

**Criminal prosecution of a male partner for sexual transmission of infectious diseases:
The views of educated people living in Togo**

To cite this article:

Kpanake, L., Patassi, A., & Mullet, E. (2013). Criminal prosecution of a male partner for sexual transmission of infectious diseases: The views of educated people living in Togo. *Sexually Transmitted Infections* 89, 290–294.

ABSTRACT

Objectives: The acceptability by people in Togo of criminal prosecution for sexual transmission of infectious diseases was examined.

Methods: One hundred and ninety-nine persons in Togo judged acceptability of criminal prosecution for sexual transmission of infectious diseases in 45 scenarios composed of combinations of four factors: (a) the type of illness, (b) the awareness of the serological status (c) the partners' marital status, and (d) the male partner's attitude toward his sexual partner following transmission of the virus.

Results: Three qualitatively different views were identified. For 50% of the participants, a male partner (with HIV, Hepatitis B, or Gonorrhoea) could be sued when he knew his serological status but did not inform his sexual partner or when he refuses to take care of his sexual partner whom he infected. When he did not know his serological status or when the female partner was also informed of this serological status, he should not be sued on condition that he accepts to take care of her. For 26%, when both partners were informed, the male partner should not be sued, irrespective of other circumstances. For 24%, when the male partner accepts to take care of the female partner whom he infected, he should not be sued.

Conclusions: Regarding criminal prosecution for sexual transmission of infectious diseases, most people in Togo disagreed with the provisions of the "Model Law for STI/HIV/AIDS for West and Central Africa". Rather, they endorsed the position of the Joint United Nations Programme on HIV and AIDS.

INTRODUCTION

Sub-Saharan Africa, the region that accounts for nearly 70% of HIV infections worldwide,¹ is increasingly resorting to criminal law as a solution to the public health challenge of HIV epidemic.^{2,3} In September 2004, West and Central African countries adopted a “Model Law for STI/HIV/AIDS for West and Central Africa”.⁴ The “model law” criminalizes HIV transmission without regard for whether the person living with HIV (PLWHIV) (1) knew that s/he was HIV-positive or not, (2) disclosed his or her HIV-positive status to his or her sexual partner or not; (3) had control over adoption of safe sex practice (e.g. negotiating condom use) or not, and (4) transmitted HIV or not.^{4,5} This “model law” has been considered a template for national legislations,^{4,5} and even some countries (e.g. Burkina Faso) have already adopted this template as national law.⁶

The application of such law provisions is, however, controversial.^{7,8} For instance, The Joint United Nations Programme on HIV and AIDS (UNAIDS), civil society organizations, and scholars raised serious ethical and legal concerns driven by the “model law”. They questioned the fairness of applying criminal law in numerous circumstances, including when: (1) the PLWHIV did not know that s/he was HIV-positive, (2) the PLWHIV disclosed his or her HIV status to his or her sexual partner, or (3) the PLWHIV and his or her sexual partner previously agreed on a level of mutually acceptable risk.^{6,9}

Many sub-Saharan African countries are considering the “model law” for enacting their national legislation HIV-specific laws.^{3,5,6} As shown above, circumstances under which such laws should be applied is on debate. Before promulgating such laws and implementing them, it is important to know the opinions of those who grapple with such laws about their own sexual behaviors: the people.

The present study

The present study examined the views of people living in Togo on the acceptability of criminal prosecution of male partners for sexual transmission of infectious diseases. Togo is a Francophone country that is located in the west coast of Africa with a population of approximately 6.2 million. It is one of the few countries in Africa still experiencing an increase in the HIV prevalence – from 0.4% in 1990 to 3.3% in 2009.¹⁰ HIV/AIDS remains the most common cause of death, representing 17% of all deaths.¹¹ HIV infection frequently occurs through rape among children,¹² and among women infected by male partners who did not disclose their HIV-positive status to them.¹³

In view of previous findings,^{14,15,16} we expected that people would not support criminal prosecution when the male partner was not aware of his serological status or when he disclosed his status to his female partner. Also based on previous findings showing a large diversity of opinions regarding such issues,^{14,15} we expected to find several different groups of respondents holding qualitatively distinct positions.

