strategies do not threaten the safety of HIV-infected women. They also highlight areas for further research on the associations between partner notification and domestic violence for women with HIV.

Unlike in developed countries, most developing countries (at least in Sub-Saharan Africa) have stuck to the cardinal principle of confidentiality in its *prima facie* sense, as it has been highlighted above. In this case it is up to the client to decide whether or not to disclose their HIV result to the third person. In most cases, it is recommended that physicians, counselors and all public health workers encourage their clients to disclose their results to their spouses voluntarily. The assumed position is that should clients persist in not disclosing their results (even in cases of discordant couples), the physician or counselor should respect their autonomy. In fact, both the Malawi National HIV/AIDS Policy and the report of the Malawi Law Commission on development of HIV/AIDS legislation clearly state that the results of any HIV test should not be disclosed to a third party without the consent of the person seeking testing and that the government and its partners should promote and encourage couple counseling and partner disclosure of HIV test results [8, 9]. Since some clients fear to disclose their HIV status to their partners due to the negative consequences enumerated in this paper, this stand on confidentiality is putting a lot of people at risk for contracting HIV. Needless to mention, international guidelines still remain amorphous since they have to pass a test of universality. For instance, the most recently released guidelines of the Council for International Organizations for Medical Sciences (CIOMS) adhere to the general rule of confidentiality, with exceptions for legal requirements [13]. Thus, debates on confidentiality unavoidably encompass legal provisions. Sound ethical procedures become theoretical if they have no legal bearing.

There is wide evidence to support the fact that voluntary disclosure, which is the present norm in most Sub-Saharan Africa countries, may also result in negative consequences such as domestic violence, withdrawal of financial support, stigma, and others. It is not clear, however, whether routine third party disclosure will exacerbate these already existing negative consequences. There is a possibility that "routine third party disclosure" to known or identifiable sexual partners, if framed well as a third party attempt to protect the victims' loved one, may instead reduce some of the negative consequences of disclosure of HIV positive results. Of course, a study to explore community, patient and VCT clients' perceptions, beliefs and attitudes would be appropriate. It would be consistent with previous recommendations to rely on empirical evidence to guide moral judgment when dealing with matters of confidentiality and disclosure in the event of saving a third party from danger. Nevertheless, we envisage that the benefits of routine disclosure to the third party might outweigh the risks of nondisclosure of the patient's HIV status.

It is a common misperception that the physician-patient medical privilege guarantees the privacy of medical information. Consequentialists are also divided on two fronts; their debate hinges on different predictions and assessments of the consequences. The Tarasoff case has been widely documented as a case in which a psychotherapist learned of a client's intention to murder a young woman. The psychotherapist observed the rules of confidentiality and the young woman was actually murdered [14].

The majority of the consequentialists believe that under such circumstances, it is ethically permissible for the caregiver to divulge confidential information to a potential victim or to a relevant authority. They apply the principle of the lesser evil to justify their action—they weigh the benefits and risks of the two possible actions and choose the one that is less risky than the other. In the Tarasoff case, overriding the rules of confidentiality would actually save the woman's life and such an action would be less evil than observing the rules of confidentiality. In contrast, the minority opinion contends that if it were a common practice to override rules of confidentiality, the fiduciary relation between the patient and doctor/health personnel would soon erode and collapse. Patients would lose confidence in the psychotherapist and would refrain from disclosing information crucial to effective therapy. As a result, violent assaults would increase because people would refuse to seek psychiatric aid or to disclose relevant information, such as violent fantasies. Hence, the debate about different rules of confidentiality hinge in part on empirical claims about what more effectively protects the interests of other persons. All the arguments do not support absolute rules of confidentiality. When rules of confidentiality are used as absolute shields, they can eventuate in outrageous and preventable injuries and losses. The best approach is to treat rules of confidentiality as *prima facie* in ethics as in law. However, we shall need to understand the circumstances under which other obligations validly override obligations of confidentiality [3]. While it is an opportune moment to re-examine policies on HIV that cause restless moments for physicians in their day to day lives, guiding principles emphasize a good empirical understanding of the target to which it is hoped the law and policy will attach. HIV/AIDS policies, like all other policies in health, must not be based on ignorance, fear, political expediency, or pandering to the demands of the citizenry for "tough" measures. Good laws and policies, like good ethics, will be founded on good data [14].

A study of HIV positive couples where both parties knew each other's sero-status indicated that almost one quarter reported perfect compliance with condom use during the first year of follow-up. Using bio-makers, the study noted that although couples are having much less "unprotected" sex than concordant negative couples, they are still under-reporting many high-risk exposures [15]. These data pose moral questions—whether it is ethically permissible to override a key principle of confidentiality and whether the anticipated benefit is worthwhile. We need to look at more data as we engage in this debate.

