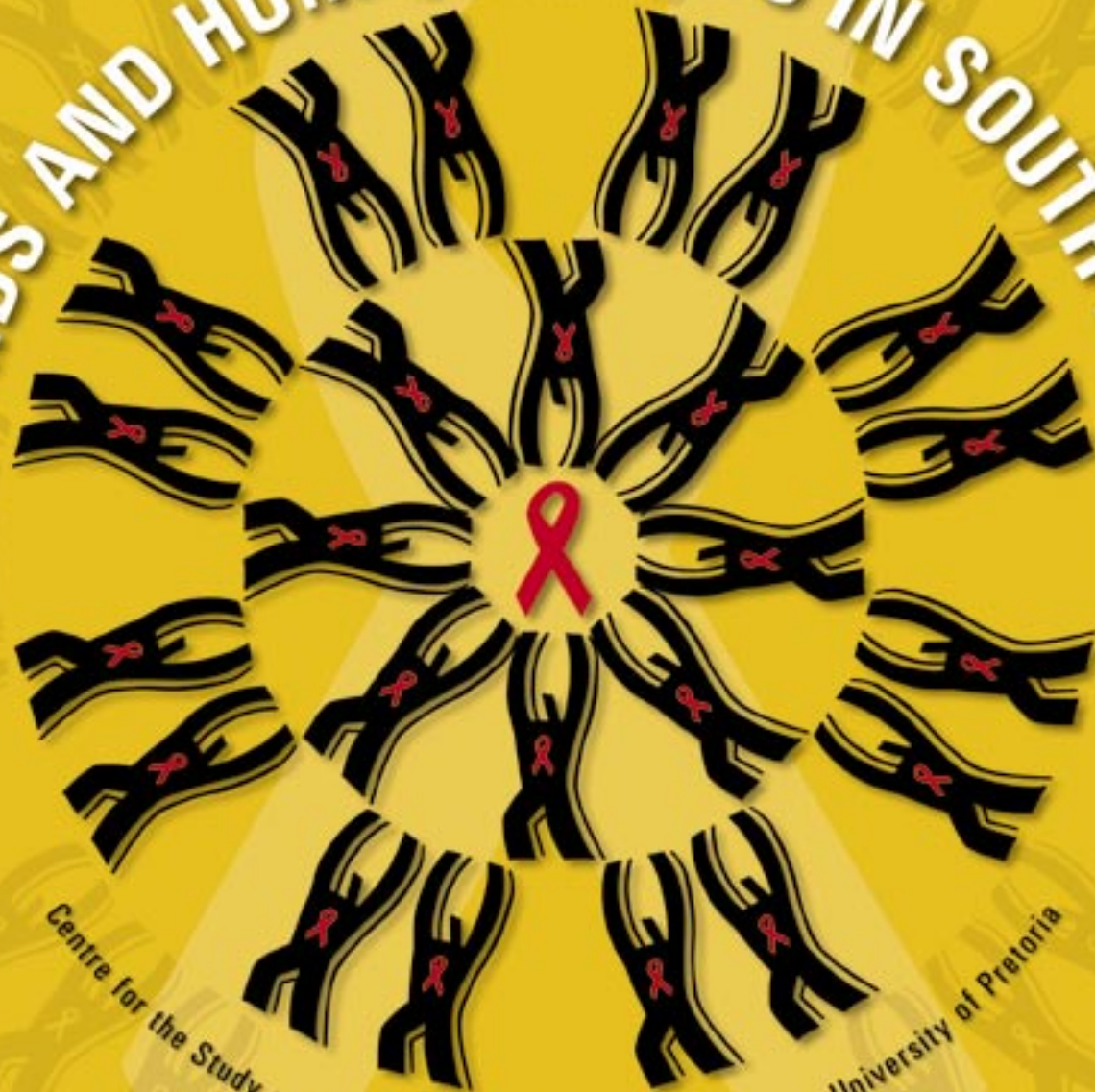


HIV/AIDS AND HUMAN RIGHTS IN SOUTH AFRICA



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1. INTRODUCTION

This country report on HIV/AIDS and human rights in South Africa is the result of a one-year joint project between the Centre for the Study of AIDS and the Centre for Human Rights, both based at the University of Pretoria, South Africa. The research project was made possible through funds provided by the Open Society Foundation. This report is one of a series of eight reports focusing on HIV/AIDS and human rights in the following countries within the Southern African Development Community (SADC): Botswana, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe. These countries have some of the highest and fastest growing rates of HIV/AIDS infection in the world, with the number of reported cases of HIV infection having tripled since the mid-1980s.

This research project was inspired by the need to develop a new approach to the HIV/AIDS epidemic in the SADC, an approach that is rights-based and that guarantees basic human rights to all people living with or affected by HIV/AIDS in the region. The study was guided by the document *HIV/AIDS and Human Rights – International Guidelines*¹ of 1996, adopted by UNAIDS and the Office of the United Nations High Commissioner for Human Rights. The Foreword of these *Guidelines* declares:

“In the context of HIV/AIDS, an environment in which human rights are respected ensures that vulnerability to HIV/AIDS is reduced, those infected with and affected by HIV/AIDS live a life of dignity without discrimination and the personal and societal impact of HIV infection is alleviated.”²

The aim of this research report, within the *SADC HIV/AIDS Framework for 2000-2004*, is to assist decision-makers to make informed policy choices for individual SADC countries. It is also intended for legislators, the judiciary, members of non-governmental organisations and people living with or affected by HIV/AIDS. All of these groups need: firstly, to be informed about

those human rights in the context of HIV/AIDS that are already protected within their countries; secondly, to be able to identify areas where there is a gap and a need to lobby for change; and finally, to initiate change in an effort to move towards a rights-based approach to HIV/AIDS.

This report is a summary of national HIV/AIDS policies, strategic frameworks, legislation, guidelines and court cases in South Africa as they relate to HIV/AIDS and human rights. A national consultant in South Africa collected the relevant documents, answered a questionnaire that was developed to structure the research, and commented on the final report.³ This report begins by briefly sketching the HIV/AIDS background for SADC and South Africa, through listing some critical statistics. The report then provides an analysis of the most important international, regional and SADC principles for HIV/AIDS and human rights, providing an overall framework against which the country report should be seen. The country report is a summary of the legal and policy framework for the protection of the human rights of those living with or affected by HIV/AIDS in South Africa, and addresses areas such as labour, health, gender, children, prisons and criminal law. This is followed by a concluding chapter with some recommendations regarding moving towards a rights-based approach to HIV/AIDS in the SADC.

It needs to be emphasised that this study focuses on the legal framework alone and does not set out to establish empirically the extent to which the respective governments are implementing the provisions in place – that is beyond the scope of this study and will require further research. Furthermore, while all efforts have been made to ensure that the information presented is reliable and up-to-date as at the end of 2003, the study’s authors do not accept any responsibility for any errors or omissions in the country reports.

¹ Available at: <http://www.unhchr.ch/hiv/guidelines.htm>

² The Foreword was written by Peter Piot, Executive Director of UNAIDS, and Mary Robinson, the former United Nations High Commissioner for Human Rights.

³ Lirette Louw, LLB, LLM (University of Pretoria), LLD Candidate (University of Pretoria).

2. BACKGROUND

In South Africa, the HIV prevalence rate amongst adults is currently 20,1% and this rate has not stabilised or decreased.

The tables below provide statistical information on all the SADC countries, with the statistics for South Africa highlighted.

2.1 Geographical size and population

The following two tables illustrate the size and population of the SADC countries in this study:⁴

Geographical size			
Botswana	581 730 km ²	South Africa	1 220 088 km²
Malawi	118 484 km ²	Swaziland	17 365 km ²
Mozambique	801 590 km ²	Zambia	752 614 km ²
Namibia	824 268 km ²	Zimbabwe	390 759 km ²

Population size		
Country	Total population	Adult population
Botswana	1 564 000	762 000
Malawi	11 572 000	5 118 000
Mozambique	18 644 000	8 511 000
Namibia	1 788 000	820 000
South Africa	43 792 000	23 666 000
Swaziland	933 000	450 000
Zambia	10 649 000	4 740 000
Zimbabwe	12 652 000	5 972 000

2.2 First reported instances of HIV infection⁵

Country	First reporting year	Number of cases
Botswana ⁶	1985	3
Malawi	1985	17
Mozambique	1986	1
Namibia ⁷	1986	1
South Africa	1982	2
Swaziland	1987	1
Zambia ⁸	1984	1
Zimbabwe	1987	119

⁴ Data from *Africa Fact Sheet*, published by African Institute of South Africa, July 1997.

⁵ According to the *Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections* (Update 2002), compiled by UNAIDS, UNICEF and WHO. Available at http://unaids.org/hiv/aidsinfo/statistics/fact_sheets/all_countries_en.html#N.

⁶ Doctors in Princess Marina Hospital in Gaborone documented the first HIV/AIDS case in 1985.

⁷ Reported by UNAIDS in the *International Partnership against AIDS in Africa - Namibia Country Visit Report*, 1 May-4 June 1999.

⁸ Reported in the *National HIV/AIDS/STD/TB Policy* published in October 2001 by the Zambian Ministry of Health.

2.3 HIV prevalence rates

The following figures are provided by the UNAIDS/WHO Working Group on Global HIV/AIDS and STI Surveillance, which works in close collaboration with national AIDS programmes.⁹ Statistics are also obtained from the *Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections, 2002 Update*, issued by UNAIDS, UNICEF and the WHO.¹⁰

Population with AIDS					
Country	Adults and children	Adults (15-49 years)	Adults (%)	Women (15-49 years)	Children (0-14 years)
Botswana	333 000	300 000	39,9%	170 000	28 000
Malawi	850 000	780 000	15%	440 000	65 000
Mozambique	1 100 000	1 000 000	13%	630 000	80 000
Namibia	230 000	200 000	22,5%	110 000	30 000
South Africa	5 000 000	4 700 000	20,1%	2 700 000	250 000
Swaziland	170 000	150 000	33,4%	89 000	14 000
Zambia	1 200 000	1 000 000	21,5%	690 000	150 000
Zimbabwe	2 300 000	2 000 000	33,7%	1 200 000	240 000

9 The estimates are from the *Table of Country-specific HIV/AIDS Estimates and Data, End 2001*, available at www.unaids.org/barcelona/presskit/barcelona%20reports/table.html. The estimates produced by UNAIDS/WHO draw on advice from the UNAIDS Reference Group on HIV/AIDS Estimates, Modelling and Projections. A measure of uncertainty applies to all estimates, depending on the reliability of the data available. Most of the data are from routine sentinel surveillance. For a detailed description of the general methodology used to produce the country-specific estimates, see Annexure I at <http://www.unaids.org/barcelona/presskit/barcelona%20report/annex1.html>.

10 Available at: http://www.unaids.org/hivaidinfo/statistics/fact_sheets/all_countries_en.html#N. The methodology used in updating and compiling these country-specific estimates is summarised in the publication as follows: "In 2001 and during the first quarter of 2002, UNAIDS and WHO worked closely with national governments and research institutions to recalculate current estimates of people living with HIV/AIDS. These calculations are based on the previously published estimates for 1997 and 1999 and recent trends in HIV/AIDS surveillance in various populations. A methodology developed in collaboration with an international group of experts was

HIV prevalence rates in young people aged 15-24 years				
Country	Female		Male	
	Low estimate	High estimate	Low estimate	High estimate
Botswana	29,99%	44,98%	12,86%	19,29%
Malawi	11,91%	17,87%	5,08%	7,62%
Mozambique	10,56%	18,78%	4,41%	7,84%
Namibia	19,43%	29,15%	8,88%	13,32%
South Africa	20,51%	30,76%	8,53%	12,79%
Swaziland	31,59%	47,38%	12,18%	18,27%
Zambia	16,78%	26,18%	6,45%	9,68%
Zimbabwe	26,40%	39,61%	9,9%	14,86%

Tuberculosis (TB) infection rates	
Country	TB prevalence for the year 2000 (unless otherwise stated)
Botswana	8 649 ¹¹
Malawi	22 570
Mozambique	Unknown
Namibia	10 497
South Africa	One sentinel site (Port Shepstone) outside major urban areas: 52% minimum, 52% median, 52% maximum.
Swaziland	2 143
Zambia	161 056. The average tuberculosis rate between 1964 and 1984 remained constant at 100 per 100 000 people. The rate of TB infections increased dramatically to nearly five-fold to over 500 per 100 000 people due to the impact of HIV/AIDS in 1996. ¹² TB co-infection has resulted in an increased mortality rate of TB patients on treatment by over 15%. ¹³
Zimbabwe	51 805

used to calculate the new estimates on prevalence and incidence of HIV and AIDS deaths, as well as the number of children infected through mother-to-child transmission of HIV. Different approaches were used to estimate HIV prevalence in countries with low-level, concentrated or generalised epidemics. The current estimates do not claim to be an exact count of infections. Rather, they use a methodology that has thus far proved accurate in producing estimates which give a good indication of the magnitude of the epidemic in individual countries. However, these estimates are constantly being revised as countries improve their surveillance and collect more information."

11 Southern African Development Community *Health Annual Progress Report 2000-2001*.

12 *National HIV/AIDS/STD/TB Policy* published in October 2001 by the Ministry of Health of the Republic of Zambia. See par 1.2.3.

13 Ibid, par 1.2.4.

Number of pregnant mothers who are HIV positive								
Country	HIV prevalence in antenatal clinics in urban areas (%)				HIV prevalence in antenatal clinics outside major urban areas (%)			
	Year	Median	Min	Max	Year	Median	Min	Max
Botswana	2001	44,9%	39,1%	55,8%	2001	34,8%	25,8%	50,9%
Malawi	2001	20,1%	18,6%	28,5%	2001	16,1%	4,5%	35,8%
Mozambique	2000	14,4%	13,0%	15,7%	2000	10,6%	4,0%	31,2%
Namibia	2000	29,6%	28,2%	31,0%	2000	17,3%	6,6%	32,5%
South Africa	2000	24,3%	8,7%	36,2%	2000	22,9%	11,2%	29,7%
Swaziland	2000	32,3%	32,3%	32,3%	2000	34,5%	27,0%	41,0%
Zambia	2001	30,7%	30,7%	30,7%	1998	13,0%	5,2%	31,0%
Zimbabwe	2000	31,1%	30,0%	33,5%	2000	33,2%	13,0%	70,7%

According to the 2002 Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections, the highest prevalence of HIV infection was recorded amongst women aged 25-29 years.

2.4 AIDS deaths in adults and children in 2001

Botswana	26 000	South Africa	360 000
Malawi	80 000	Swaziland	12 000
Mozambique	60 000	Zambia	120 000
Namibia	13 000	Zimbabwe	200 000

2.5 Number of HIV/AIDS orphans (up to 14 years) by end of 2001

Botswana	69 000	South Africa	660 000
Malawi	470 000	Swaziland	35 000
Mozambique	420 000	Zambia	570 000
Namibia	47 000	Zimbabwe	780 000

3. OVERVIEW OF APPLICABLE INTERNATIONAL, REGIONAL AND SADC LEGAL NORMS

This section examines the international, regional and SADC framework for the protection of human rights, as it relates to HIV/AIDS, to form the backdrop against which the national framework of South Africa should be considered. The international and regional human rights treaties examined do not include any HIV/AIDS-specific provisions. Nevertheless, a number of articles can be highlighted in the various treaties as they indirectly impact on people living with HIV/AIDS or their families. For instance, the *International Covenant on Economic, Social and Cultural Rights (ICESCR)* affirms that state parties to the *Covenant* should recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.¹⁴ The *Covenant* then continues that state parties, in order to achieve this right, should prevent, treat and control epidemic, endemic, occupational and other diseases.¹⁵ These provisions would clearly apply to HIV/AIDS.

This section also briefly summarises the state reports submitted by South Africa in terms of its obligations under the various treaties that it has ratified, with a specific focus on HIV/AIDS reporting and recommendations made by the treaty monitoring bodies in relation to HIV/AIDS.¹⁶

Finally, SADC and Organisation of African Unity (OAU)/African Union (AU) HIV/AIDS instruments and policies are discussed, followed by a short discussion on *HIV/AIDS and Human Rights – International Guidelines*, issued by UNAIDS and the Office of the United Nations High Commissioner for Human Rights.

¹⁴ Article 12(1) of the *ICESCR*.

¹⁵ Article 12(2)(c).

¹⁶ State reporting is a useful tool to monitor a state party's progress in implementing the various provisions of a treaty. Usually, states submit a report shortly after ratifying a treaty (initial report) and thereafter the state must report to the monitoring body every two

3.1 Applicable international legal norms

There are no HIV/AIDS-specific treaties within the international legal framework. The *International Covenant on Civil and Political Rights (ICCPR)* and the *International Covenant on Economic, Social and Cultural Rights (ICESCR)* both came into force in 1976, about four years before the first HIV/AIDS case was documented. Nevertheless, specific provisions of these treaties may be applied to various legal situations affecting people living with or affected by HIV/AIDS. The *Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)* is similar, having been adopted in the early days of the epidemic. The *Convention on the Rights of the Child (CRC)*, however, was adopted in 1989, nearly ten years after the first reported case of HIV/AIDS. The fact that in the CRC no mention is made of HIV/AIDS with respect to children can be viewed as a missed opportunity to develop policy for this vulnerable group.

The status of these treaties is as follows (all dates denote ratification or accession, except when marked with 's,' in which case the treaty has only been signed by the state party):¹⁷

Country	ICCPR	ICCPR First Optional Protocol	ICESCR	CEDAW	CEDAW Optional Protocol	CRC
Botswana	08/01/2000			12/09/1996		13/04/1995
Malawi	22/03/1994	11/09/1996	22/03/1994	11/04/1987	7/09/2000 ^s	01/02/1991
Mozambique	21/10/1993			16/05/1997		26/05/1994
Namibia	28/02/1995	28/02/1995	28/02/1995	23/12/1992	22/12/2000	30/10/1990

years. Unfortunately, most African states are behind in submitting reports internationally and regionally.