METHODS

Participants

Overall, 300 individuals living in Kara, a small town north of Togo, were approached during daytime by one of 8 research assistants while they were walking along the main sidewalks of the city. Research assistants explained to them the intents and purposes of the study and sought their participation. Of those approached, 66.33% accepted to participate, and provided informed consent. The 199 participants (117 women and 82 men) were unpaid volunteers. Their mean age was 24.24 years (SD = 5.49, range = 18-59). Forty-one per cent had a university degree, 52%

secondary level schooling, and 7% primary level schooling. Sixty-three per cent self-identified as Christian, 16% as Muslim, 14% as Animists, and 7% as Atheists.

Materials

The material consisted of 45 cards containing a vignette of a few lines, a question, and a response scale. Thirty-six vignettes were composed according to a four within-subject factor design: (a) the type of illness (AIDS, Hepatitis B, or Gonorrhoea); (b) the awareness of the male partner's serological status among both partners (not aware that he was infected, aware that he was infected but did not disclose it, aware that he was infected and disclosed it); (c) the partner's marital status (married or not); and (d) the male partner's attitude toward his female partner following transmission of the virus (supportive, leave), $3 \times 3 \times 2 \times 2$. Nine additional vignettes were composed according to a two-factor design: Type of illness \times Awareness, 3×3 . In these vignettes the female partner had had several sexual partners and not just one as in the previous vignettes. The question was, "To what extent is it acceptable, in this case, to sue the male partner for transmission of an infectious disease?" The response scale was a 11-point scale with anchors of "Not acceptable at all" and "Completely acceptable." The cards were rearranged in random order for each participant.

Procedure

We used the same procedure as has been applied in numerous studies on public's opinions about controversial health issues.^{17,18} Each participant was tested individually. The session had two phases. In the first phase, also known as the familiarization phase, the participants were given 16 vignettes taken randomly from the complete set. They read each vignette, and then made an

acceptability rating. After completing the 16 ratings, they were allowed to look back at their responses and change them. In the second phase, the main study phase, the participants were given the whole set of 45 vignettes. They made ratings at their own pace but were not allowed to compare their responses nor to go back and make changes. The participants took 40-60 minutes to complete both phases.

RESULTS

To look for groupings of participants, a cluster analysis (K-means) was performed on the raw data from the main design and from the additional design. Three clusters of participants were identified. The main design is shown in Figure 1, with mean ratings pooled across levels of type of illness and marital status.

The first cluster ($N=52$) was termed *Knowledge of Status*. As can be observed in the left-hand panel of Figure 1, curves are clearly ascending: when both partners were informed but they decided not to take precautions, the mean rating was lower ($M=4.25$) than when they were not informed ($M=7.74$), or when only the male partner was informed that he was infected ($M=8.91$). The other factors had no effect.

The second cluster ($N=48$), was termed *Subsequent Behavior*. As can be observed in the center panel of Figure 1, curves are clearly separated: when the male partner decided to take care of his wife or of his girlfriend, mean ratings were lower ($M=1.58$) than when he decided to leave ($M=8.25$). Curves were slightly ascending, that is, the knowledge factor had only a weak effect.

The third cluster ($N=99$), the majority cluster, was termed *Knowledge and Behavior*. As can be observed in the right-hand panel of Figure 1, curves are clearly separated, clearly ascending, and they converge on the right. When both partners were informed (and they

nevertheless decided not to take precautions), and when the male partner accepted to take care of his wife or of his girlfriend, the mean rating ($M=3.30$) was lower than in the other cases ($M=7.57$).

Differences in the composition of these clusters were assessed with Chi-square statistics. There were significantly more men (35%) than women (19%) in the first cluster than in the two others (65% vs. 81%), $Chi^2(1)=6.16, p < .02$. There was no significant difference as a function of education or religion.

An ANOVA was performed on the raw data from the main design using STATISTICA. The design was Cluster x Subsequent Behavior x Type of Illness x Knowledge of Status x Marital Status, $3 \times 2 \times 3 \times 3 \times 2$. Cluster was a between-subject factor. The other factors were within-subject factors. Owing to the great number of comparisons conducted, the significance threshold was set at .001 (.05/31) using the Bonferroni technique.