Ethics, morals and law

Assuming that preventing the death of uninfected persons is the goal, it is hoped that when uninfected persons are informed about their "special risk," they will avoid exposing themselves to the risk. Of course, this is not a trivial condition; many people willingly risk illness and injury out of love and other honorable motivations. Arguments in favor of breaching confidentiality are, thus, often dismissed. According to the ethical principle of autonomy or respect for persons, confidentiality is critical to a physician-patient relationship. Like other ethical principles underlying that relationship, however, it cannot be absolute. When it needs to be breached, all efforts to do so with patient consent should be undertaken. In cases where this cannot be achieved, the physician cannot escape their responsibility to serve the public welfare. This implies that the duty of confidentiality is always limited and subject to other overriding values. Thus, by passing on this information, the physician is not "breaching" confidentiality but adhering to another value considered compelling enough in the situation at hand to trump that of confidentiality—that of protecting a third party from serious harm. After all, prevention is better than the cure.

Indeed, disclosure of the patient's HIV status to sexual partners is essential for stopping the spread of HIV infection. Women in some parts of the world have described the difficulties that disclosure entails, and have called for more counseling and health education. It is quite evident that there is a will to disclose, but it remains a difficult exercise. There is no empirical evidence to show that alternatives like routine third party disclosure have been offered and rejected by communities/ patients. Yet divulging confidentiality might lead to horrible effects, including loss of trust in health care systems, affecting health-seeking behaviors including VCT, and social and economic consequences. Therefore, it is important to return to he cornerstone of moral reasoning—information gathering.

Conclusion

It might seem outrageous to some to seek empirical evidence for whether or not third party disclosure of HIV results among identifiable couples results in better public health outcomes in Sub-Saharan Africa. Previous proactive initiatives such as mobile voluntary counseling and testing and the "opt-out" strategy, however, have provided tremendous positive outcomes. Dialogue with communities, patients, and members in the health care systems can produce valuable contributions. We are cognizant of the likely negative consequences of routine third party disclosure especially its impact on health seeking behaviors, VCT uptake, domestic violence, and unnecessary marital dissolution. And yet the frustration of dealing with the "privilege" of identifiable couples unwilling to disclose, and the undisputable fact that it places the negative party at a much higher risk of infection is quite inconsistent with public health missions, and hurts the moral judgment of many. We suggest a new initiative designed to advocate *routine third party disclosure of HIV results to identifiable sexual partners in Sub-Saharan Africa*. We also suggest that the results of such a policy change be carefully studied. This might be the lesser of two evils and might give better public health outcomes in the fight against HIV/AIDS.

References

1. Stuart, Rennie, et al. 2006. Desperately seeking targets: the ethics of routine HIV testing in low-income countries. *Bulletin for the World Health Organization* 84: 52–57.
2. Botswana Networld on Ethics, Law, HIV/AIDS (BONELA). 2003. *Event report: Routine versus compulsory test.* http://www.bonela.co.bw/Reports/SeminarReport. Accessed 27 Nov 2005.
3. Beauchamp, T., and J. Childress. 1994. *Principles of biomedical ethics*. New York: Oxford University Press.
4. Soyinka, F. 2007. Phyiscian's dilemma in the management of HIV/AIDS in Africa. IN CODESRIA, CLNS, ORSTOM international symposium of social science and AIDS in Africa. www.codesria.org/links/publications/aids/soyinka. Accessed 6 Nov 2007.
5. Nwanma, Vincent. 2005. *In AIDS fight, men make a difference* (*Campaigns in Africa seek to change male behavior*): *Silence no more*, *Africa fights AIDS*. New York, Africa Renewal, U.N. Department of Public Information.
6. World Health Organization. 2003. *The right to know: New approaches to HIV testing and counseling.* http://www.who.int/hiv/ev. Accessed 3 Oct 2008.
7. Kirungi, Fred. 2005. *Uganda beating back AIDS, leadership, education and openness are keys to progress: Silence no more, Africa fights AIDS*. New York: Africa Renewal, U.N. Department of Public information.
8. Malawi Law Commission. (2007). *Report of the Malawi Law Commission on the development of HIV and AIDS legislation.*
9. *The Malawi National HIV/AIDS Policy*. June (2003). http://www.ilo.org/public/english/protection/trav/aids/laws/malawi1.pdf. Accessed 6 Nov 2007.
10. Kadida, Jillo. 2005. *Daily Nation*, Nairobi Kenya, 14 July.
11. Office of the United Nations High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS. 2007. *International Guidelines on HIV/AIDS and Human Rights*. http://data.unaids.org/Publications/IRC-pub07/jc1252-internguidelines_en.pdf. Accessed 6 Nov 2007.
12. Rothenberg, Karen, and Stephen Paskey. 1995. The risk of domestic violence and women with HIV infection: Implications for partner notification, public policy, and law. *American Journal of Public Health* 85 (11): 1569–1576.
13. Council for International Organizations of Medical Sciences. 2002. *International ethical guidelines for biomedical research involving human subjects*. Geneva.
14. Elliot, Richard, and Mirriam Maluwa. 2002. *Criminal Law, public health and HIV transmission: A policy options paper prepared for a joint United Nations Programme on HIV/AIDS*. http://data.unaids.org/publications/IRC-pub02/JC733-CriminalLaw_en.pdf. Accessed 3 Oct 2008.
15. Susan, Allen, et al. 2003. Sexual behavior of HIV discordant couples after HIV counseling and testing. *Official Journal of the International Aids Society* 17 (5): 733–740.