¹⁷ Status of ratification of international human rights treaties as of 02 November 2003 provided by the Office of the United Nations High Commissioner for Human Rights. Available at: www.unhcr.ch/pdf/report.pdf. Date accessed: 24 November 2003.

Country	ICCPR	ICCPR First Optional Protocol	ICESCR	CEDAW	CEDAW Optional Protocol	CRC
South Africa	10/03/1999	28/11/2002	03/10/1994*	14/01/1996		16/07/1995
Swaziland						06/10/1995
Zambia	10/07/1984	10/07/1984	10/07/1984	21/07/1985		05/01/1992
Zimbabwe	13/08/1991		13/08/1991	12/06/1991		11/10/1990

States parties submit reports to the various treaty monitoring bodies that are established in terms of the treaties. These reports may include details of measures taken by the state to address the issue of HIV/AIDS, but it is not compulsory to report in this form. Treaty bodies in turn examine the state reports and issue Concluding Observations.

In general, international treaties do not have a direct impact on the domestic legal systems of specific countries. These treaties can – and should – guide legislators to draft national laws to fulfil their obligations and to incorporate the treaty rights into domestic legislation. However, it will become clear in Section Four that this has seldom been the case.

Various provisions in the selected treaties that are particularly relevant for HIV/AIDS are described below.

International Covenant on Civil and Political Rights (ICCPR)

- *Article 2:*
 - (1) Each State Party to the present Covenant undertakes to respect and to ensure to all individuals within its territory and subject to its jurisdiction the rights recognised in the present Covenant, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.
 - (3) Each State Party to the present Covenant undertakes:
 - (a) To ensure that any person whose rights or freedoms as herein recognised are violated shall have an effective remedy, notwithstanding that the violation has been committed by persons acting in an official capacity;
 - (b) To ensure that any person claiming such a remedy shall have his right thereto determined

by competent judicial, administrative or legislative authorities, or by any other competent authority provided for by the legal system of the State, and to develop the possibilities of judicial remedy;

(c) To ensure that competent authorities shall enforce such remedies when granted.

- *Article 6:* (1) Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life.
- *Article 7:* No one shall be subjected to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation.
- *Article 17:*
 - (1) No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honour and reputation.
 - (2) Everyone has the right to protection of the law against such interference or attacks.
- *Article 19:* (2) Everyone shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally in writing or in print, in the form of art, or through any other media of his choice.
- *Article 22:* Everyone shall have the right to freedom of association with others ...
- *Article 24:* (1) Every child shall have, without any discrimination as to race, colour, sex, language, religion, national or social origin, property or birth, the right to such measures of protection as are required by his status as a minor, on the part of his family, society and the State.
- *Article 26:* All persons are equal before the law and are entitled without any discrimination to the equal protection of the law. In this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

First Optional Protocol to the International Covenant on Civil and Political Rights

- *Article 1:* A State Party to the Covenant that becomes a Party to the present Protocol recognises the competence of the Committee to receive and consider communications from individuals subject to its jurisdiction who claim to be victims of a violation by that State Party of any of the rights set forth in the Covenant. No communication shall be received

by the Committee if it concerns a State Party to the Covenant which is not a party to the present Protocol.

International Covenant on Economic, Social and Cultural Rights (ICESCR)

- *Article 2:*
(1) Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realisation of the rights recognised in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.
(2) The States Parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.
- *Article 6:* (1) The States Parties to the present Covenant recognise the right to work, which includes the right of everyone to the opportunity to gain his living by work which he freely chooses or accepts, and will take appropriate steps to safeguard this right.
- *Article 7:* The States Parties to the present Covenant recognise the right of everyone to the enjoyment of just and favourable conditions of work which ensure in particular: ... (b) Safe and healthy working conditions; (c) Equal opportunity for everyone to be promoted in his employment to an appropriate higher level, subject to no considerations other than those of seniority and competence ...
- *Article 9:* The States Parties to the present Covenant recognise the right of everyone to social security, including social insurance.
- *Article 10:* The States Parties to the present Covenant recognise that: ... (3) Special measures of protection and assistance should be taken on behalf of all children and young persons without any discrimination for reasons of parentage or other conditions. Children and young persons should be protected from economic and social exploitation. Their employment in work harmful to their morals or health or dangerous to life or likely to hamper their normal development should be punishable by law. States should also set age limits below which the paid employment of child labour should be prohibited and punishable by law.
- *Article 11:* (1) The States Parties to the present Covenant recognise the right of everyone to

an adequate standard of living for himself and his family, including adequate food, clothing and housing, and to the continuous improvement of living conditions ...

- *Article 12:*
(1) The States Parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
(2) The steps to be taken by the States Parties to the present Covenant to achieve the full realisation of this right shall include those necessary for: (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child; (b) The improvement of all aspects of environmental and industrial hygiene; (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases; (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.
- *Article 13:* (1) The States Parties to the present Covenant recognise the right of everyone to education. They agree that education shall be directed to the full development of the human personality and the sense of its dignity, and shall strengthen the respect for human rights and fundamental freedoms ...
- *Article 15:* (1) The States Parties to the present Covenant recognise the right of everyone: ... (b) To enjoy the benefits of scientific progress and its applications ...

Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)

- *Article 1:* For the purposes of the present Convention, the term “discrimination against women” shall mean any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.
- *Article 2:* States Parties condemn discrimination against women in all its forms, agree to pursue by all appropriate means and without delay a policy of eliminating discrimination against women and, to this end, undertake:
(a) To embody the principle of the equality of men and women in their national constitutions or other appropriate legislation if not yet incorporated therein and to ensure, through law

- and other appropriate means, the practical realisation of this principle;
- (b) To adopt appropriate legislative and other measures, including sanctions where appropriate, prohibiting all discrimination against women;
 - (c) To establish legal protection of the rights of women on an equal basis with men and to ensure through competent national tribunals and other public institutions the effective protection of women against any act of discrimination;
 - (d) To refrain from engaging in any act or practice of discrimination against women and to ensure that public authorities and institutions shall act in conformity with this obligation;
 - (e) To take all appropriate measures to eliminate discrimination against women by any person, organisation or enterprise;
 - (f) To take all appropriate measures, including legislation, to modify or abolish existing law, regulations, customs and practices which constitute discrimination against women;
 - (g) To repeal all national penal provisions which constitute discrimination against women.
- *Article 10:* States Parties shall take all appropriate measures to eliminate discrimination against women in order to ensure to them equal rights with men in the field of education and in particular to ensure, on a basis of equality of men and women: ... (f) The reduction of female student drop-out rates and the organisation of programmes for girls and women who have left school prematurely; (h) Access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning.
 - *Article 11:* (1) States Parties shall take all appropriate measures to eliminate discrimination against women in the field of employment in order to ensure, on a basis of equality of men and women, the same rights, in particular: (a) The right to work as an inalienable right of all human beings; ... (e) The right to social security, particularly in cases of retirement, unemployment, sickness, invalidity and old age and other incapacity to work, as well as the right to paid leave; (f) The right to protection of health and to safety in working conditions, including the safeguarding of the function of reproduction.
 - *Article 12:*
 - (1) States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.
 - (2) Notwithstanding the provisions of paragraph 1 of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-

natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

- *Article 14:* (2) States Parties shall take all appropriate measures to eliminate discrimination against women in rural areas in order to ensure, on a basis of equality of men and women, that they participate in and benefit from rural development and, in particular, shall ensure to such women the right: ... (b) To have access to adequate health care facilities, including information, counselling and services in family planning; (c) To benefit directly from social security programmes; (d) To obtain all types of training and education, formal and non-formal, including that relating to functional literacy, as well as, inter alia, the benefit of all community and extension services, in order to increase their technical proficiency; ... (h) To enjoy adequate living conditions, particularly in relation to housing, sanitation, electricity and water supply, transport and communications.

Optional Protocol to the Convention on the Elimination of Discrimination against Women

- *Article 1:* A State Party to the present Protocol (“State Party”) recognises the competence of the Committee on the Elimination of Discrimination against Women (“the Committee”) to receive and consider communications submitted in accordance with Article 2.
- *Article 2:* Communications may be submitted by or on behalf of individuals or groups of individuals, under the jurisdiction of a State Party, claiming to be victims of a violation of any of the rights set forth in the Convention by that State Party ...

Convention on the Rights of the Child (CRC)

- *Article 1:* For the purposes of the present Convention, a child means every human being below the age of 18 years unless, under the law applicable to the child, majority is attained earlier.
- *Article 2:*
 - (1) States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child’s or his or her parent’s or legal guardian’s race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.
 - (2) States Parties shall take all appropriate measures to ensure that the child is protected against all forms of discrimination or punishment on the basis of the status, activities, ex-

- pressed opinions, or beliefs of the child's parents, legal guardians or family members.
- *Article 3:* (1) In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.
 - *Article 6:*
 - (1) States Parties recognise that every child has the inherent right to life.
 - (2) States Parties shall ensure to the maximum extent possible the survival and development of the child.
 - *Article 13:* (1) The child shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of the child's choice.
 - *Article 15:* (1) States Parties recognise the rights of the child to freedom of association and to freedom of peaceful assembly.
 - *Article 16:*
 - (1) No child shall be subjected to arbitrary or unlawful interference with his or her privacy, family, home or correspondence, nor to unlawful attacks on his or her honour and reputation.
 - (2) The child has the right to the protection of the law against such interference or attacks.
 - *Article 17:* States Parties recognise the important function performed by the mass media and shall ensure that the child has access to information and material from a diversity of national and international sources, especially those aimed at the promotion of his or her social, spiritual and moral well-being and physical and mental health ...
 - *Article 24:*
 - (1) States Parties recognise the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. State Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services;
 - (2) States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures: (a) To diminish infant and child mortality; (b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care; (c) To combat disease and malnutrition, including within the frame-

work of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water; (d) To ensure appropriate pre-natal and post-natal health care for mothers; (f) To develop preventive health care, guidance for parents and family planning education and services.

(3) States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.

- *Article 26:* (1) States Parties shall recognise for every child the right to benefit from social security, including social insurance, and shall take the necessary measures to achieve the full realisation of this right in accordance with their national law.
- *Article 27:* (1) States Parties recognise the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development.
- *Article 28:* (1) States Parties recognise the right of the child to education, and with a view to achieving this right progressively and on the basis of equal opportunity, they shall, in particular: (a) Make primary education compulsory and available free to all; (b) Encourage the development of different forms of secondary education, including general and vocational education, make them available and accessible to every child and take appropriate measures such as the introduction of free education and offering financial assistance in case of need; (c) Make higher education accessible to all on the basis of capacity by every appropriate means; (d) Make educational and vocational information and guidance available and accessible to all children; (e) Take measures to encourage regular attendance at schools and the reduction of drop-out rates.
- *Article 33:* States Parties shall take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances ...
- *Article 34:* States Parties undertake to protect the child from all forms of sexual exploitation and sexual abuse. For these purposes, States Parties shall in particular take all appropriate national, bilateral and multilateral measures to prevent: (a) The inducement or coercion of a child to engage in any unlawful sexual activity; (b) The exploitative use of children in prostitution or other unlawful sexual practices; (c) The exploitative use of children in pornographic performances and materials.
- *Article 36:* States Parties shall protect the child against all other forms of exploitation prejudicial to any aspects of the child's welfare.

3.2 State reporting

South Africa's initial report (CRC/C/51/Add.2) to the Committee on the Rights of the Child was submitted on 4 December 1997 and referred to the HIV/AIDS epidemic in the following instances:¹⁸

1. The South African Law Commission has recently appointed project committees to examine legislation on the prevention of family violence, children in difficult circumstances, and HIV/AIDS policy in schools.¹⁹
2. A number of Presidential Lead Projects of the Reconstruction and Development Programme (RDP) seek to provide basic services to children in the most disadvantaged areas, particularly informal settlements and rural areas. These include housing, water and sanitation, electrification, health-care services, primary school nutrition, clinic building programmes, and HIV/AIDS awareness and prevention.²⁰
3. Of the total number of AIDS cases reported up to December 1994, 10.7% were children.²¹
4. In order to address the problem of teenage pregnancy and STD/HIV infection in adolescents, the Department of Education has included life-skills education in the formal school curriculum. Condom distribution is under way; the female condom has been introduced, and primary health care and family planning staff have already been trained in its use.²²
5. The HIV/AIDS epidemic is of profound significance to the well-being of the children of South Africa. Rape and the sexual abuse of children are increasing rapidly and are a matter of grave concern.²³
6. The report discussed the results of a national HIV survey of women attending antenatal clinics of the public health services in October and November 1996. The report stated that up to 30% of paediatric hospital beds were occupied by HIV/AIDS patients and that management in these cases focused on the immediate concomitant fungal infections, as antiviral medication was well beyond the scope of the health budget of the country.²⁴

7. The South African National AIDS Programme consists of all the "traditional" elements, which constitute the response of any country. Following on the recommendations of the National STD/HIV/AIDS Review conducted during 1997, an expanded programme needs to be launched, which will draw in more sectors than previously and give particular attention to development and gender issues. An important strategy is the Life Skills Education Programme in schools, which was preceded by specific teacher training.²⁵
8. Proposals from the Department of Welfare include strategies to develop programmes to encourage foster care and adoption of HIV/AIDS orphans within the broader family and community. Expansion of the current special care and foster care grants might be suitable options in this regard. The new policy on the child and youth care system makes provision for community-based care alternatives, as well as appropriate residential care when absolutely necessary.²⁶
9. The report highlighted harmful traditional practices and how they relate to HIV/AIDS. It specifically referred to scarification of the skin with subsequent application of "medicine" which is commonly practised either as a preventive measure or to "release the disease" from a painful part of the body. The instrument, usually a razor blade, is not sterilised and raises the potential risk of spreading HIV and the hepatitis B virus.²⁷
10. The South African Law Commission, in collaboration with the Department of Education, has developed a policy for reaching learners with HIV/AIDS.²⁸
11. The HIV/AIDS epidemic can be regarded as a contributory cause and consequence of the sexual exploitation of children. The dangerous myth that sex with a virgin or young girl will either cure or prevent AIDS has resulted in an increase in child sexual exploitation. In addition, HIV/AIDS leaves increasing numbers of children orphaned, who often resort to selling their bodies to survive in child-headed families.²⁹
12. A small private sector initiative called The House has been established to remove children from undesirable places and to assist in the rehabilitation of persons under the age of 21 who are involved in prostitution and other undesirable activities. The House will also engage in public education in matters relating to drug abuse, juvenile prostitution and HIV/AIDS.³⁰

¹⁸ South Africa's initial report is available at: [http://www.unhchr.ch/tbs/doc.nsf/\(Symbol\)/d2c94c67c4df8870802567ef0035d7c8?OpenDocument](http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/d2c94c67c4df8870802567ef0035d7c8?OpenDocument).

¹⁹ Par 13.

²⁰ Par 127.

²¹ Par 221.

²² Par 250.

²³ Par 254.

²⁴ Par 255 a) - d).

²⁵ Pars 256 - 257.

²⁶ Par 258.

²⁷ Par 273(c).

²⁸ Par 408.

²⁹ Par 553.

³⁰ Par 578.

The Committee on the Rights of the Child considered the initial report of South Africa on 25 and 26 January 2000 and adopted Concluding Observations (CRC/C/15/Add.122) at its 615th meeting held on 28 January 2000.³¹ The Committee observed the following with respect to HIV/AIDS:

- While the Committee notes that the state party has launched a Partnership Against HIV/AIDS Programme (1998) which aims, inter alia, to establish counselling and treatment centres for people living with HIV/AIDS and sexually transmitted diseases, it remains concerned about the high and increasing incidence of HIV/AIDS and STDs.
- The Committee recommends the reinforcement of training programmes for youth on reproductive health, HIV/AIDS and STDs.
- The Committee further recommends the full participation of youth in the development of strategies to respond to HIV/AIDS at the national, regional and local levels.
- Particular emphasis should be placed on changing public attitudes toward HIV/AIDS and identifying strategies to address the continued discrimination experienced by children and adolescents infected with HIV.³²

3.3 Applicable regional legal norms

The *African Charter on Human and Peoples' Rights (ACHPR)* was adopted in 1981 but makes no specific reference to HIV/AIDS. The *African Charter on the Rights and Welfare of the Child (ACRWC)* was adopted nearly ten years later, in 1990, but still does not include any reference to HIV/AIDS. It is only within the *Guidelines on State Reporting to the African Committee on the Rights and Welfare of the Child* that mention is made of HIV/AIDS. The *Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa*, which has been adopted but is not yet in force, mentions HIV/AIDS in a cursory manner.³³ This is very unfortunate, given the impact of HIV/AIDS on African women.

The status of these treaties in respect of the states under discussion is as follows (all dates denote ratification or accession, except when marked with 's,' in which case the treaty has only been signed by the state party):³⁴

Country	ACHPR	ACRWC
Botswana	17 July 1986	
Malawi	17 November 1989	16 September 1999
Mozambique	22 February 1989	15 July 1998
Namibia	30 July 1992	13 July 1999 ^s
South Africa	09 July 1996	07 January 2000
Swaziland	15 September 1995	29 June 1992 ^s
Zambia	19 January 1984	28 February 1992 ^s
Zimbabwe	30 May 1986	19 January 1995

Excerpts from various provisions in the regional treaties that are particularly relevant for HIV/AIDS are listed below.

African Charter on Human and Peoples' Rights (ACHPR)

- *Article 2:* Every individual shall be entitled to the enjoyment of the rights and freedoms recognised and guaranteed in the present Charter without distinction of any kind such as race, ethnic group, colour, sex, language, religion, political or any other opinion, national and social origin, fortune, birth or other status.
- *Article 4:* Human beings are inviolable. Every human being shall be entitled to respect for his life and the integrity of his person. No one may be arbitrarily deprived of this right.
- *Article 5:* Every individual shall have the right to the respect of the dignity inherent in a human being and to the recognition of his legal status ...
- *Article 6:* Every person shall have the right to liberty and to the security of his person ...
- *Article 9:*
 - (1) Every individual shall have the right to receive information.