The cluster effect was significant, $F(2,194)=89.90, \eta^2_p=.48$. Post-hoc analyses using the Tukey honestly significant difference test showed that the mean rating observed in the Knowledge of Status cluster ($M=6.97$) was significantly higher than the mean rating observed in the Knowledge and Behavior cluster ($M=6.15$), which was significantly higher than the mean rating observed in the Subsequent Behavior cluster ($M=4.92$). The Subsequent Behavior effect was significant, and it was a strong effect, $F(1,194)=1132.17, \eta^2_p=.85$. When the male partner decided to take care of his partner, mean rating was lower ($M=4.28$) than when he decided to leave ($M=7.74$). The Type of Illness effect was significant but it was a weak effect, $F(2,388)=7.10, \eta^2_p=.04$. Post-hoc analyses showed that when the illness was gonorrhoea, the mean rating observed was lower ($M=5.82$) than when the illness was AIDS (6.13). The other two comparisons were not significant. The Knowledge of Status effect was significant, and it was

strong, $F(2,388)=236.92$, $\eta^2_p=.55$. Post-hoc analyses showed that when both partners were informed but decided not to take precautions the mean rating was lower ($M=4.71$) than when none of them was informed ($M=5.75$), and that when none of them was informed, the mean rating was significantly lower than when only the male partner was informed ($M=7.57$). The Marital Status effect was not significant.

The Cluster x Subsequent Behavior interaction was significant, $F(2,194)=258.91$, $\eta^2_p=.73$. The effect of subsequent behavior was stronger among participants from the Subsequent Behavior cluster (the difference between the highest and the lowest means was $8.25-1.58=7.67$) than among participants from the Knowledge of Status cluster ($7.17-6.77=0.40$) or the Knowledge & Behavior cluster ($7.79-4.50=3.29$). The Cluster x Knowledge of Status interaction was significant, $F(4,388)=47.54$, $\eta^2_p=.33$. The knowledge of status effect was stronger among participants in the Knowledge of Status cluster ($8.91-4.25=4.66$) than among participants in the Subsequent Behavior cluster ($5.90-4.49=1.41$) or in the Knowledge & Behavior cluster ($7.90-5.40=2.50$). The Subsequent Behavior x Knowledge of Status interaction was significant, $F(2,388)=15.97$, $\eta^2_p=.08$. The effect of knowledge of status was stronger ($6.16-2.80=3.36$) when the partner decided to take care of his female partner than when he decided to leave the partner ($8.96-6.63=2.33$). Finally, the Cluster x Behavior x Knowledge of Status interaction was significant, $F(4,388)=9.16$, $\eta^2_p=.09$. It is depicted in Figure 1.

Mean ratings regarding the additional design, pooled across levels of type of illness are shown in Figure 2. An ANOVA was performed on these data, also using part of the data from the main design. The design was Cluster x Type of Illness x Knowledge of Status x Number of Partners (one partner vs. several partners), $3 \times 3 \times 3 \times 2$. As in the previous analysis, the cluster effect, the knowledge of status effect, and the Cluster x Knowledge interaction were significant.

The Number of Partners effect was significant, $F(1,196)=208.56$, $\eta^2_p=.52$. When the female partner has had several male sexual partners, the mean rating was lower ($M=5.91$) than when she has had only one ($M=7.64$). The Knowledge of Status x Number of Partners was significant, $F(2,392)=47.84$, $\eta^2_p=.20$. When the female partner has had only one partner, the lowest rating was observed when both knew but decided not to take precautions. When the female partner has had several partners, the lowest mean rating was observed when they did not know (see Figure 2). Finally, the Cluster x Knowledge x Number interaction was significant, $F(4,392)=10.50$, $\eta^2_p=.10$. It is depicted in Figure 2.

DISCUSSION

The present study examined the views of people living in Togo on the acceptability of criminal prosecution of male partners for sexual transmission of infectious diseases to female partners. Overall, participants considered that a male partner who infected his female partner sexually can, at least in some cases, be sued; but, as expected, there are qualitatively different positions regarding the circumstances in which the male partner might be sued.

A first minority position is that the main circumstance to be considered is whether both partners knew in advance the male partner's serological status or not. Participants holding this view consider that a male partner could be sued (a) when he knew his status but did not inform his partner, or (b) when he did not know his status, except in the case where he was not the only sexual partner. When both partners were informed, participants consider that the male partner should not be sued. This view applies irrespective of: the severity of the transmitted illness, subsequent care-taking behavior, and marital status, and was more common among men than among women.

A second minority position is that the main factor to be considered is the subsequent care-taking behavior. Participants holding this view consider that a male partner could be sued each time he refuses to take care of his sexual partner whom he infected. This view applies irrespective of: the severity of the transmitted illness, knowledge of status, and marital status. This position is, however, attenuated when he was not the only sexual partner and was more common among women than among men.

The majority position is that both factors must be taken into account but in a disjunctive way. Participants holding this view consider that a male partner could be sued (a) when he refuses to take care of her sexual partner, or (b) when he knew his status but did not inform his partner. When he did not know his status or when the female partner was also informed of his status, he should not be sued on condition that he accepts to take care of her. This position is attenuated when he was not the only sexual partner, and was more common among women than among men.

The results showing a variety of views are consistent with the variety of views found among men who have sex with men in the UK,^{14,15} and USA.¹⁶ Overall, this study shows that as regards criminalization of HIV and other STI transmission, most of the people in Togo do not agree with the provisions of the “Model Law for STI/HIV/AIDS for West and Central Africa”. Rather, they endorse the position of the UNAIDS,⁹ which urges governments not to apply criminal law to cases “where the person: did not know that s/he was HIV positive; did not understand how HIV is transmitted; disclosed his or her HIV-positive status to the person at risk, ...or previously agreed on a level of mutually acceptable risk with the other person.” (p.1)

Limitations

The study had some limitations. First, the group of participants was a convenience sample, and was only of a moderate size. Second, the participants responded to vignettes, not to real patients. The use of vignettes, however, is useful: it permits statistical analyses to reveal how people weigh and combine separate factors in order to formulate their judgment. Third, only the male partner's case was considered. Additional studies should be conducted on the female partner's case.

Despite these limitations, this paper offers the first empirical findings on African people's views regarding criminal prosecution for HIV and other STI transmission. It provides insights for development and implementation of publicly-supported legislation which prevent HIV and other STI transmission without undermining human rights in sub-Saharan Africa.

References

1. World Health Organization. *HIV/AIDS. Fact sheet N° 360*. Geneva: WHO, 2012.
<http://www.who.int/mediacentre/factsheets/fs360/en/index.html#> (accessed 12 November 2012).
2. Pearshouse R. Legislation contagion: the spread of problematic new HIV laws in Western Africa. *HIV AIDS Policy Law Rev* 2007;12:4-11.
3. Pearshouse R. Legislation contagion: building resistance. *HIV AIDS Policy Law Rev* 2008;13:4-10.
4. AWARE-HIV/AIDS. *Regional workshop to adopt a model law for STI/HIV/AIDS for West and Central Africa: General report*. N'Djamena: AWARE-HIV/AIDS, 2004.
5. Pearshouse R. *A human rights analysis of the N'djamena model legislation on AIDS and HIV-specific legislation in Benin, Guinea, Guinea-Bissau, Mali, Niger, Sierra Leone and Togo*. Canadian HIV/AIDS Legal Network, 2007.
6. Sanon P, Kaboré S, Wilen J, *et al*. Advocating prevention over punishment: the risks of HIV criminalization in Burkina Faso. *Reprod Health Matters* 2009;17:146-53
7. Gurnham D. What role should criminal justice play in the fight against STIs? *Sex Transm Infect* 2012;88:4-5.
8. Chalmers J. The criminalisation of HIV transmission. *Sex Transm Infect* 2002;78:448-51.
9. UNAIDS. Policy brief: Criminalization of HIV transmission. Geneva: UNAIDS, 2008.
<http://www.undp.org/content/undp/en/home/librarypage/hiv-aids/undp-and-unaid-policy-brief-on-criminalization-of-hiv-transmission.html>, (accessed 7 November 2012).
10. UNAIDS. Epidemiological fact sheet: Togo. Geneva: UNAIDS, 2009.
<http://www.unaids.org/fr/regionscountries/countries/togo/> (accessed 12 November 2012).