31 The Committee's Concluding Observations can be accessed at: [http://www.unhcr.ch/tbs/doc.nsf/\(Symbol\)/CRC.15.add.122.En?Opendocument](http://www.unhcr.ch/tbs/doc.nsf/(Symbol)/CRC.15.add.122.En?Opendocument).

32 Par 31, pages 9 - 10.

33 Status of ratification and signature of the ACHPR and ACRWC compiled by the University of Minnesota, Human Rights Library as of 1 January 2000. Available at www1.umn.edu/humanrts/instree/afchildratifications.htm and www1.umn.edu/humanrts/instree/ratzlafchr.htm.

Accessed: 13 September 2002.

34 Article 14(1) states that: "States Parties shall ensure that the right to health of women, including sexual and reproductive health, is respected and promoted. This includes:... (d) the right to self protection and to be protected against sexually transmitted infections, including HIV/AIDS ..."

- (2) Every individual shall have the right to express and disseminate his opinions within the law.
- *Article 10:* (1) Every individual shall have the right to free association, provided that he abides by the law.
- *Article 11:* Every individual shall have the right to assemble freely with others. The exercise of this right shall be subject only to necessary restrictions provided for by law, in particular those enacted in the interest of national security, the safety, health, ethics, and rights and freedoms of others.
- *Article 12:* (1) Every individual shall have the right to freedom of movement and residence within the borders of a State provided he abides by the law.
- *Article 15:* Every individual shall have the right to work under equitable and satisfactory conditions, and shall receive equal pay for equal work.
- *Article 16:*
 - (1) Every individual shall have the right to enjoy the best attainable state of physical and mental health.
 - (2) States Parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.
- *Article 17:*
 - (1) Every individual shall have the right to education.
 - (2) Every individual may freely take part in the cultural life of his community.
 - (3) The promotion and protection of morals and traditional values recognised by the community shall be the duty of the State.
- *Article 18:*
 - (1) The family shall be the natural unit and basis of society. It shall be protected by the State which shall take care of its physical health and morals.
 - (2) The State shall have the duty to assist the family which is the custodian of morals and traditional values recognised by the community.
 - (3) The State shall ensure the elimination of every discrimination against women and also ensure the protection of the rights of the woman and the child as stipulated in international declarations and conventions.
 - (4) The aged and the disabled shall also have the right to special measures of protection in keeping with their physical or moral needs.
- *Article 19:* All peoples shall be equal; they shall enjoy the same respect and shall have the

same rights. Nothing shall justify the domination of a people by another.

- *Article 24:* All peoples shall have the right to a general satisfactory environment favourable to their development.

African Charter on the Rights and Welfare of the Child (ACRWC)

- *Article 3:* Every child shall be entitled to the enjoyment of the rights and freedoms recognised and guaranteed in this Charter irrespective of the child's or his/her parents' or legal guardians' race, ethnic group, colour, sex, language, religion, political or other opinion, national and social origin, fortune, birth or other status.
- *Article 4:* (1) In all actions concerning the child undertaken by any person or authority the best interests of the child shall be the primary consideration.
- *Article 5:* (1) Every child has an inherent right to life. This right shall be protected by law.
- *Article 8:* Every child shall have the right to free association and freedom of peaceful assembly in conformity with the law.
- *Article 10:* No child shall be subject to arbitrary or unlawful interference with his privacy, family home or correspondence, or to the attacks upon his honour or reputation, provided that parents or legal guardians shall have the right to exercise reasonable supervision over the conduct of their children. The child has the right to the protection of the law against such interference or attacks.
- *Article 11:*
 - (1) Every child shall have the right to an education.
 - (2) The education of the child shall be directed to: ... (h) the promotion of the child's understanding of primary health care.
 - (3) States Parties to the present Charter shall take all appropriate measures with a view to achieving the full realisation of this right and shall in particular: ... (e) take special measures in respect of female, gifted and disadvantaged children, to ensure equal access to education for all sections of the community.
- *Article 14:*
 - (1) Every child shall have the right to enjoy the best attainable state of physical, mental and spiritual health.
 - (2) State Parties to the present Charter shall undertake to pursue the full implementation of this right and in particular shall take measures: (a) to reduce infant and child mortality

rate; (b) to ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care; (c) to ensure the provision of adequate nutrition and safe drinking water; (d) to combat disease and malnutrition within the framework of primary health care through the application of appropriate technology; (e) to ensure appropriate health care for expectant and nursing mothers; (f) to develop preventative health care and family life education and provision of service; (g) to integrate basic health service programmes in national development plans ...

- *Article 21:* (1) States Parties to the present Charter shall take all appropriate measures to eliminate harmful social and cultural practices affecting the welfare, dignity, normal growth and development of the child and in particular: (a) those customs and practices prejudicial to the health or life of the child; and (b) those customs and practices discriminatory to the child on the grounds of sex or other status.
- *Article 24:* State Parties which recognise the system of adoption shall ensure that the best interest of the child shall be the paramount consideration ...
- *Article 25:* (2) State Parties to the present Charter: (a) shall ensure that a child who is parentless, or who is temporarily or permanently deprived of his or her family environment, or who in his or her best interest cannot be brought up or allowed to remain in that environment shall be provided with alternative family care, which could include among others, foster placement, or placement in suitable institutions for the care of children;
- *Article 27:* States Parties to the present Charter shall undertake to protect the child from all forms of sexual exploitation and sexual abuse and shall in particular take measures to prevent:
 - (a) the inducement, coercion or encouragement of a child to engage in any sexual activity;
 - (b) the use of children in prostitution or other sexual practices;
 - (c) the use of children in pornographic activities, performances and materials.
- *Article 28:* States Parties to the present Charter shall take all appropriate measures to protect the child from the use of narcotics and illicit use of psychotropic substances ...

According to Article 43(1) of the ACRWC, state parties must undertake to submit to the African Committee of Experts of the Rights and Welfare of the Child, through the Chairperson of the Commission of the African Union, reports on the measures that have been adopted to give

effect to the provisions of the ACRWC, and the progress made in the enjoyment of the rights guaranteed in the Charter. The *Guidelines* for reporting specify that the state parties should indicate what measures are in place for children in need of special protection, specifically in reference to AIDS orphans, in terms of Article 26 of the *Charter*.³⁵ States are also encouraged to provide specific statistical information and indicators relevant to children in need of special protection.³⁶ The first report under ACRWC is due within two years of the state's ratification of the *Charter*, and thereafter reports are due every third year. Unfortunately, not one of the eight countries in this study has submitted reports to date.

3.4 SADC framework for addressing HIV/AIDS

In September 1997, the SADC Council of Ministers adopted the first relevant document addressing HIV/AIDS-related issues, the *Code of HIV/AIDS and Employment in SADC*, as developed by the Employment and Labour Sector. The main objectives of the *Code* are to sensitise employers to the issue of employee rights and HIV/AIDS, and to provide a framework for states to consolidate national employment codes on HIV/AIDS-related issues. It addresses public sector employers, legislators, employees and trade unions.

In August 1999, the 14 member states adopted the *SADC Health Protocol*.³⁷ Article 10 specifically deals with HIV/AIDS and sexually transmitted diseases (STDs). The article urges states parties to harmonise policies and approaches for the prevention and management of HIV/AIDS and STDs, and to develop regional policies and plans that work towards an inter-sectoral approach to the epidemic.

In December 1999, the SADC HIV/AIDS Task Force adopted the vision document *A SADC Society with Reduced HIV/AIDS*. It was adopted to guide the work of the SADC in the development and implementation of a multi-sectoral *HIV/AIDS Framework for 2000-2004* (hereinafter referred to as the *Strategic Framework*). The *Strategic Framework* is in principle guided by Article 10 of the *SADC Health Protocol*; all SADC sectors agree to use their comparative advantages

35 Par 21(g) of the (Adopted) *Guidelines for Initial Reports of State Parties under the ACRWC*.

36 Par 22.

37 *SADC Health Protocol*. Available at: <http://196.36.153.56/doh/department/sadc/docs/protocol99.html>.

to address the needs of those sectors and the communities they serve, whether transport, mining, tourism, etc. One of the principles that has been acknowledged as important in the development of the *Strategic Framework* is the respect for the rights of individuals.³⁸

The only sector in the *Strategic Framework* that specifically mentions stigmatisation and discrimination is the Human Resources Development. This sector aims to provide information to reduce stigma and to change attitudes by, amongst other initiatives, integrating HIV/AIDS education and life skills into school curricula across the region.³⁹

In September 2000, the SADC Council of Ministers approved the *Health Sector Policy Framework Document*, as developed by the SADC Health Ministers.⁴⁰ A significant part of the programme focuses on HIV/AIDS and sexually transmitted diseases. One of the policy objectives in the programme, geared towards HIV/AIDS control, is to protect and promote the rights of individuals, in particular those living with or most vulnerable to HIV/AIDS.

A month prior to the adoption of the *Health Sector Policy Framework*, the SADC Health Ministers adopted *Principles to Guide Negotiations with Pharmaceutical Companies on Provision of Drugs for Treatment of HIV/AIDS-Related Conditions in SADC Countries*.⁴¹ These principles focus on enabling SADC countries to make informed decisions in their negotiations with pharmaceutical companies and to consider factors such as sustainability, affordability, accessibility, appropriateness, acceptability and equity before accepting offers for free drugs or reduced prices on HIV/AIDS-related drugs.

In July 2003, the SADC Heads of Government signed the *SADC Declaration on HIV/AIDS*.⁴² The *Declaration* affirms the commitment to address the pandemic and the issues relating to HIV/AIDS in the SADC region through multi-sectoral intervention. A new *SADC HIV/AIDS Strategic Framework and Programme of Action 2003-2007* was also issued.

3.5 Relevant OAU/AU resolutions on HIV/AIDS

Over the years, the Assembly of Heads of State and Government of the Organisation of African Unity (OAU, now called the African Union or AU) adopted a number of resolutions addressing the HIV/AIDS epidemic. Only those relevant to HIV/AIDS and human rights are discussed here.

In June 1994, the *Tunis Declaration on AIDS and the Child in Africa* was adopted by the OAU at the Assembly of Heads of State and Government in Tunis, Tunisia.⁴³ The *Declaration* declares a commitment to: “Elaborate a national policy framework to guide and support appropriate responses to the needs of affected children covering social, legal, ethical, medical and human rights issues.”⁴⁴

In July 1996, at the Thirty-Second Ordinary Session of the Heads of State and Government of the OAU, a *Resolution on Regular Reporting of the Implementation Status of OAU Declarations on HIV/AIDS in Africa* was adopted by the Assembly.⁴⁵ The *Resolution* urged African leaders to implement those declarations and resolutions that had been adopted in the past, specifically referring to the *Tunis Declaration*.

On 27 April 2001, the Heads of State and Government gathered for a special summit devoted specifically to address the exceptional challenges of HIV/AIDS, tuberculosis and other related infectious diseases. This resulted in the *Abuja Declaration on HIV/AIDS, Tuberculosis and other Related Infectious Diseases*, and the *Abuja Framework for Action for the Fight against HIV/AIDS, Tuberculosis and Other Related Infectious Diseases*, aimed at implementation of the principles set forth in the *Abuja Declaration*.⁴⁶

In the *Abuja Declaration*, the Heads of State acknowledged that “stigma, silence, denial and discrimination against people living with HIV/AIDS increases the impact of the epidemic and constitutes a major barrier to an effective response to it.”⁴⁷ The *Abuja Framework* conceptualises the

38 *Managing the impact of HIV/AIDS in SADC*, August 2000, at page 8. Available at: <http://196/36/153/56/doh/department/sadc/docs>.

39 *Ibid.*, at p 28.

40 Available at: <http://196.36.153.56/doh/department/sadc/docs/framework/html>.

41 Available at: http://196.36.153.56/doh/department/sadc/docs/negotiate_principles.html.

42 Available at: http://www.sadc.int/index.php?lang=english&pth=legal/declarations/&page=declaration_on_HIV_AIDS

43 AHG/Decl I (XXX) 1994.

44 Par 2(1).

45 AHG/Res 247 (XXXII) 1996. Available at: <http://www.onusida-aoc.org/Eng/Abuja%20Declaration.html>.

46 Available at: <http://www.onusida-aoc.org/Eng/Abuja%20Declaration.htm>.

47 Par 12.

commitments made in the *Abuja Declaration* into strategies followed by subsequent activities to be implemented by member states in collaboration with all stakeholders. The protection of human rights is recognised as one of the priority areas, and the following strategies are identified:

- develop a multi-sectoral national programme for awareness of and sensitivity to the negative impact of the pandemic on people, especially vulnerable groups;
- enact relevant legislation to protect the rights of people infected and affected by HIV/AIDS and TB;
- strengthen existing legislation to: (a) address human rights violations and gender inequities, and (b) respect and protect the rights of infected and affected people;
- harmonise approaches to human rights between nations for the whole continent; and
- assist women in taking appropriate decisions to protect themselves against HIV infection.

3.6 International guidelines on HIV/AIDS and human rights

In 1996 UNAIDS, in collaboration with the Office of the United Nations High Commissioner for Human Rights, adopted *HIV/AIDS and Human Rights – International Guidelines*. The *Guidelines* focus on three crucial areas: “(1) improvement of governmental capacity for acknowledging the government’s responsibility for multi-sectoral co-ordination and accountability; (2) widespread reform of laws and legal support services, with a focus on anti-discrimination, protection of public health, and improvement of the status of women, children and marginalised groups; and (3) support for increased private sector and community participation in the response to HIV/AIDS, including building the capacity and responsibility of civil society to respond ethically and effectively.”⁴⁸

The *Guidelines* deal with the following human rights principles:

- *Guideline 1*: Encourage states to adopt a multi-sectoral approach through an effective national framework.
- *Guideline 2*: Enable community organisations to carry out activities in the field of ethics, human rights and law. Consult widely with such organisations in drafting all HIV policies.
- *Guideline 3*: Review and reform public health laws to adequately address HIV/AIDS.
- *Guideline 4*: Review and reform criminal laws and correctional systems to ensure that they are

consistent with international human rights obligations and address HIV/AIDS without targeting vulnerable groups.

- *Guideline 5*: Enact or strengthen anti-discrimination laws to protect vulnerable groups. Ensure privacy, confidentiality and ethics in research involving human subjects.
- *Revised Guideline 6*: Enact legislation to provide for the regulation of HIV-related goods, services and information in order to ensure widespread availability of quality prevention measures and services, adequate HIV prevention and care information, and safe and effective medication at an affordable price. Ensure that all persons on a sustained and equal basis have access to quality goods, services and information for HIV/AIDS prevention, treatment, care and support, including anti-retroviral and other safe and effective medicines, diagnostics and related technologies for the treatment of HIV/AIDS and related opportunistic infections.⁴⁹
- *Guideline 7*: Implement and support legal support services to educate people affected by HIV/AIDS about their rights, develop expertise on HIV-related legal issues and use means other than courts such as human rights commissions to protect the rights of people affected by HIV/AIDS.
- *Guideline 8*: States, together with communities, should promote an enabling and prejudice-free environment for women, children and other vulnerable groups.
- *Guideline 9*: Promote the distribution of creative education, training and media programmes designed to change attitudes of discrimination and stigmatisation around HIV/AIDS.
- *Guideline 10*: Translate human rights principles into codes of conduct with accompanying mechanisms to implement and enforce these codes.
- *Guideline 11*: States should ensure monitoring and enforcement mechanisms to guarantee and protect HIV-related human rights.
- *Guideline 12*: States should share experiences concerning HIV-related human rights issues at an international level and through UN agencies such as UNAIDS.

48 See Foreword in the *Guidelines*.

49 Guideline 6 was revised in 2002 and is available at: <http://www.unhchr.ch/hiv/g6.pdf>.

4. LEGAL FRAMEWORK FOR THE PROTECTION OF HIV/AIDS AND HUMAN RIGHTS IN SOUTH AFRICA

4.1 National legal system: General background

4.1.1 The form of government and the domestic legal system within the country

South Africa's constitutional order is ten years old. The apartheid system officially came to an end on 27 April 1994, the day of the first democratic election in South Africa.

The 1993 *Interim Constitution*, Act 200 of 1993, came into force on 27 April 1994. The *Interim Constitution* brought about three fundamental changes in South Africa. Firstly, it brought an end to the racially qualified constitutional order that had accompanied 300 years of colonialism, segregation and apartheid. Secondly, the doctrine of parliamentary sovereignty was replaced by the doctrine of constitutional supremacy and a Bill of Rights was incorporated to safeguard human rights. Thirdly, the strong central government of the past was replaced by a system of government with federal elements.⁵⁰ One of the *Interim Constitution's* principal purposes was to set out the procedures for the negotiation and drafting of a 'final' *Constitution*. The final *Constitution of the Republic of South Africa*, Act 108 of 1996, entered into law on 10 December 1996. The basic principles and features underlying the new constitutional order are constitutionalism, the rule of law, democracy and accountability, separation of powers with checks and balances, co-operative government and devolution of power.⁵¹

In terms of the new constitutional order, South Africa has a clear separation of powers between the legislature (Parliament), the judiciary and the executive (Cabinet). The new South African system is comprised of three spheres of government: national, provincial and local. Each sphere has powers and functions as delineated in the *Constitution*. All spheres are distinct, yet interdependent on the others.

The South African legal system is a mixture of Roman Dutch Law and English Common Law with the new constitutional dispensation. The Constitution is the supreme law of South Africa. The Constitutional Court is the court of final instance in all matters relating to the interpretation, protection and enforcement of the provisions of the Constitution. Some matters fall exclusively within the jurisdiction of the Constitutional Court whilst others will normally first be heard by the High Court. The highest court for non-constitutional matters is the Supreme Court of Appeal. The superior courts are called High Courts and lower courts are the Magistrate's Courts. Other courts include the small claims courts and certain specialised courts such as the Labour Courts.⁵²

4.1.2 Human rights provisions within the National HIV/AIDS Strategic Framework and the National HIV/AIDS Policy

In 1994, the NACOSA *National AIDS Plan for South Africa* was launched. This covered the period from 1996/7-2000/1. The *HIV/AIDS/STD Strategic Plan for South Africa, 2000-2005*, replaced the NACOSA *Plan* in February 2000. The *Strategic Plan* outlines a multi-sectoral response to the epidemic. The Department of Health monitors implementation of the *Strategic Plan*. Five priority areas are identified in the *Plan*: prevention; treatment care and support; human rights and legal issues; research, surveillance, monitoring and evaluation; and information, education and social mobilisation.

The following guiding principles in the *Strategic Plan* impact on human rights:

- people with HIV/AIDS, their partners, families and friends shall not suffer from any form of discrimination;

50 J De Waal, I Currie and G Erasmus: *The Bill of Rights Handbook* (2001), page 2.

51 Ibid, page 6.

52 Section 151 of Chapter VII of the *Labour Relations Act* of 1995 establishes a Labour Court with concurrent jurisdiction to the Supreme

Court. The jurisdiction and powers of the Labour Court are set out in Sections 157 and 158. Section 167 establishes a Labour Appeal Court which is the final court of appeal for all judgments and orders made by the Labour Court in respect of the matters within its exclusive jurisdiction.

- the vulnerable position of women in society shall be addressed to ensure that they do not suffer discrimination, or remain unable to take effective measures to prevent infection; and
- confidentiality and informed consent with regard to HIV testing and test results shall be protected.⁵³

Another piece of the broader government framework on HIV/AIDS is the *Partnership Against AIDS* launched in October 1998. Initially, the government's efforts in combating HIV/AIDS were restricted to the health sector. The launch of the *Partnership Against AIDS* included other government departments and key sectors of society in a broad based and multi-sectoral fight against the disease. The *Partnership Against AIDS Declaration* aims to expand sectoral involvement in HIV/AIDS as part of a mass mobilisation campaign. In January 2000, the partnership was formalised in the South African National AIDS Council (SANAC), under the leadership of the current deputy president, Jacob Zuma. The government strengthened its contribution to the *Partnership Against AIDS in 2002* by establishing a Presidential Task Team on AIDS consisting of ministers and led by the deputy president.⁵⁴

The South African government has also undertaken the following activities with respect to HIV/AIDS and human rights:

- a tender to monitor human rights abuses against HIV-positive persons was advertised in 2002;
- a major campaign to promote openness and acceptance of HIV-positive people has been initiated; and
- an evaluation of the legal framework to identify areas that may need to be strengthened to create a supportive environment for people living with HIV/AIDS has already commenced.⁵⁵

In 1997, an alliance of mayors and municipal leaders in Africa together with the United Nations Development Programme developed the African Mayors' Initiative for Community Action on AIDS at the Local Level. South Africa, as one of 17 countries participating, adopted a declaration to develop a response by municipal leaders to HIV/AIDS. As a result of this declaration, the

government published an *HIV/AIDS Manual for Municipalities*. The *Manual* states that: "Government together with welfare and other organisations has started to respond to the AIDS crisis, but without a coherent and collective approach at local level their efforts will not achieve as much as it could. Municipalities are ideally placed to play the co-ordinating and facilitating role that is needed to make sure that partnerships are built to bring prevention and care programmes to every community affected by AIDS."⁵⁶ The *Manual* makes direct reference to the human rights of people living with HIV/AIDS and includes guidelines on how to develop a local strategy on HIV/AIDS, and how to run AIDS campaigns and projects.⁵⁷

The National HIV/AIDS and STD Programme is under the National AIDS Unit of the Department of Health. The National Programme includes the government AIDS Action Plan and the HIV/AIDS Public Awareness Campaign. It aims to guide both the government sector and civil society on appropriate responses to HIV/AIDS, STD's and TB. The National HIV/AIDS Programme is not involved in implementation; rather, it provides guidance, policy and technical support to the provinces in the implementation of interventions, working primarily with the provincial health departments.

4.1.3 Domestication of international and regional human rights treaties

Section 231 of the *Constitution* regulates the signing, ratification and the transformation of treaties into domestic law. Section 231 provides the following:

- 1) The negotiating and signing of all international agreements is the responsibility of the national executive.
- 2) An international agreement binds the Republic only after it has been approved by resolution in both the National Assembly and the National Council of Provinces, unless it is an agreement referred to in subsection (3).
- 3) An international agreement of a technical, administrative or executive nature, or an agreement which does not require either ratification of accession, entered into by the national executive, binds the Republic without approval by the National Assembly and the National Council of

53 See page 15 of the *Strategic Plan*.

54 *Summary of Government's Position following Cabinet's Discussion*, 17 April 2002, at www.gov.za/issues/hiv/hivgovposition02.htm. Accessed: 27 July 2002.

55 *The South African Government's Response to the HIV/AIDS Epidemic - Controversies and Priorities*, at <http://196.36.153.56/doh/aids/docs/>

[gov-aids.html](http://www.gov.za/issues/hiv/hivgovposition02.htm). Accessed: 27 July 2002.

56 *Manual* is available at <http://www.etu.org.za/toolbox/docs/localgov/webaidsmun.html>.

57 Ibid.

Provinces, but must be tabled in the Assembly and the Council within a reasonable time.

- 4) Any international agreement becomes law in the Republic when it is enacted into law by national legislation, but a self-executing provision of an agreement that has been approved by Parliament is law in the Republic unless it is inconsistent with the Constitution or an Act of Parliament.
- 5) The Republic is bound by international agreements which were binding on the Republic when this Constitution took effect.

Therefore, an Act of Parliament or other form of national legislation is necessary for a ratified treaty to be incorporated into domestic law.⁵⁸ Three principal methods are employed by the Legislature to transform treaties into domestic law: the provisions of a treaty may be embodied in the text of an Act of Parliament; the treaty may be included as a schedule to a statute; or an enabling Act of Parliament may give the Executive power to bring a treaty into effect by means of proclamation or notice in the *Government Gazette*.

Each ministry is responsible for the ratification and implementation of international agreements within its sector. South Africa has implemented international agreements, either through dedicated legislation such as the legislation implementing the *Hague Convention on Child Abduction*, or through various pieces of legislation, which was the means used to implement the provisions of the *International Covenant on Civil and Political Rights*.⁵⁹

4.2 HIV/AIDS-specific regulations

4.2.1 Litigation on HIV/AIDS and human rights within domestic courts

Constitutional Court of South Africa

*Hoffmann v South African Airways*⁶⁰

Before the enactment of the *Employment Equity Act*, the Constitutional Court decided in this case that the denial of employment to a prospective employee for reasons of his HIV status constituted unfair discrimination and violated the right to fair labour practices guaranteed in the *Constitution*.⁶¹

*Minister of Health and others v Treatment Action Campaign and others*⁶²

For detailed discussion, see Section 4.7.1 of the country report.

*Van Biljon & Others v Minister of Correctional Services*⁶³

Four HIV-infected prisoners applied for a declaratory order that their right to adequate medical treatment entitled them to anti-retroviral drugs (which they had received initially, but which were discontinued by the Department of Correctional Services). The Minister argued that the state was only obliged to provide the applicants with the same standard of care as was provided in state hospitals, where the use of the drugs was limited; and, the applicants would not have qualified for ARVs under the policy in place. The Court granted the order, finding that in determining what constitutes “adequate medical treatment”, it is necessary to examine what the state can afford to provide.⁶⁴ In this case, the Court found that the applicants should receive the treatment, but this does not entitle all prisoners with HIV to receive ARVs. A prisoner’s right to medical treatment requires an examination of the circumstances of the particular case.

*Jordan and others v Republic of South Africa*⁶⁵

For a detailed discussion, see section 4.6.4 of the country report.

High Court of South Africa

*VRM v The Health Professions Council of South Africa and others*⁶⁶

The applicant alleged that her doctor had conducted a HIV test without her informed consent and without providing pre- and post-test counselling. The applicant further alleged that her

58 An Act of Parliament is national legislation and, in terms of Section 239 of the *Constitution*, it also includes subordinate legislation made in terms of an Act of Parliament, and legislation that was in force when the *Constitution* took effect and that is administered by the national Government.

59 Sivu Maqungo, Principal State Law Advisor, interviewed 5 September 2002.

60 CCT 17/00; 2001 (1) SA 1 (CC).

61 Pre-employment HIV-testing is now illegal in South Africa according to Section 7(2) of the *Employment Equity Act* No 55 of 1998, unless such testing is justifiable by the Labour Court in terms of Section 50 (4) of the Act. The *Employment Equity Act*, like the *Labour Relations*

Act, covers everyone except the South African National Defence Force, the National Intelligence Agency, and the Secret Services.

62 CCT 9/02; 2002 (5) SA 721 (CC).

63 CPD, 1997; 1997 (4) SA 441 (C).

64 For various reasons, only two of the four applicants in this case were considered by the Court. These two applicants were entitled to ARVs at State expense.

65 CCT31/01.

66 26129/2001.

doctor did not disclose her HIV status to her and that he did not advise her on measures to take to reduce the risk of MTCT during birth. The Judge dismissed the case with costs upon finding that a proper case was not made out for the relief sought.

*Applicant v Administrator, Transvaal and Others*⁶⁷

In this case, a provincial hospital promised to treat the applicant with expensive medication (Gancyclovir) and even inserted a catheter into the applicant for this purpose. The hospital then rescinded its decision, stating that the drug was too expensive and it did not want to set a precedent. The Court ordered the administration of the medicine but stressed the need to examine the specifics of each case. This decision did not mean that all AIDS patients were entitled to the medication.

*S v Cloete*⁶⁸

In this case, a prisoner was granted early release due to his HIV condition. The Judge ruled that: “his condition is such and has changed so that to continue to serve imprisonment would be far harsher a sentence for him than for any other person serving a similar sentence.”

*Venter v Nel*⁶⁹

The Court granted the plaintiff damages on the grounds that the defendant had infected her with HIV during sexual intercourse. Damages awarded took into account both future medical expenses as well as the possibility of a reduction in life expectancy, psychological stress, and pain and suffering.

*Perreira v Buccleuch Montessori Nursery*⁷⁰

Karen Perreira applied to enrol her foster daughter, Tholakele, at the Buccleuch Montessori Nursery School in January 2001. At the time she made the application, she informed the principal of Tholakele’s HIV-positive status. The school indicated that they wished to defer the enrolment until the child was three years old and ‘past the biting stage’. The Court found that

the school had not taken a final decision to exclude Tholakele, but had simply “deferred” her enrolment. The court dismissed the application with costs.

Supreme Court of Appeal

*Jansen van Vuuren and Another NNO v Kruger*⁷¹

The applicant’s doctor disclosed his HIV status without prior authorisation from the applicant to two other doctors whilst playing a game of golf. The Appellate Division ruled in favour of the applicant’s right to confidentiality and stated that the ‘public interest’ did not warrant the disclosure.

Labour Court of South Africa

*Joy Mining Machinery Division of Harnischfeger SA Pty Ltd v National Union of Metal Workers of South Africa*⁷²

The Labour Court ruled that anonymous voluntary HIV testing of employees in terms of Section 7(2) of the *Employment Equity Act*, Act 55 of 1998, is legal. The Court enumerated 11 grounds that must be taken into account when performing voluntary HIV tests, such as: (1) the test to be used is the ELISA Saliva Test; (2) at no time will the participating employee be asked his/her name, nor will such information be recorded on the sample; (3) that the employer make it clear that it does not intend to discriminate against HIV-positive employees, etc.

*A v SAA*⁷³

The applicant was refused employment with South African Airways after testing HIV positive in a pre-employment test. The Court held that excluding “A” from the position of cabin attendant on the grounds of his HIV status was unjustified and awarded him compensation.

CCMA (Commission for Conciliation, Mediation and Arbitration)

*Zungu v ET Security Services*⁷⁴

The applicant alleged that his dismissal was unfair and that, even though he had full-blown AIDS,

67 1993 (4) SA 733.

68 1995 (1) SACR 367 (W).

69 1997 (4) SA 1014 (D).

70 Case no. 02/4377.

71 1993 (4) SA 842 (A).

72 J158-2002.

73 J1916/99.

74 KN50648.

he was still capable of performing his duties as a security guard. The CCMA found to the contrary and stated that the applicant was lawfully dismissed and the severity of the opportunistic infection he suffered from made it impossible for him to perform his duties, and that the respondent acted in good faith.

Unreported case law

*C v Minister of Correctional Services and W and Others v Minister of Correctional Services and Others*⁷⁵

The Supreme Court ruled in favour of the applicants 'C' and 'W', specifying that pre-test counselling is compulsory in order to obtain informed consent for HIV testing.

Booyesen v Correctional Services (2000)

A prisoner took the Department of Correctional Services (DCS) to Court for not allowing him visitation rights with his gay partner who was dying of AIDS. The case was eventually settled out of Court and the DCS allowed the visitation.

PW v Minister of Correctional Services (1994)

For a detailed discussion, see section 4.9.1 of the country report.

4.2.2 National legislation that addresses (directly or indirectly) issues in relation to HIV/AIDS

- *Medicines and Related Substances Control Amendment Act, Act 90 of 1997*, on the use of generic medicines
- *Promotion of Equality and Prevention of Unfair Discrimination Act, Act 4 of 2000*. See Sections 34(1) and (2) for direct reference to HIV/AIDS
- *Employment Equity Act, Act 55 of 1998*. Sections 6, 7(1) and (2) and 50(4) deal specifically with HIV/AIDS
- *Code of Good Practice on Aspects of HIV/AIDS and Employment*, which is issued in terms of Section 54(1)(a) of the *Employment Equity Act*
- *Criminal Law Amendment Act, Act 105 of 1997*, provides for harsher sentencing of HIV positive rapists.
- *Schedule 6 (a)(iv) of Criminal Procedure Second Amendment Act, Act 85 of 1997*, makes the

granting of bail more difficult in instances where the suspected rapist is known to be HIV positive

- *Compulsory HIV Testing of Alleged Sexual Offenders Bill of 2002*

4.2.3 HIV/AIDS policies, guidelines and programmes

- *HIV/AIDS/STD Strategic Plan for South Africa, 2000-2005*
- *Social Welfare Action Plan on HIV/AIDS, 1997*
- *National Guidelines for Social Services to Children Infected and Affected by HIV/AIDS, August 2002*
- *Charter of Rights on AIDS and HIV, 1992 (non-binding)*
- *National Patient's Rights Charter (non-binding), 1999*
- *National Policy on Testing for HIV, August 2000*
- *The South African Medical Association Guidelines on Human Rights, Ethics and HIV, 2001*
- *Guidelines on the Adequate Treatment of Opportunistic Infections, 2002*
- *Ethical Considerations for HIV/AIDS Clinical and Epidemiological Research, January 2000*
- *Guidelines for Good Clinical Practice in the Conduct of Trials in Human Participants in South Africa, Department of Health*
- *Guidelines on Ethics for Medical Research: HIV/AIDS Preventive Vaccine Trials* drafted by the South African Medical Research Council in May 2002 and to be approved shortly
- *Management of Occupational Exposure to the Human Immunodeficiency Virus (HIV), Department of Health, 1999*
- *Department of Defence policy on The Management of Human Immune Deficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), 2001*
- *Life Office's Association Protocol on HIV Testing, October 2000*. Ensuring that the insurance industry adequately protects the rights of HIV-positive people
- *Policy Guideline for Management of Transmission of Human Immunodeficiency Virus (HIV) and Sexually Transmitted Infections in Sexual Assault, Department of Health*
- *National Policy on HIV/AIDS, for Learners and Educators in Public Schools, and Students and Educators in Further Education and Training Institutions, 1999*
- *Management Strategy: HIV/AIDS in Prisons, October 2002*

⁷⁵ Unreported CPD Supreme Court 2434/96.

The South African National AIDS Council (SANAC) is the highest body that advises government on all matters relating to HIV/AIDS. Its major functions include: advising government on HIV/AIDS/STD policy; monitoring the implementation of the *Strategic Plan* in all sectors of society; and advocating for the effective involvement of sectors and organisations in implementing programmes and strategies.⁷⁶ The deputy president chairs the body.

4.2.4 Domestic incorporation of the International Guidelines on HIV/AIDS and Human Rights

In May 1997, at the first annual conference of the South African Human Rights Commission, the Commission adopted a significant plan of action for HIV/AIDS and committed itself to promoting non-discrimination against people living with HIV/AIDS. It also became the first national human rights body to formally endorse the *HIV/AIDS and Human Rights - International Guidelines*,⁷⁷ and called upon the South African government to implement them.

4.2.5 HIV/AIDS within the government's social assistance plan

Section 27(1)(c) of the *Constitution* states that: "Everyone has the right to have access to social security, including, if they are unable to support themselves and their dependants, appropriate social assistance." Section 27(2) states that: "The state must take reasonable legislative and other measures, within available resources, to achieve the progressive realisation of each of the rights."

The *Social Assistance Act, Act 59 of 1992*, was enacted to provide for the rendering of social assistance to different categories of persons. The Act does not specifically mention people living with HIV/AIDS. It does, however, provide for disability grants and foster care grants, amongst others. People living with HIV/AIDS can qualify for a disability grant if they satisfy the criteria as stipulated in the Act. Section 2(a) of the *Social Assistance Act* states that social grants can be made to the aged, disabled persons and war veterans. The definition of a "disabled person" is: "any person who has attained the prescribed age and is, owing to his physical or mental disability, unfit to obtain by virtue of any service, employment or profession the means needed to enable him to provide for his maintenance." Thus, an HIV-positive person will only qualify for a disability grant if his/her illness prevents him/her from working.

The *Social Assistance Act* was amended in 1994 to further regulate the grants and financial awards to certain persons and bodies. In 1997, the *Welfare Laws Amendment Act* came into force in order to provide for uniformity of equality of access to and effective regulation of social assistance throughout the country.