11. World Health Organization. *World Health Statistics: Mortality country fact sheet*. Geneva: WHO, 2006.
12. Pitché P, Kombaté K, Gbadoé AD, *et al.* Les maladies sexuellement transmissibles chez le jeune enfant à Lomé (Togo). Place de l'abus sexuel [Sexually transmitted diseases among children in Lomé, Togo. Role of sexual abuse]. *Arch Pediatr* 2001;8:25-31.
13. Moore AR, Oppong J. Sexual risk behavior among people living with HIV/AIDS in Togo. *Soc Sci Med* 2007;64:1057-66.
14. Dodds C. Homosexually active men's views on criminal prosecutions for HIV transmission are related to HIV prevention need. *AIDS Care* 2008;20:509-14.
15. Dodds C, Weatherburn P, Bourne A, *et al.* Sexually charged: *The views of gay and bisexual men on criminal prosecutions for sexual HIV transmission*. London: Sigma Research, 2009.
16. Horvath KJ, Weinmeyer R, Rosser S. Should it be illegal for HIV-positive persons to have unprotected sex without disclosure? An examination of attitudes among US men who have sex with men and the impact of state law. *AIDS Care* 2010;22:1221-28.
17. Ahmed RA, Sorum PC, Mullet E. Young Kuwaitis' views of the acceptability of physician-assisted-suicide. *J Med Ethics* 2010;36:671-76.
18. Kamble S, Sorum PC, Mullet E. Young Indians' views of the acceptability of physician-assisted suicide. *Int Perspect Psychol* 2012;1:165-76.

Figure 1:

Patterns of results corresponding to the three clusters: *Knowledge of Status* (left-hand panel), *Subsequent Behavior* (center panel), and *Knowledge and Behavior* (right-hand panel). In each panel, (a) the mean acceptability judgments are on the y-axis, (b) the three levels of awareness of the serological status are on the x-axis, and (c) the two curves correspond to the two levels of the male partner's attitudes towards his partner.

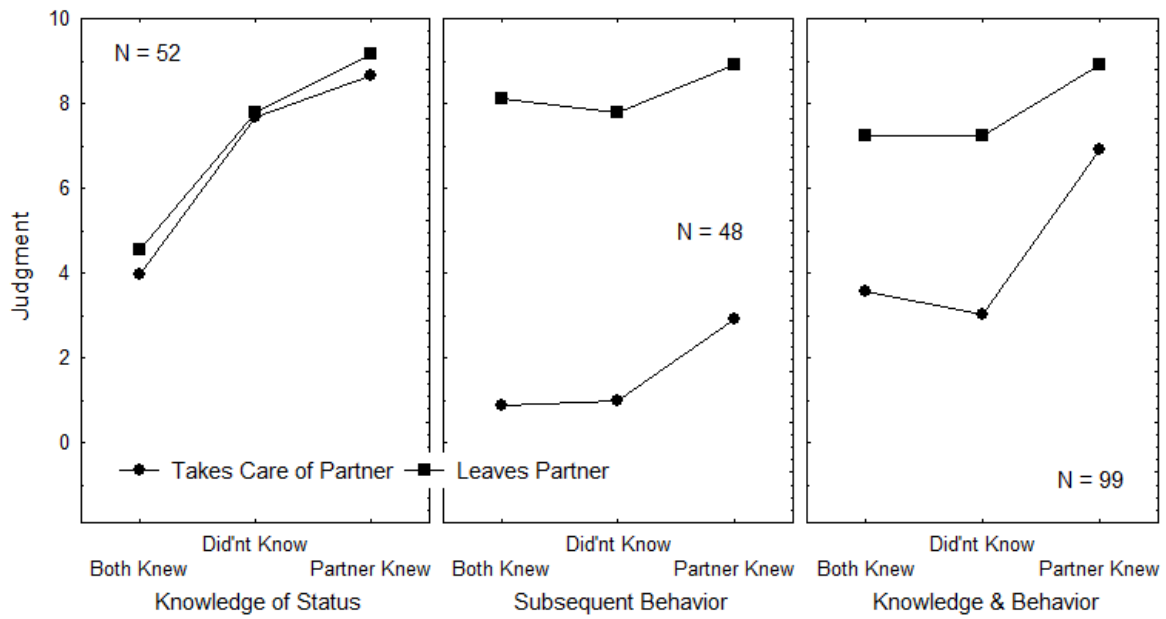


Figure 2:

Effect of the number of sexual partners the other person has had on the patterns of results.