The Department of Social Development annually publishes educational material entitled *You and Social Grants*, with step-by-step instructions on how to apply for social grants.⁷⁸ The brochure also explains the "means test", the different social grants available and the documents required for application. The brochure specifies the amounts that will be granted under the various social grants for the current year, i.e. R620 per month for a disability grant in 2002.

In 1996, policy and programme shifts were initiated to transform welfare services specifically in relation to services for the elderly, people with disabilities and PLWHAs, the upgrading of secure care facilities and the implementation of the *National Plan of Action for Children*. In 1997, a *Social Welfare Action Plan on HIV/AIDS* was developed to focus the role of the welfare sector in addressing HIV/AIDS.

The Department of Social Development organised a conference in June 2002 to co-ordinate action for children affected and infected by HIV/AIDS. The recommendations resulting from this conference included:

- a co-ordination structure with three levels;
- engaging in a national process for identifying orphans, vulnerable children and duty bearers, and the creation of a database;
- fast-tracking the process for accessing social security grants;
- determining how civil society through NGOs, Community Based Organisations (CBOs) and Faith-Based Organisations (FBOs) could assist the Department of Social Development with social grants;
- engaging in a national process for creating awareness about services available to orphans and vulnerable children; and

⁷⁶ See page 12 of the *HIV/AIDS/STD Strategic Plan for South Africa 2000-2005*.

⁷⁷ Heywood, M. *Human rights violations of people with HIV/AIDS: the implications for equitable development in South Africa*, September 1998, page 34.

⁷⁸ *You and Social Grants 2000* can be accessed at www.welfare.gov.za/Documents/2002/ugrant/html. Accessed: 3 September 2002.

- suggestions as to how the Department of Social Development could fast-track the process for the establishment of home/community based care.

The *National Guidelines for Social Services to Children Infected and Affected by HIV/AIDS* was published in August 2002. These *Guidelines* originate from the *National Strategic Framework*. One of the objectives of the *Guidelines* is to “make information available on welfare services and grants”.⁷⁹

Whilst there were no special provisions for children infected/affected by HIV/AIDS before the August *Guidelines*, caregivers of these children could access financial support in the form of the child support grant (for children younger than seven years), the care dependency grant or the foster grant in terms of the *Social Assistance Act*.

The government update on the National HIV and AIDS Programme for 2003 stated that:⁸⁰

- there has been expanded access to the child support grant and successive increases in the amount of the grant, a major benefit to families affected by HIV/AIDS;⁸¹
- the grant will be extended over the next three years to reach children up to the age of 14 years; and
- apart from the health grant, there is also a conditional grant of R66 million to the Department of Social Development to focus on home/community-based care and specifically address the issues of orphans and vulnerable children, social relief (including food parcels), counselling and child care.

South Africa is currently considering introducing a basic income grant to address the shortcomings in the social assistance system.⁸² Enhancing the fight against HIV/AIDS is identified as a benefit of the proposed grant. It is anticipated that such a grant will reach those most affected by HIV/AIDS, i.e. young adults who currently have very little access to social grants.

79 This is especially important since a study released in March 2002 indicated that the vast majority (73%) of public health clinics and hospitals reported that they referred clients elsewhere for advice and assistance with accessing a social security grant. *Rapid Appraisal of Primary Level Health Care Services for HIV-positive Children at Public Clinics in South Africa*, a project of the Children's Institute, University of Cape Town (UCT) in collaboration with the Child Health Unit, University of Cape Town.

4.3 Health sector

4.3.1 HIV/AIDS and the right of access to health care

Section 27 (1)(a) of the *Constitution* states that: “Everyone has the right to have access to health care services, including reproductive health care.” According to Section 27(2): “The state must take reasonable legislative and other measures, within available resources, to achieve the progressive realisation of each of the rights.”

The Department of Health's 1999 *National Patient's Rights Charter*, although not legally binding, declares that everyone has the right of access to health care services that includes:

- receiving timely emergency care at any health care facility that is open regardless of one's ability to pay;
- treatment and rehabilitation that must be explained to the patient to enable the patient to understand such treatment or rehabilitation and the consequences thereof;
- provision for special needs in the case of newborn infants, children, pregnant women, the aged, disabled persons, patients in pain and persons living with HIV or AIDS;
- counselling without discrimination, coercion or violence on matters such as reproductive health, cancer or HIV/AIDS;
- palliative care that is affordable and effective in cases of incurable or terminal illness;
- a positive disposition displayed by health-care providers that demonstrates courtesy, human dignity, patience, empathy and tolerance; and
- health information that includes the availability of health services and how best to use such services. The provision of such information should be in the language understood by the patient.

4.3.2 HIV testing, notification and confidentiality

HIV/AIDS is currently not a notifiable disease in South Africa. The Department of Health in April 1999 issued *Draft Regulations relating to Communicable Diseases and the Notification of Notifiable Medical Conditions*, which is currently not being implemented.

80 *Update on the National HIV and AIDS Programme*, 19 March 2003, available at: <http://www.gov.za/issues/hiv/update19mar03full.htm>.

81 At the end of 2002, a total of 2,5 million child beneficiaries were registered.

82 See *South Africans For a Basic Income Grant* available at http://www.drc.org.za/docs/Background_Briefing.doc.

In December 1999, the HIV/AIDS and STD Directorate of the Department of Health released recommendations on the use of rapid HIV tests in *Rapid HIV Tests and Testing*. It is recommended that these rapid tests be used according to the same ethical standards as any other HIV test, so requiring the principles of pre- and post- test counselling, informed consent, privacy and confidentiality are adhered to. The Department of Health in August 2000 issued the *National Policy on Testing for HIV* in terms of Section 2 of the *National Policy for Health Act, 1990 (Act 116 of 1990)*. The *National Policy* outlines circumstances under which HIV testing may be conducted and contains regulations as to informed consent, pre-test and post-test counselling.

With respect to confidentiality, the law is clear that a patient has a legal right to confidentiality about his/her health and medical treatment. The Appellate Division of the Supreme Court confirmed this position in *Jansen van Vuuren and Another v Kruger*,⁸³ ruling that a doctor cannot disclose the HIV-positive status of his patient to other doctors without the patient's consent. The South African Medical Association *Guidelines on Human Rights, Ethics and HIV* state that confidentiality may be breached if the patient provides informed consent, or if it is absolutely necessary and the only way to protect identified third parties at risk. The *Guidelines* recommend the following when dealing with sexual partners of HIV-positive patients:

- counsel the patient on the need to inform third parties at risk;
- attempt to obtain the patient's informed consent and offer to assist in the process of disclosure;
- point to legal and other risks associated with negligent sexual behaviour; and
- ensure that there is an identified third party at risk, that the patient will really put the third party at risk and inform the patient about the planned disclosure.

4.3.3 Patients' rights

The Minister of Health launched the *National Patients' Rights Charter* in 1999. According to the service description of the Department of Health, the purpose and expected outcome of the *Patients' Rights Charter* and complaints procedure is to deal effectively with complaints and rectify service delivery problems, and as a result improve the quality of care; raise awareness

of rights, responsibilities and expectations; and empower users. The Introduction to the *Patients' Rights Charter* proclaims that: "To ensure the realisation of the right of access to health care services as guaranteed in the *Constitution* of the Republic of South Africa, the Department of Health is committed to upholding, promoting and protecting this right and therefore proclaims this *Patients' Rights Charter* as a common standard for achieving the realisation of this right." The *Charter* enumerates rights of patients' which should be observed and implemented, and goes further by also outlining responsibilities of every patient.

The South African Medical and Dental Council (SAMDC) first published guidelines on *The Management of Patients with HIV Infection or AIDS* in 1994. The Health Professions Council of South Africa (HPCSA) has since replaced SAMDC, and in 2001, the HPCSA introduced new guidelines. The South African Medical Association (SAMA) is a voluntary body for doctors and other health care workers. SAMA has its own set of guidelines called *The South African Medical Association Guidelines on Human Rights, Ethics and HIV*.

4.3.4 Access to essential HIV/AIDS drugs

On 17 April 2002, the South African Cabinet issued a statement emphasising the commitment of the government to treat and manage opportunistic infections; provide health care to South Africans, especially those with HIV; and the critical importance of drugs dealing with infections such as meningitis, oral thrush, TB and pneumonia. The Cabinet urged the public to assist government in monitoring the availability of such drugs.⁸⁴

The Department of Health issued *Guidelines on the Adequate Treatment of Opportunistic Infections 2002*, and has started training health care providers in the implementation of these guidelines. The challenges, according to the Department of Health, are to ensure that health care providers are skilled in early diagnosis of these conditions and that facilities do not deplete stocks of these essential drugs.⁸⁵

According to the Government, treatment for TB is free and available in the public health sector and antibiotics such as Bactrim are available. Innovative joint HIV/AIDS and TB management

83 1993 (4) SA 842 (A).

84 Cabinet Statement on HIV/AIDS, 17 April 2002 at <http://www.gov.za/speeches/cabinet/taids02.thm>. Accessed: 27 July 2002.

85 *The South African Government's Response to the HIV/AIDS Epidemic - Controversies and Priorities* at <http://196.36.153.56/doh/aids/docs/gov-aids.html>. Accessed: 27 July 2002.

sites to prevent the onset of infection in people infected with HIV are part of the interventions introduced.⁸⁶ The Diflucan Partnership Programme between Pfizer and the government in 2000 to provide Diflucan⁸⁷ free of charge has been extended indefinitely.

The issue of provision of anti-retroviral drugs (ARVs) has been controversial in South Africa. Until very recently, the government's stance on ARVs was as follows:

- ARVs are not available in public health-care facilities. At current prices, these drugs are beyond the reach of most citizens. Even with an 80%-90% reduction in drug prices, these drugs would still be unaffordable.
- Apart from the issue of cost, the introduction of ARVs in the health system will require the training of health providers on the appropriate use of these drugs, laboratory facilities to monitor regularly the effect of these drugs on the patients to tailor therapy, infrastructure to procure and safely distribute these drugs, and a supportive environment to ensure compliance to therapy.
- In the absence of these reforms, it would be impossible to monitor patients and failure to adhere to treatment schedules would result in the development of resistant strains of the virus that would be impossible to contain with existing drugs. Close monitoring of the toxic side-effects of anti-retrovirals requires a certain level of medical expertise that is not always feasible in rural areas.
- The focus of the government remains the improvement of access to all drugs, including ARVs.⁸⁸

In August 2003, the government announced its intention to provide ARVs at state hospitals. However, the government has requested some time for the development of a plan, and the implementation of the plan. By November 2003, the government had provided few details on the planned rollout of ARVs, beyond its renewed commitment to provide the drugs at state hospitals.

The *National Drug Policy for South Africa* was published in 1995 with the goal of ensuring an adequate and reliable supply of safe, cost-effective drugs of acceptable quality to all citizens of South Africa, and the rational use of drugs by prescribers, dispensers and consumers. The *National Drug Policy* aims to promote the availability of safe and effective drugs at the lowest possible cost by monitoring and negotiating drug prices, by rationalising the drug pricing system in the public and private sectors, and by promoting the use of generic drugs.⁸⁹

In 1997, Parliament passed the *Medicines and Related Substances Control Amendment Act, Act 90 of 1997*. Section 10 of the Act allows the Minister of Health to legally use parallel importing in the public interest whilst Section 22F lists measures to regulate generic substitution of medicines. For almost three years, the Pharmaceutical Manufacturers' Association (PMA) challenged the legislation in Court, thereby delaying the implementation of the Act. On 19 April 2001, the PMA withdrew the court application and agreed to pay all the costs of the case. Under the Act, pharmacists will be required to offer consumers a generic substitute, regardless of their prescription by a doctor, on all off-patent products. In terms of the *Patents Act, Act 57 of 1978*, government ministers can apply for compulsory licences "for public purposes". Compulsory licensing has not been utilised by the government to date.

The government further highlighted the following efforts in terms of affordable drugs:⁹⁰

- Multinational companies have granted voluntary licences to South African companies to manufacture several generic ARVs.
- South Africa is working towards an appropriate World Trade Organization agreement that will facilitate developing countries' access to essential medicines for major health problems, including HIV/AIDS, TB and malaria.
- NEPAD is engaging in a programme for a number of African countries to work with pharmaceutical companies to manufacture affordable drugs for dangerous diseases, including HIV/AIDS and TB, on the African continent.

86 Mohapeloa, V. *Government's plan to deal with HIV/AIDS*, 24 March 2003 available at [wysiywyg://1128/http://allafrica.com/stories/200303240913.html](http://www.wysiywyg://1128/http://allafrica.com/stories/200303240913.html).

87 An anti-fungal drug used to treat two of the most common opportunistic infections associated with HIV/AIDS.

88 *The South African Government's Response to the HIV/AIDS Epidemic - Controversies and Priorities* at <http://196.36.153.56/doh/aids/docs/gov-aids.html>. Accessed: 27 July 2002.

89 Section 4.2 of the *National Drug Policy* refers specifically to the use of generic drugs and states that amongst other goals, the availability of generic, essential drugs will be encouraged through the implementation of incentives that favour the use and production of generic drugs in the country. In October 2003, the competition Commission found various drug companies that supply ARVs to be in contravention of the *Competitions Act*. For more information, see: www.tac.org.za.

90 *Update on the National HIV and AIDS Programme* 19 March 2003 available at <http://www.gov.za/issues/hiv/update19mar03full.htm>.

4.3.5 Medical trials on human subjects

Section 12 (2) of the *Constitution* states that: “Everyone has the right to bodily and psychological integrity, which includes the right - a) to make decisions concerning reproduction; b) to security in and control over their body; and c) not to be subjected to medical or scientific experiments without their informed consent.”

The HIV/AIDS/STD Directorate published *Ethical Considerations for HIV/AIDS Clinical and Epidemiological Research* in January 2000. The *Ethical Guidelines* are intended to supplement the Medical Research Council’s Guidelines for Medical Research by addressing several issues raised in HIV-related research. The Department of Health has also issued *Guidelines for Good Clinical Practice in the Conduct of Trials in Human Participants in South Africa*.

In May 2002, the South African Medical Research Council released *Draft Guidelines on Ethics for Medical Research: HIV/AIDS Preventive Vaccine Trials* for comments by interested parties. Special provision is made for the protection of vulnerable populations: “where relevant, the research protocol should describe the social contexts of a proposed research population that create conditions for possible exploitation or increased vulnerability among potential research participants. Steps must be taken to overcome these conditions, and promote and protect the dignity, safety and welfare of the participants.”⁹¹ The *Guidelines on Ethics for Medical Research* further aims to define informed consent and recommends that special measures should be taken to protect persons who are limited in their ability to provide informed consent due to their social or legal status.⁹²

The South African AIDS Vaccine Initiative (SAAVI) has two locally generated “candidate vaccines” that have started Phase One Trials. In addition, South Africa is involved in trials of candidate vaccines that have been developed outside the country.

In December 2002, the Ministerial Committee on Health Research Ethics published a Booklet entitled *What you should know when deciding to take part in a clinical trial as a research participant*.⁹³

The booklet explains the nature of various clinical trials, and highlights the possible adverse effects. It further outlines the volunteers’ constitutional rights and what constitutes informed consent, i.e. what a participant must know and what he/she has a right to be informed about. Lastly, it outlines the role of ethics committees in ensuring the protection of volunteers’ rights, dignity and well being.

4.3.6 Condoms

The National HIV/AIDS Programme, in one of its sub-programmes, focuses on barrier methods. The Programme will try to achieve the following:

- ensuring an uninterrupted supply of good quality condoms to all provinces;
- expanding condom supply to non-traditional outlets such as hotels, clubs, spaza shops and taxi ranks;
- making the female condom available in areas where there is a demand, and popularising it;
- motivating for the provision of condoms in institutions of higher learning; and
- ensuring condom supply in high transmission areas such as trucking routes, single sex hostels, and where commercial sex work is prevalent.⁹⁴

Prevention is one of the five priority areas identified under the *HIV/AIDS/STD Strategic Plan for South Africa 2000-2005*. Condom procurement and distribution is an important part of the prevention policy. The government has undertaken the following activities:

- the Department of Health through the HIV/AIDS/STD Directorate procures and distributes male condoms to all provinces;
- condoms are supplied freely to the public;
- all condoms supplied by government undergo quality testing by the South African Bureau of Standards (SABS) in accordance with WHO standards; and
- strategies to improve access to condoms through non-traditional outlets, for example spaza shops, clubs and taxi ranks, are being implemented.⁹⁵

91 Page 11 of the *Draft Guidelines on Ethics for Medical Research*.

92 See pages 14-18. The *Guidelines on the Ethics for Medical Research* also contains separate processes to follow where women or children partake in vaccine trials.

93 The Booklet is available at <http://www.doh.gov.za/aids/docs/gcp2.html>.

94 National AIDS Unit, Department of Health, at <http://196.36.153.56/doh/aids/mnu.html>. Accessed: 27 July 2002.

95 *The South African Government’s Response to the HIV/AIDS Epidemic - Controversies and Priorities* at <http://196.36.153.56/doh/aids/docs/gov-aids.html>. Accessed: 27 July 2002.

The government supplies a limited amount of female condoms (about 1 million) at selected sites in provinces, and a phased-in strategy to expand access is currently being developed.

The quantity of free condoms supplied by government to promote safe sexual behaviour has increased yearly. In 2001, 250 million condoms were distributed through the health sector (compared to 20 million distributed in 1992).⁹⁶ In 2002, 350 million condoms were distributed free of charge by the government. The government is set to increase the distribution of condoms at non-traditional outlets and to double the number of sites where female condoms are available.

4.3.7 HIV/AIDS and the mentally ill

The Child, Youth, Women and Family Mental Health Sub-Directorate of the Directorate on Mental Health and Substance Abuse focuses on the promotion of mental health and the prevention of mental illness, including a focus on HIV/AIDS. Policies and protocols to improve mental health of children, youth, women and families are aimed to assist provinces in implementation. A new *Mental Health Care Bill* was drafted and presented to Parliament in 2001. Chapter 3 of the *Bill* deals specifically with the rights and duties of mental health care users. Section 10 states: “(1) A mental health care user may not be unfairly discriminated against on the grounds of his or her mental health status. (2) Every mental health care user must receive care, treatment and rehabilitation services according to standards equivalent to those applicable to any other health care user.” Section 14 allows for limitations on adult relationships, stating: “Subject to conditions applicable to providing care, treatment and rehabilitation services in health establishments, the head of a health establishment may limit intimate relationships of adult mental care users only if due to mental illness, the ability of the user to consent is diminished.”

4.4 Equality and non-discrimination

4.4.1 The Constitution and the right to equality and non-discrimination

Section 9 of the *Constitution* deals with equality and the right to non-discrimination. Section 9 (3) states that: “The state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social

origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth.” Although Section 9 does not include HIV/AIDS as an explicit ground, it can be read into “disability,” or it can be treated as an “other ground” under Section 9 (3).

4.4.2 Specialised legislation on equality and non-discrimination

Section 9 (4) of the *Constitution* states that: “No person may unfairly discriminate directly or indirectly against anyone on one or more grounds in terms of subsection (3). National legislation must be enacted to prevent or prohibit unfair discrimination.” The *Promotion of Equality and Prevention of Unfair Discrimination Act, Act 4 of 2000*, was enacted in 2001. The *Act* does not include HIV status as an explicit ground for non-discrimination. However, it defines prohibited grounds as: “any other ground where discrimination on that other ground - i) causes or perpetuates systemic disadvantage; ii) undermines human dignity; or iii) adversely affects the equal enjoyment of a person’s rights and freedoms in a serious manner that is comparable to discrimination on a ground listed in paragraph (a).” This would clearly cover HIV/AIDS.

The non-inclusion of HIV/AIDS as a prohibited ground will be reviewed in the future. Section 34 (1) and (2) of the *Act* states that: “In view of the overwhelming evidence of the importance, impact on society and link to systemic disadvantage and discrimination on the grounds of HIV/AIDS status, socio-economic status, nationality, family responsibility and family status –

- a) special consideration must be given to the inclusion of these grounds in paragraph (a) of the definition of “prohibited grounds” by the Minister;
 - b) the Equality Review committee must, within one year, investigate and make the necessary recommendations to the Minister.
- 2) Nothing in this section –
- a) affects the ordinary jurisdiction of the courts to determine disputes that may be resolved by the application of law on these grounds;
 - b) prevents a complainant from instituting proceedings on any of these grounds in a court of law;
 - c) prevents a court from making a determination that any of these grounds are grounds in terms of paragraph (b) of the definition of “prohibited grounds” or are included within one or more of the grounds listed in paragraph (a) of the definition of “prohibited grounds.”

⁹⁶ *Condom Use in South Africa* at www.health.gov.za/hiv_aids/redhot.htm. Accessed: 24 July 2002.

There is also an important policy document, the *Charter of Rights on AIDS and HIV*, embracing human rights principles that are essential to ensure non-discrimination in the public health system in South Africa. The Charter was drafted in 1992, incorporating principles from international documents such as the *Montreal Manifesto of the Universal Rights and Needs of People Living with HIV Disease*, and the United Kingdom *Declaration of the Rights of People with HIV and AIDS*. The Charter was publicly launched on World AIDS Day in 1992 and was endorsed by a wide range of individuals and organisations, both nationally and internationally.

4.5 Labour rights

4.5.1 HIV/AIDS in the workplace

Constitutional protection

Section 23 (1) of the *Constitution* states that: “Everyone has the right to fair labour practices.” Section 39 (1) of the *Constitution* requires a court, tribunal or forum to consider international law in interpreting the Bill of Rights. These organs must, therefore, take into consideration the *SADC Code on HIV/AIDS and Employment of 1997*.

Labour legislation

The *Labour Relations Act*⁹⁷ was enacted in December 1995 to give effect to Section 27 of the *Interim Constitution*. Chapter VIII of the *Labour Relations Act* deals with unfair dismissals in Sections 185-197. Section 185 reads: “Every employee has the right not to be unfairly dismissed.” Section 187 (e) states the following constitute the grounds of automatic unfair dismissal: “that the employer unfairly discriminated against an employee, directly or indirectly, on any arbitrary ground, including, but not limited to race, gender, sex, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, political opinion, culture, language, marital status or family responsibility.” Schedule 7, Part B, of the *Labour Relations Act*, outlines residual unfair labour practices, disputes about unfair labour practices, and the powers of the Labour Court and Commission. Schedule 8 contains a *Code of Good Practice: Dismissal* with guidelines in cases of dismissal arising from ill health or injury.

The *Employment Equity Act, Act 55 of 1998*, was enacted to deal with unfair discrimination in employment. According to Section 6: “No person may unfairly discriminate, directly or indirectly, against an employee, in any employment policy or practice, on one or more grounds, including race, gender, sex, pregnancy, marital status, family responsibility, ethnic or social origin, colour, sexual orientation, age, disability, religion, HIV status, conscience, belief, political opinion, culture, language and birth.” The *Employment Equity Act* further states in Section 7(1) that: “Medical testing of an employee is prohibited, unless – a) legislation permits or requires the testing; or b) it is justifiable in the light of medical facts, employment conditions, social policy, the fair distribution of employee benefits or the inherent requirements of a job. (2) Testing of an employee to determine that employee’s HIV status is prohibited unless such testing is determined justifiable by the Labour Court in terms of Section 50 (4) of the Act.” Section 50 (4) states that: “If the Labour Court declares that the medical testing of an employee as contemplated in Section 7 is justifiable, the court may make any order that it considers appropriate in the circumstances, including imposing conditions relating to –

- a) the provision of counselling;
- b) the maintenance of confidentiality;
- c) the period during which the authorisation for any testing applies; and
- d) the category or categories of jobs or employees in respect of which the authorisation for testing applies.”⁹⁸

In January 2003, the Labour Court in Cape Town ruled that the voluntary HIV testing of workers is not prohibited by Section 7 (2) of the *Employment Equity Act*, and furthermore that companies do not have to obtain prior permission from the Labour Court to institute voluntary testing programmes. The Court found that anonymous and voluntary HIV testing did not violate Section 7 (2) because the testing was not compulsory or intended to discriminate against employees. Generally, companies conduct anonymous voluntary HIV testing to determine the prevalence of the disease for planning purposes. More companies are expected to begin voluntary testing programmes when the Johannesburg Securities Exchange SA introduces regulations requiring listed firms to report on risk management in terms of HIV/AIDS as part of their annual financial reports.⁹⁹

⁹⁷ Act 66 of 1995.

⁹⁸ Before the enactment of the *Employment Equity Act*, the Constitutional Court decided in *Hoffman v SAA CCT 17/00* that the denial of employment to a prospective employee for reasons of his HIV status constituted unfair discrimination and violated the right to fair

labour practices as guaranteed in the *Constitution*.

⁹⁹ See discussion at: <http://www.bday.co.za/bday/content/direct/1,3523,1266263-6079-0,00.html>.

A *Code of Good Practice on Aspects of HIV/AIDS and Employment* has been added to both the *Employment Equity* and the *Labour Relations Acts*. The *Code* is issued in terms of Section 54(1)(a) of the *Employment Equity Act* and is based on the principle that no person may be unfairly discriminated against on the basis of HIV status. The *Code* makes reference to other pieces of legislation in order to assist employers and employees to apply its principles consistently. The other Acts referred to are: *Labour Relations Act*, *Occupational Health and Safety Act, Act 85 of 1993*, *Mine Health and Safety Act, Act 29 of 1996*, *Compensation for Occupational Injuries and Diseases Act, Act 130 of 1993*, *Basic Conditions of Employment Act, Act 75 of 1997*, *Medical Schemes Act, Act 131 of 1998* and the *Promotion of Equality and Prevention of Unfair Discrimination Act, Act 4 of 2000*. The *Code* states that employees with HIV/AIDS may not be unfairly discriminated against in the allocation of employee benefits and recommends the adoption of workplace HIV/AIDS policies to ensure non-discrimination.

In 1999, the Department of Health's HIV/AIDS/STD Directorate published guidelines on the *Management of Occupational Exposure to the Human Immuno-deficiency Virus (HIV)*. These guidelines also contain recommendations regarding HIV post-exposure prophylaxis treatment and compensation for occupationally acquired HIV infection, administered by the Compensation Commission (formerly known as the Workmen's Compensation Commission).

The *Employment Equity Act* and the *Labour Relations Act* cover everyone except the South African National Defence Force, the National Intelligence Agency and the Secret Services. The South African National Defence Force previously had a pre-employment HIV testing policy. On 30 April 2001, the Department of Defence approved a departmental HIV policy called *The Management of Human Immune Deficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS)*. According to the *Policy*, HIV testing of any employee of the Department is not compulsory. However, it may "be required to accurately determine the health status of employees who have been identified to participate in operational deployments."¹⁰⁰ The *Policy* addresses measures for the containment of the epidemic and the care and support of members and their dependants infected and affected by HIV. In addition, it contains specific guidelines to ensure a non-discriminatory work environment.

4.5.2 HIV/AIDS and medical schemes

On 1 August 1999, the *Medical Schemes Act, Act 131 of 1998*, came into force. The Act regulates and reforms private health care insurers and providers. According to Section 24 (2) (e): "no medical scheme shall be registered under the Act unless the Council is satisfied that the medical scheme does not or will not unfairly discriminate directly or indirectly against any person on one or more arbitrary grounds, including race, gender, marital status, ethnic or social origin, sexual orientation, pregnancy, disability and state of health." Further, Section 29 states that: "The Registrar shall not register a medical scheme under section 24, and no medical scheme shall carry on any business, unless provision is made in its rules for the following matters: ... (n) The terms and conditions applicable to the admission of a person as a member and his or her dependants, which terms and conditions shall provide for the determination of contributions on the basis of income or the number of dependants or both the income and the number of dependants, and shall not provide for any other grounds, including age, sex, past or present state of health of the applicant or one or more of the applicant's dependants, the frequency of rendering of relevant health services to an applicant of one or more of the applicant's dependants other than for the provisions as prescribed." The Act therefore prohibits health insurers from unfairly excluding people living with HIV/AIDS from health insurance.

The *Medical Schemes Act* is expected to regulate the industry by replacing the principles of risk and exclusion or limitation with principles of community rating and social solidarity. In other words, where a person can afford the premiums associated with health insurance, an insurer cannot exclude him or her. In addition, registered members will not be forced to pay higher premiums based on age or health status; rather member contributions will be based on an "average" and will only increase if the principal member wishes to register additional dependants.¹⁰¹

Regulation No. 1262 of 20 October 1999 under the *Medical Schemes Act* provides that HIV-associated diseases are categorised under the prescribed minimum benefits that provide for the compulsory cover of medical and surgical management for opportunistic infections or localised malignancies. The Regulations require a review every two years with the specific focus of developing protocols for the medical management of HIV/AIDS.¹⁰²

100 See <http://www.mil.za/CSANDF/SurgeonGeneral/AIDSCampaign/MasiWeb2/prod02.htm>. Accessed: 22 August 2002.

101 DW Webber *AIDS and the Law in South Africa: An Overview*, at: www.hri.ca/partners/alp/resource/docs/saview99.doc. Accessed: 22

August 2002.

102 (GN 20061 RG 6530/ 7 May 1999).

All medical schemes in South Africa are legally obliged to adequately and fully fund the treatment for opportunistic infections as part of the mandated Basic Minimum Package of Care and Treatment.¹⁰³ At present, minimum benefits for HIV/AIDS do not include anti-retroviral drugs. However, according to the *Draft Amendment to General Regulations under the Medical Schemes Act*, published for comments on 30 April 2002, input is requested on the provision of ARVs, and the wording of the existing benefit.

The *Code of Good Practice on Aspects of HIV/AIDS and Employment* refers specifically to employee benefits in Section 10. It recommends that employees who are ill with HIV/AIDS should be treated the same as other employees with comparable life-threatening diseases with respect to access to employee benefits. Where a medical scheme is offered as part of the employee benefit package, care must be taken that the scheme does not discriminate, directly or indirectly, on the basis of HIV status.

4.5.3 Insurance and HIV/AIDS

The Life Office's Association (LOA) is an association of life insurance companies in South Africa. In October 2000, the LOA adopted an *HIV Testing Protocol*. The *Protocol* forms part of the Code of Conduct of the LOA and is therefore binding on all member offices. The purpose of the *Protocol* is to ensure that the life insurance/assurance industry adheres to the highest standards in all aspects of HIV screening of applicants for life insurance. It addresses issues such as identification, confidentiality, informed consent, pre- and post-test counselling, transmission of test results, accreditation of test kits and laboratories, and the use of exclusion clauses. The *Protocol* also clearly states that the results of tests should only be relayed to the doctor or clinic named by the applicant on his or her consent form, and that under no circumstances may any HIV test result be communicated to any sales intermediary or other unauthorised person.

According to G (3) of the LOA *Protocol*: "If the HIV test is reported as reactive and in cases where the results are discordant the result should be seen as reactive and uninsurable. The following procedure will then be followed:

a) The case is declined.

- b) The necessary entry is made on the LOA Life Register.¹⁰⁴
- c) The client is informed that the medical evidence has been submitted to his nominated doctor.
- d) A copy of the laboratory report, clearly marked "Private and Confidential" is sent to the nominated doctor.
- e) The company concerned will pay for one counselling session at the rate agreed with SAMA from time to time.
- f) Any further tests that may be undertaken will be at the client's own expense."

According to Annexure 2 of the *Protocol*, refusal to take the test will result in the denial of the application. Annexure 2 also states that: 1) existing cover will remain valid unless periodic re-testing for the AIDS virus is required; 2) existing cover may also have an AIDS exclusion clause which means that if the policy holder requires treatment for any AIDS related illness, his or her claim will not be paid; and, 3) existing policies that do not have an AIDS exclusion clause will not be invalidated as a result of the test results being positive. According to the *Protocol*, there are some insurance companies that offer special policies or alternative products for people with HIV. Most insurers, however, charge higher premiums and often limit the amount of insurance available.

4.6 Gender rights

4.6.1 Legal status of women and the role of cultural practices

The equality clause in the *Constitution* states in Section 9 (3) that: "The state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth." Women therefore have formal equality. A Commission on Gender Equality (CGE) was established in accordance with Section 187 of the *Constitution*. The purpose and function of the Commission is set out in the *Commission on Gender Equality Act, Act 39 of 1996*.

103 The South African Government's Response to the HIV/AIDS Epidemic -Controversies and Priorities, at: <http://196.36.153.56/doh/aids/docs/gov-aids.html>. Accessed: 27 July 2002.

104 The rejected applicant's name is put in code on the Life Register as someone who has been refused insurance. This means that future applications by the applicant to different insurance companies will also be denied.

The *Promotion of Equality and Prevention of Unfair Discrimination Act, Act 2 of 2000*, lists gender, sex, pregnancy and marital status as grounds for non-discrimination in an effort to grant full and equal enjoyment of rights and freedoms to women. The *Employment Equity Act* makes special provision for women as part of the so-called “designated groups” to ensure equal employment opportunities through affirmative action policies to rectify the imbalances between men and women in employment.

The following are examples of customary practices that contribute to women’s vulnerability to HIV in South Africa:

- The often preferred “tight, dry sex”, as practiced by men and women in some communities, can lead to vaginal tearing which places women at greater risk of contracting HIV.
- Polygyny, a legitimate and socially accepted form of customary marriage, allows for a man to have multiple wives. An infected partner in a polygynous marriage predisposes all other members of the union to contracting the virus.
- Certain other customary practices related to marital rites (known as *ukugena*, *ukuvusa* and *seantlo*) often involve unprotected sexual intercourse between the widow of a deceased partner and another man (usually a male relative of the deceased) chosen by the deceased’s family. These practices are primarily aimed at procreation with the sole intent being to produce an heir.
- Ritual circumcision for young boys as part of initiation ceremonies heralding the boys’ “coming of age”, often entails using the same instrument for the circumcision of a number of boys.
- Several other skin-piercing procedures utilised in health, therapeutic, ceremonial and aesthetic practices carry the potential risk of HIV transmission through infected blood if hygienic instruments are not used.¹⁰⁵

Other customary practices such as virginity testing, mostly conducted in the province of Kwazulu-Natal, also make women vulnerable. The persistence of the myth that having sex with a virgin will cure HIV infection is very problematic. South Africa’s initial report to the Committee on the Rights of the Child also mentions the practice of scarification of the skin as a common practice.

4.6.2 Legislation and policies protecting women and the most vulnerable in society

Section 39 (3) of the *Constitution* states that: “The Bill of Rights does not deny the existence of any other rights or freedoms that are recognised or conferred by common law, customary law or legislation, to the extent that they are consistent with the Bill.” This means that all customary laws and legislation must be consistent with the Bill of Rights and may not discriminate against women in a way that is contrary to the equality clause and legislation in place.

The *Recognition of Customary Marriages Act, Act 120 of 1998*, and the repealing of Section 11A of the *Black Administration Act, Act 38 of 1927*, has elevated the legal status of women married under customary law.

The *Prevention of Family Violence Act, Act 133 of 1993*, declares marital rape a crime and provides for a woman who has been assaulted by her husband to lay a criminal charge or obtain an interdict against him.

The *Domestic Violence Act, Act 116 of 1998*, provides for the arrest without a warrant of anyone suspected of having committed an act of domestic violence (Section 3), for the application of a protection order (Section 4), and for the application and issuing of an interim protection order (Section 5). Section 7 lists the powers of a court in terms of a protection order. These powers are broad and include amongst others: prohibiting the respondent from committing any act of domestic violence; prohibiting the respondent from entering the complainant’s residence; and/or prohibiting the respondent from entering the complainant’s place of employment.

There is a new *Sexual Offences Bill* before Parliament that will replace the 1957 *Sexual Offences Act*. The draft *Bill* covers both the substantive and procedural law relating to sexual offences. According to the South African Law Commission, the intention behind the *Bill* is to: “encourage victims of sexual violence to use the criminal justice system, to improve the experiences of those victims who choose to enter the system, and to increase the conviction rate whilst at the same time giving due regard to the rights accorded to alleged perpetrators of sexual offences.”¹⁰⁶

¹⁰⁵ Pieterse, M. *Traditional African Society and HIV/AIDS - Research Report for AIDS Law Project 1999* as quoted in *ALP Regional Audit on HIV/AIDS, Human Rights and Other Relevant Issues* (2000), at page 12.

¹⁰⁶ See Press Statement: *South African Law Commission, Project 107: Sexual Offences*. Available at: http://www.doj.gov.za/docs/2003_01_21.2salc.

The *Bill* expands the existing definition of rape and Section 3 (1) reads: “Any person who unlawfully and intentionally commits any act which causes penetration to any extent whatsoever by the genital organs of that person into or beyond the anus or genital organs of another person, or any act which causes penetration to any extent whatsoever by the genital organs of another person into or beyond the anus or genital organs of the person committing the act, is guilty of the offence of rape.” An act that causes penetration is prima facie unlawful if it is committed under false pretences or by fraudulent means (Section 3 (2)). Section 3 (4) (c) defines false pretences or fraudulent means as circumstances where a person: “intentionally fails to disclose to the person in respect of whom an act which causes penetration is being committed, that he or she is infected by a life-threatening sexually transmittable infection in circumstances in which there is a significant risk of transmission of such infection to that person.” Thus, a person can be found guilty of rape where he/she had the knowledge that he/she was HIV positive and did not disclose it to his/her sexual partner. Section 3 (6) declares that a marital or other relationship will not be a defence to a charge of rape.

The *Criminal Procedure Second Amendment Act, Act 85 of 1997*, and the *Compulsory HIV Testing of Alleged Sexual Offenders Bill 2002* are discussed in detail in Section 4.8.

4.6.3 Administering ARVs to rape survivors

The government has committed to providing a comprehensive package of care for victims of sexual assault, including counselling, testing for HIV, pregnancy and STD's.¹⁰⁷ According to Cabinet, a standardised national protocol will be finalised as soon as possible to address issues such as the counselling of survivors and the risks of using anti-retrovirals as preventative drugs, to enable survivors to make an informed choice.

The Department of Health has issued a *Policy Guideline for Management of Transmission of Human Immuno-deficiency Virus (HIV) and Sexually Transmitted Infections in Sexual Assault*. The *Policy* states that all women and men, aged 14 years and older, presenting to a health facility after being raped should be counselled by the examining health worker about the potential risks of HIV transmission post-rape. If the survivor presents him/herself within 72 hours of being raped, ARV therapy should be offered to prevent HIV transmission. Unfortunately, anti-retrovirals are not presently easily accessible and are therefore of limited use in assisting rape survivors.

4.6.4 Commercial sex workers

Commercial sex work is criminalised in South Africa in terms of the *Sexual Offences Act, Act 23 of 1957*. This was challenged in the Constitutional Court in the case of *Jordan and others v Republic of South Africa*.¹⁰⁸ The Constitutional Court ruled unanimously that the law criminalising the keeping of a brothel was constitutional.¹⁰⁹ The Court's 11 judges were, however, divided 6 to 5 in ruling on the constitutionality of the provisions criminalising sex for sale. The majority ruled that the sections of the *Sexual Offences Act* criminalising sex for sale were not discriminatory against women, stating that the provision applied to both men and women, and that both the customer and prostitute could be charged under the Act.¹¹⁰

Nevertheless, the decriminalisation of prostitution is still being discussed in South Africa.¹¹¹

4.6.5 Homosexuality and HIV/AIDS

Section 9 (3) of the *Constitution* states that: “The state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience,

¹⁰⁷ See Cabinet Statement on HIV/AIDS of 17 April 2002.

¹⁰⁸ CCT31/01. This case followed as an appeal from a high court judgment which ruled that the provisions of the *Sexual Offences Act* criminalising prostitution were unconstitutional but dismissed the appeal in respect of the sections of the *Act* which criminalise keeping or managing a brothel. The appellants challenged the constitutionality of Sections 2, 3 (b), 3 (c) and 20 (1)(aA) of the *Sexual Offences Act*. The first appellant, the owner of a brothel, was charged with a contravention of Section 2 of the *Act*. The second appellant, who was a salaried employee of the first appellant, was charged with a contravention of Section 2 read with Sections 3 (b) and 3 (c) of the *Act*. The third appellant, being a sex worker who worked at the brothel and who committed an act of indecency with the police agent, was charged with a contravention of Section 20(1)(aA) of the *Act*. The constitutionality of these provisions were challenged with reference to a number of constitutional rights such as the right to equality, the right to privacy, the right to dignity, the right to

trade and the right of access to health care.

¹⁰⁹ The judgment can be accessed at <http://www.concourt.gov.za/judgments/2002/jordan.doc>.

¹¹⁰ The Court therefore declined to confirm the order of the High Court declaring invalid Section 20(1)(aA) of the *Sexual Offences Act*. The minority judgment, however, ruled that the provision did discriminate against women by making the prostitute the primary offender and reinforcing sexual double standards, thereby perpetuating gender stereotypes.

¹¹¹ See for example, the South African Law Commission's Project 107, Discussion Paper 102, which investigates changes to the *Sexual Offences Act*. Discussion Paper 3 in this project specifically deals with prostitution. The closing date for public comments was 28 February 2002 and no further developments have been publicised to date. Executive summary of this project of the SALC can be accessed at: <http://www.server.law.wits.ac.za/salc/discussn/dp102execsum.pdf>.

belief, culture, language and birth.” Section 9 (4) has a similar section prohibiting ordinary people from discriminating against each other on the same grounds.

The criminalisation of sodomy was challenged in the Constitutional Court.¹¹² The Court found that the common law offence of sodomy and its inclusion in certain statutory schedules and legislation were not reasonable or justifiable limitations on the rights of gay men to equality, dignity and privacy.¹¹³ The offences were accordingly found to be unconstitutional and invalid.

4.7 Children’s rights

4.7.1 Health care, orphans and HIV/AIDS

Section 28 (1) (c) of the *Constitution* states that: “Every child has the right to basic nutrition, shelter, basic health care services and social services.” Government has introduced free health care for children under six and free health care for pregnant women up to six weeks post-delivery.

The Department of Health has issued *Recommendations for Managing HIV Infection in Children* that are intended to provide a practical approach for managing HIV/AIDS and related infections within the health care system in South Africa. Section 10 states that: “No child should be denied health care simply on the basis of their HIV status.” Since ARVs were not available in the public sector when the *Recommendations* were issued in 2000, guidelines for the use of ARVs and children are not included.

The PMTCT Programme of the South African government has been very controversial. In his State of the Nation address on 8 February 2002, the President emphasised that: “preventing mother-to-child transmission of HIV forms part of government’s programme of HIV/AIDS prevention. It is also part of a broader strategy to combat HIV/AIDS that depends critically on

building partnerships across society.” As part of its PMTCT policy, the Government supplied Nevirapine to HIV-positive pregnant women in identified pilot sites.¹¹⁴ The Treatment Action Campaign (TAC) successfully challenged the government on its PMTCT Programme, first in the High Court and eventually in the Constitutional Court.

On 4 April 2002, the Constitutional Court issued an interim order requiring: “that government make Nevirapine available in public health facilities where in the opinion of the attending medical practitioner in consultation with the medical superintendent of a clinic or hospital, it is medically indicated and the preconditions for its prescription already exist.” The interim order was applicable until the case was heard and final judgment issued by the Court.

The case was heard on the merits in May 2002. The judgment, issued in July 2002, was as follows: “It is declared that:

- a) Sections 27(1) and (2) of the Constitution require the government to devise and implement within its available resources a comprehensive and co-ordinated programme to realise progressively the rights of pregnant women and their newborn children to have access to health services to combat mother-to-child transmission of HIV.
- b) The programme to be realised progressively within available resources must include reasonable measures for counselling and testing pregnant women for HIV, counselling HIV-positive pregnant women on the options open to them to reduce the risk of mother-to-child transmission of HIV, and making appropriate treatment available to them for such purposes.
- c) The policy for reducing the risk of mother-to-child transmission of HIV as formulated and implemented by government fell short of compliance with the requirements in subparagraphs (a) and (b) in that:
 - i) Doctors at public hospitals and clinics other than the research and training sites were not enabled to prescribe Nevirapine to reduce the risk of mother-to-child transmission of HIV even where it was medically indicated and adequate facilities existed for the testing

112 *National Caution for Gay and Lesbian Equality and another v Minister of Justice and others* 1999 (1) SA 6 (CC).

113 Sodomy was included as a schedule in the *Criminal Procedure Act (Act 51 of 1977)* and the *Security Officers Act (Act 92 of 1987)*, and in Section 20 (a) of the *Sexual Offences Act*.

114 Research was presented on the use of Nevirapine to reduce mother-to-child transmission of HIV at the AIDS Conference in July 2000. Based on these results, the government developed a more comprehensive programme to reduce HIV transmission to babies and to

conduct further research on the subject resulting in the 18 national research sites in May 2001. By the end of 2001, these sites involved 215 clinics and hospitals. Women attending these sites are offered counselling and voluntary testing for HIV. Mothers who are HIV positive are also offered Nevirapine for themselves and their babies, vitamins to improve their health during pregnancy, preventative measures to prompt treatment of infections in mother and baby, and formula feed if they choose not to breastfeed. *Government’s Programme to Reduce HIV Infection in Babies*, at: www.gov.za/issues/hiv/hivbabies.htm. Accessed: 27 July 2002.

and counselling of the pregnant women concerned.

- ii) The policy failed to make provision for counsellors at hospitals and clinics other than at research and training sites to be trained in counselling for the use of Nevirapine as a means of reducing the risk of mother-to-child transmission of HIV.

“Government is ordered without delay to:

- a) Remove the restrictions that prevent Nevirapine from being made available for the purpose of reducing the risk of mother-to-child transmission of HIV at public hospitals and clinics that are not research and training sites.
- b) Permit and facilitate the use of Nevirapine for the purpose of reducing the risk of mother-to-child transmission of HIV and to make it available for this purpose at hospitals and clinics when in the judgment of the attending medical practitioner acting in consultation with the medical superintendent of the facility concerned this is medically indicated, which shall if necessary include that the mother concerned has been appropriately tested and counselled.
- c) Make provision for counsellors based at public hospitals and clinics other than the research and training sites to be trained in the counselling necessary for the use of Nevirapine to reduce the risk of mother-to-child transmission of HIV.
- d) Take reasonable measures to extend the testing and counselling facilities at hospitals and clinics throughout the public health sector to facilitate and expedite the use of Nevirapine for the purpose of reducing the risk of mother-to-child transmission.”¹¹⁵

The government subsequently issued a statement that: “it welcomed the fact that the protracted court case on the provision of Nevirapine to prevent mother-to-child transmission of HIV had come to a conclusion. We accept the ruling of the court on this matter.”¹¹⁶ On 23 March 2003, the government reported that provinces were implementing the Constitutional Court ruling, and that by the end of December 2002, over 101 202 women had visited the facilities attached to the 18 PMTCT research sites, with 63 217 accepting voluntary counselling and testing, and 17 274 testing HIV positive.¹¹⁷

The Department of Health has issued a *Policy Guideline and Recommendation for Feeding of Infants of HIV-positive Mothers*. The *Policy Guideline* outlines recommendations for the feeding of healthy infants whose mothers are known to be HIV positive, and are not designed for ill infants or infants with HIV/AIDS. The *Policy Guideline* states that: “Breastfeeding is a significant and preventable mode of HIV transmission to infants and there is an urgent need to educate, counsel and support women and families so that they can make decisions about how best to feed infants in the context of HIV.” It does not address the provision of breast milk substitutes by health-care services, or the cost of provision of such substitutes. The *Policy Guideline* does, however, mention that the cost of providing formula should be weighed against the savings of preventing HIV infection in newborn babies.

In 2000, the Inter-Ministerial Committee on HIV/AIDS requested that a national strategy for children infected and affected by HIV/AIDS be developed. The Minister for Welfare, Population and Development is responsible for the development and implementation of the strategy. According to the constitutive document, the *National Strategic Framework for Children Infected and Affected by HIV/AIDS (NSF)* will ensure that children who are affected by HIV/AIDS have access to integrated services that address their basic needs for food, shelter, education, health care, family or alternative care, and protection from abuse and maltreatment: “The *National Strategic Framework* will address the immediate and urgent needs of children at the present time and also develop a longer-term strategy that will prepare South Africa adequately for future challenges. The *NSF* will link with and build upon existing government strategies in order to engender an effective and concerted governmental response to HIV/AIDS.”

The *NSF* states that: “it is clear that orphans are particularly vulnerable and particular emphasis will be placed upon meeting their needs.”¹¹⁸ One of the objectives of the *NSF* is to ensure that the comprehensive childcare legislation being developed by the South African Law Commission deals effectively with the needs of orphans and this includes the protection of children’s inheritance. The *NSF* sets out a framework for the implementation of the strategy focusing specifically on community based care and support models such as foster care, adoption

¹¹⁵ *Minister of Health and others v Treatment Action Campaign and others* CCT 8/02, 2002 (5) SA 721 (CC) par 135.

¹¹⁶ *Statement by government on the Constitutional Court judgment regarding PMTCT* at www.gov.za/search97cgi/s97.cgi?action=View. Accessed: 28 August 2002.

¹¹⁷ *Mohapeloa, V. Government’s Plan to deal with HIV/AIDS* available at: wysiwyg://128/http://allafrica.com/stories/200303240913.html.

¹¹⁸ The document also indicates that: “In most parts of the industrialised world, usually no more than 1% of the child population is orphaned. Before the onset of HIV/AIDS, societies in the developing world absorbed orphans into the extended family and communities at a rate of just over 2,5 % of the child population. Today, as a consequence of AIDS, 11% of Ugandan children are orphans, 9% in Zambia and 7% in Zimbabwe. The scenario is likely to be repeated in South Africa.”

placements for children, and securing of other placements for children such as cluster caring or placement of children with relatives within the community.

The Department of Social Development's Strategic Plan is informed by the Ten Point Plan, which represents the priorities to be addressed by the social development sector during the period 2000 to 2005. One of the ten points includes HIV/AIDS and declares that: "Our programmes will include a range of services to support the community based care and assistance for the people living with HIV/AIDS. Particular attention will be given to orphans and children infected and affected by HIV/AIDS." In August 2002, the Department of Social Development issued *National Guidelines for Social Services to Children Infected and Affected by HIV/AIDS*. The Introduction to the *National Guidelines* states that: "The crisis has led to a situation where the protection of the rights of orphaned and vulnerable children in many communities can no longer take place effectively without outside assistance."

The *Child Care Act, Act 74 of 1983*, identifies children who are in need of care in terms of the law. Although the *Child Care Act* does not have any provisions on HIV testing in cases of adoption, Child Welfare's policy has been to test everyone involved in adoption. If an adoptive parent tests HIV positive, the adoption process is halted. However, if a child tests positive the information is disclosed to the future parents in order to assist them in deciding whether to adopt or not. The Department of Social Development has submitted a draft discussion paper on foster care for the revision of the *Child Care Act* to the South African Law Commission. The document addresses the placement of HIV/AIDS-infected and affected children and proposes new options of permanency planning for children in alternative care.

At the beginning of 2003, the *Children's Bill* was tabled in Parliament. This *Bill* strives to: "define the rights and responsibilities of children; to define parental responsibilities and rights; to determine principles and guidelines for the protection of children and the promotion of their well-being; to regulate matters concerning the protection and well-being of children, especially those that are the most vulnerable; to consolidate the laws relating to the welfare and protection of children; and to provide for incidental matters." Part 3 of the *Bill* deals with protective measures relating to the health of children, and Sections 135-140 specifically address issues of HIV/AIDS. Section 136 outlines when a child may be tested for HIV and who may give consent

should the child be under the age of 12 years. Section 137 requires that the state pay for an HIV test where the child is under the age of three years for the purposes of placing the child in foster care or for adoption. Sections 138 and 139 of the *Bill* deal with pre- and post-test counselling and confidentiality. Section 140 states that no person may refuse to sell or to provide free condoms to a child.

4.7.2 HIV/AIDS and the educational system

Section 9 of the *Constitution*, the equality clause, protects children against discrimination. Additionally, Section 29 (1) (a) declares that: "Everyone has the right to a basic education, including adult basic education." The Preamble to the *South African Schools Act, Act 84 of 1996*, seeks to protect children against discrimination by stating that: "... this country requires a new national system for schools which will redress past injustices in educational provision ...combat racism and sexism and all other forms of unfair discrimination and intolerance ... " Section 3 (1) of the *Schools Act* provides for compulsory attendance of school for learners from the age of 7 until the age of 15 or the ninth grade, whichever occurs first. Section 5 (1) requires that: "A public school must admit learners and serve their educational requirements without unfairly discriminating in any way." Section 5 (3) declares that: "No learner may be refused admission to a public school on the grounds that his or her parent - a) is unable to pay or has not paid the school fees determined by the governing body under Section 39." Additionally, girls who become pregnant are legally entitled to remain in school.

On 10 August 1999, the Department of Education published the *National Policy on HIV/AIDS, for Learners and Educators in Public Schools, and Students and Educators in Further Education and Training Institutions*. Section 2.6 of the Policy states that: "Learners and students with HIV/AIDS should lead as full a life as possible and should not be denied the opportunity to receive an education to the maximum of their ability. Likewise, educators with HIV/AIDS should lead as full a professional life as possible, with the same rights and opportunities as other educators and with no unfair discrimination being practised against them. Infection control measures and adaptations must be universally applied and carried out regardless of the known or unknown HIV status of individuals concerned." Section 3.1 continues by stating that: "No learner, student or educator with HIV/AIDS may be unfairly discriminated against directly or indirectly." Section 4.1 of the *Policy* declares that: "No learner or student may be denied admission to or

continued attendance at a school or an institution on account of his or her HIV/AIDS status or perceived HIV/AIDS status.”¹¹⁹

With respect to teachers, the *National Policy on HIV/AIDS, for Learners and Educators in Public Schools, and Students and Educators in Further Education and Training Institutions* in Section 2.10 states that: “Appropriate course content should be available for the pre-service and in-service training of educators to cope with HIV/AIDS in schools. Enough educators to educate learners about the epidemic should also be provided.” Section 2.10.2 further provides that: “Because of the sensitive nature of the learning content, the educators selected to offer this education should be specifically trained and supported by the support staff responsible for life skills and HIV/AIDS education in the school and province ... Educators should also be informed by the principal and educator unions of courses for educators to improve their knowledge of and skill to deal with HIV/AIDS ... All educators should be trained to give guidance on HIV/AIDS. Educators should respect their position of trust and the constitutional rights of all learners and students in the context of HIV/AIDS.”

A teacher-training programme geared to enhance facilitation skills to enable educators to communicate sex education in a relaxed but professional manner has been implemented under the Life Skills and HIV/AIDS Education Programme of the Department of Health, in conjunction with the Department of Education.¹²⁰ The Department of Health has produced a handbook for educators based on the *National Policy on HIV/AIDS, for Learners and Educators* called *The HIV/AIDS Emergency Guidelines for Educators*. The handbook is available in English, Afrikaans, isiZulu, isiXhosa, Sepedi, Sesotho and Xisonga.¹²¹

The *National Policy on HIV/AIDS, for Learners and Educators* advises that: “Besides sexuality education, morality, and life skills education being provided by educators, parents should be encouraged to provide their children with healthy morals, sexuality education and guidance regarding sexual abstinence until marriage and faithfulness to their partners.” Furthermore, the *Policy* recommends that learners receive education about HIV/AIDS and abstinence in the

context of life-skills education on an ongoing basis. Life-skills and HIV/AIDS education should not be presented as an isolated learning concept, but should be integrated in the whole curricula. It should be presented in a scientific but understandable way. Section 9 of the *Policy* deals with education on HIV/AIDS and sets out detailed guidelines covering life skills and HIV/AIDS education programmes for all learners, students, educators and other staff members.

According to the Cabinet, promoting public awareness, life skills and HIV/AIDS education programmes forms part of the core effort to prevent transmission of HIV. HIV/AIDS education is now a compulsory part of the school curriculum and full implementation is expected by the end of 2003. The Life Skills Education Programme has been strengthened through the *Integrated Strategy for Children*. This initiative of the Department of Education, in conjunction with the Department of Health, is aimed at providing information about HIV, and focusing on skills development, attitudes and motivational support. Topics covered in this programme include self-esteem, understanding sexuality, preventing HIV and prevention of STD's.¹²² The Life Skills Programme is to be expanded to all primary and secondary schools over a three-year period. It has already commenced in primary schools and is now in its second year.¹²³

In addition, the School Health Service, as part of the primary health care package for South Africa, is expected to provide health-promoting services by acting in a co-ordinating role, and by making use of the skills and capacity in different sectors of society, including learners and educators. According to the guidelines of this programme, educators are directly involved in activities such as the distribution of health-promoting educational materials, the promotion of healthy sexuality, and dealing with the results of unhealthy sexual behaviour.

4.8 Criminal law and HIV/AIDS

The *Criminal Law Amendment Act, Act 105 of 1997*, provides for life imprisonment for an HIV-positive first offender who is convicted of rape, but a lesser minimum sentence of ten years for

¹¹⁹ But see the recent judgment of the High Court of *Perreira v Buccleuch Montessori Nursery School*, discussed in Section 4.2.1 of this report.

¹²⁰ AIDS Law Project *Regional Audit on HIV/AIDS, Human Rights and Other Relevant Issues*, page 18.

¹²¹ The handbook is available at http://education.pwv.gov.za/HIV/AIDS_Folder/aids%20book.pdf. Printed in 2000 (reprinted in 2002).

¹²² AIDS Law Project *Regional Audit on HIV/AIDS, Human Rights and Other Relevant Issues*, page 18.

¹²³ The South African Government's *Response to the HIV/AIDS Epidemic - Controversies and Priorities* at <http://196.36.153.56/doh/aids/docs/gov-aids.html>. Accessed: 27 July 2002.

a first offender who is not HIV positive. The Act does not require evidence of HIV transmission to support the imposition of a higher sentence. In amending the *Criminal Procedure Act of 1977*, the *Criminal Procedure Second Amendment Act, Act 85 of 1997*, now makes the eligibility for bail more difficult in rape cases where the accused is known to be HIV positive.¹²⁴ The accused is generally denied bail if he/she is HIV positive, although bail may be granted if the accused establishes “exceptional circumstances”.¹²⁵

The South African Law Commission has investigated possible changes to the definition of the crime of rape, and the possibility of requiring a sexual offender to undergo an HIV test if requested by the victim and ordered by the Magistrate. These have been incorporated into two separate bills that have been tabled in Parliament. The *Compulsory HIV Testing of Alleged Sexual Offenders Bill of 2002* has the following objectives: “To provide for a speedy procedure for a victim of an alleged sexual offence in which exposure to the body fluids of the alleged offender may have occurred; to apply for the compulsory HIV testing of the alleged offender; and the disclosure of the test results to the victim and the alleged offender; and to provide for incidental matters.”¹²⁶ The *Bill* proposes that police officials hand out a notice containing information regarding compulsory HIV testing of an alleged offender to the victim or an interested person when a sexual offence is reported.¹²⁷

According to Section 3, any victim who may have been exposed to the body fluids of an alleged offender, or any interested person on behalf of such victim, may apply to a Magistrate for an order that the alleged offender be tested for HIV. Three requirements need to be met before the Magistrate can issue an order for the HIV test: a) a sexual offence has been committed against the victim by the alleged offender, b) the victim may have been exposed to the body

fluids of the alleged offender, and c) that no more than 50 calendar days have elapsed from the date on which it is alleged that the offence took place.¹²⁸ The results of the test may not be admitted as evidence in criminal or civil proceedings; the use of the test results is restricted to the primary purpose of the legislation.¹²⁹ To ensure confidentiality, the result of the test may only be communicated to the victim or the interested person and the alleged offender.¹³⁰ The legislation does not specifically provide for counselling when the victim is informed of the alleged offender’s HIV status, and concerns have been raised about this issue.¹³¹

The South African Law Commission has investigated the possibility of criminalising harmful HIV-related behaviour and in June 2001 published a report¹³² recommending that harmful HIV-related behaviour should not be criminalised, furnishing the following reasons: a) it may harm rather than help people vulnerable to infection; b) it may make discrimination against people living with HIV/AIDS worse; and c) it may harm public health efforts to stop the spread of HIV.

4.9 HIV/AIDS and prisons

South Africa has 236 prisons built to accommodate 100 384 prisoners. However, there is severe overcrowding: 51 of South Africa’s prison facilities held more than double the number of prisoners for which they were designed,¹³³ a further 101 prisons were more than 175% full, and 105 were between 100% and 175% full.¹³⁴ A conservative estimate of HIV prevalence amongst South African prisoners is approximately 41% for 2002. However: “No HIV prevalence survey has been conducted in South African Prisons and until such a survey is conducted one cannot confidently conclude that any statistical figure on HIV infection is real”.¹³⁵ The Department of

124 Schedule 6 (a)(iv) states that: Rape when committed by a person, knowing that he has the acquired immune deficiency syndrome or the human immuno-deficiency virus.

125 Section 60 (11).

126 See the Preamble to the *Bill*.

127 See Section 2 of the proposed *Bill*.

128 Section 4(3)(a-c).

129 Section 6 of the *Bill* read together with 2.4 of the *Memorandum on the Objects of the Compulsory HIV Testing of Alleged Sexual Offenders Bill, 2002*.

130 Section 10. According to Section 11, any person who maliciously makes an application or discloses the result of such an HIV test in contravention of section 10 is guilty of an offence and is liable on conviction to a fine or to imprisonment for a period not exceeding six months.

131 This is a troublesome position/attitude according to Lisa Vetten, Gender Coordinator at the Centre for the Study of Violence and Reconcilia-

tion. Quoted in Lackay, A. *HIV testing for rape suspects* 25 February 2003 available wysiwyg://1/http://www.news24.com/News_s_Focus/0,6119,2-7-659_1316547,00.html.

132 *Aspects of the Law Relating to HIV/AIDS, Fifth Interim Report, The Need for a Statutory Offence Aimed at Harmful HIV-Related Behaviour*, June 2001.

133 This was the case as of June 2002. See <http://www.dispatch.co.za/2002/20/24/southafrica/LIFE2.HTM>.

134 As of 24 October 2002.

135 See <http://www.pmg.org.za/docs/2002/viewminute.hph?id=1724>. Accessed: 20 August 2002. This statement from the DCS was made in reaction to the estimate of Judge Johannes Fagan, Inspecting Judge of Prisons, that as many as 60% of prisoners could be HIV positive. The DCS disputed this figure as being “unrealistic and unreliable”. This estimate was based on the only study ever conducted on the nature and extent of HIV prevalence in a South African prison. The study was conducted at Westville Medium B, a men’s maximum security prison in KwaZulu-Natal.

Correctional Services (DCS) is planning to conduct a prevalence survey in prisons in 2003 and 2005, and will rely on the experience and expertise of the Department of Health to conduct the survey.

The Department of Correctional Services engages in the following to address HIV/AIDS:¹³⁶

- awareness campaigns for inmates and personnel;
- training of personnel and inmates, including training-of-trainers programmes;
- peer education amongst inmates;
- condom availability;
- treatment of sexually transmitted infections and HIV/AIDS complications;
- early placement / parole of the terminally ill; and
- partnership with the Department of Health and other departments, CBOs, NGOs, churches, universities, etc.

The Department of Correctional Services' *Management Strategy: HIV/AIDS in Prisons* is a revision of the 1996 *Management Strategy: AIDS in Prisons: Desegregation of Prisoners with HIV/AIDS*, and provides for the needs of all offenders (adults and juveniles, male and female, the children of female offenders and pregnant female offenders).¹³⁷ The implementation of the *Management Strategy* is mandatory, and non-compliance by any official of the Department of Correctional Services or by any prisoner may subject them to disciplinary procedures.

The goals of the *Management Strategy* include the provision of guidelines for monitoring the spread of HIV/AIDS, co-ordinating of activities for preventing the spread of HIV/AIDS, and caring for prisoners with HIV/AIDS. The *Management Strategy* is based on the principle of full

commitment to the provision of a non-discriminatory, non-stigmatising, supportive environment for all infected and affected personnel and prisoners. Section 6.11 specifically requires that both prisoners and personnel be sensitised about the dangers of unprotected sex, violations of human rights, and the criminalisation of non-consensual sex. The protection of human rights is further enshrined in Section 6.12, which states that: "the observance of human rights is critical for the protection of the vulnerable...both prisoners and personnel in all prisons should be trained in human rights issues." It specifically mentions the right of all prisoners, including those who are HIV positive, to privacy, bodily autonomy, integrity and safety.¹³⁸

The *Management Strategy* recommends that condoms (including female condoms) be easily accessible to both prisoners and personnel at all times and in all prisons,¹³⁹ and that information about the use and benefits should accompany the distribution of condoms. It also requires that used condoms be disposed of in a manner that will not be a source of infection to other prisoners and officials.¹⁴⁰

Section 12 of the *Correctional Services Act*¹⁴¹ states that: "Every prisoner has the right to adequate medical treatment." Subsection (4)(b) provides that no prisoner may be compelled to undergo medical examination, intervention or treatment without informed consent unless failure to submit to such treatment will pose a threat to the health of others.

According to the Health and Physical Care Directorate within the Department of Correctional Services: "Health education is given on admission to prison, when consulting the medical officer/practitioner and/or during health education sessions on a continuous basis on a number of topics, including STIs (including HIV/AIDS) and tuberculosis." This is also required in the *Management Strategy*.¹⁴² An official of the health team screens all offenders on admission to identify the

¹³⁶ See <http://www.dcs.gov.za/OffenderManagement/Healthservices.htm>.

¹³⁷ The purpose behind the revision was to align the *Management Strategy* to the National Department of Health policies and make provision for the inclusion of the latest management strategies. Specifically, the *Management Strategy* aimed to include the following strategies: 1) Prevention which involves the promotion of safe sexual practices, prevention of mother-to-child transmission, management and control of STD's, provision of condoms and access to voluntary counselling and testing. 2) Treatment, care and support. 3) Research and monitoring which includes regular surveillances. 4) Human rights where recognition and respect of the rights of those living and affected with HIV/AIDS are acknowledged. Information obtained from a presentation by KM Mabena, Acting Director of Health and HIV Policy in the DCS, on 18 February 2003, held at the Institute for Security Studies.

¹³⁸ See 6.12 of the *Management Strategy*. These rights are enshrined in the *Constitution*. See Sections 12 and 14.

¹³⁹ Provision is also made for the distribution of female condoms to female prisoners. See Section 6.3 of the *Management Strategy*.

¹⁴⁰ The revised *Management Strategy* has addressed some of the issue arising from the 1996 Strategy. For example, the 1996 Strategy required that: "A prisoner may not receive condoms before having undergone education/counselling regarding AIDS, the use of condoms and the dangers of high-risk behaviour. The fact that a prisoner received counselling must be recorded on his/her medical file." This practice deterred prisoners from accessing condoms. Under the new *Management Strategy*, prisoners can freely access condoms placed discreetly throughout the prison in plastic containers and provision is made for the discarding of used condoms.

¹⁴¹ Act 111 of 1998.

¹⁴² See Section 6.2 of the *Management Strategy*.

presence of certain medical conditions, take the necessary medical interventions; or to make referrals to other officials of the multidisciplinary team, e.g. social workers. Specifically, offenders are screened for contagious and communicable diseases.¹⁴³ The *Management Strategy* also provides for a full medical check on all offenders entering the prison system and thereafter at regular intervals.¹⁴⁴ Multipurpose clinics have been established within the prisons to effectively treat different diseases at the primary level. Health education is provided to all offenders regarding communicable diseases. Babies (in prison with their mothers) are also immunised against communicable diseases in accordance with the National Immunisation Programme.¹⁴⁵

Section 6.4 of the *Management Strategy* is as follows: “The compulsory testing of offenders to determine the presence of HIV status is considered as unnecessary, or ineffective endeavour with no treatment basis, unethical, and is therefore forbidden. Testing ‘offenders’ for HIV antibodies must only be carried out upon request of the prisoner, by recommendation of a registered nurse or by written order of the attending medical officer/practitioner.” Prisoners must consent in writing to voluntary testing accompanied by pre- and post-test counselling.¹⁴⁶

With respect to “records”, the Department of Correctional Services recognises that: “This is the most critical issue when rendering nursing care. All interventions carried out on the patients are and must be recorded, and confidentiality maintained at all times.”¹⁴⁷ The *Management Strategy* further states that: “Information regarding the HIV status of a prisoner or official must not be divulged to anyone, including other officials, other prisoners, and relatives without the written consent of the prisoner or official concerned.”¹⁴⁸ This information must be kept confidential at all times and a breach of confidentiality is subject to disciplinary action.

Section 6.7 of the *Management Strategy* states that the provision of anti-retroviral drugs to prisoners (including Nevirapine to pregnant women and their babies) and the management of opportunistic infections will be in keeping with the policies of the Department of Health. It also states that the distribution of anti-retroviral drugs must be accompanied with information as to use and side-effects.

Section 6.10 of the *Management Strategy* does not allow for HIV-positive prisoners to be separated from other prisoners.¹⁴⁹ Even where medical isolation is required, it must be carried out without any reference to the prisoner’s HIV status.

143 Screening at: <http://www.dcs.gov.za/OffenderManagement/Healthservices.htm> .

144 See 6.1 of the *Management Strategy*.

145 See *STI's including HIV/AIDS* at: <http://www.dcs.gov.za/OffenderManagement/Healthservices.htm>.

146 See Section 6.4 of the *Management Strategy*.

147 Records at: <http://www.dcs.gov.za/OffenderManagement/Healthservices.htm> .

148 See 6.5 of the *Management Strategy*.

149 Segregation of HIV-positive prisoners in South Africa ended in 1996, after the acceptance of the World Health Organization’s 1993 *Guidelines on HIV Infection and AIDS in Prisons*.

5. CONCLUSIONS AND RECOMMENDATIONS

This research project has shown that although HIV/AIDS has not been included in any international or regional treaties, relevant resolutions and guidelines do exist, and specific provisions in the major treaties will apply to the situations of people living with or affected by HIV/AIDS. Some states have included the measures that they undertook to address HIV/AIDS in their state reports, and the treaty monitoring bodies have often commented on these efforts in Concluding Observations. Clearly, most, if not all, of the 8 SADC countries surveyed have yet to incorporate treaty obligations into domestic legislation. It is also clear that most countries still operate with a policy-based approach to HIV/AIDS, rather than a rights-based approach, even though the UNAIDS and OHCHR *HIV/AIDS and Human Rights – International Guidelines* offers guidance to move from policy to rights.

It is against this background that the country reports should be analysed. Firstly, the aim is to identify those human rights principles that already exist which can assist with the adoption of a human rights-based approach, and secondly, to identify and make recommendations where the governments' responses have not included human rights.

Three general trends should be highlighted:

- Firstly, the HIV/AIDS responses in the various countries from the reporting of the first case in the mid-1980s has followed a very similar approach. Initially, in each country the Ministry of Health co-ordinated the response through a short-term plan, which focused mainly on issues of blood screening. This was followed by one or more medium-term plans in the mid-to late 1990s, ultimately heralding the multi-sectoral approach adopted by all the countries by the end of the 1990s. Thus, all eight countries adopted national strategic frameworks on HIV/AIDS and all except South Africa, Namibia and Mozambique adopted further national policies on HIV/AIDS to give effect to the goals in the strategic frameworks. To varying degrees, this development from short-term plans to multi-sectoral strategic frameworks was also accompanied by a gradual inclusion of human rights provisions in the HIV/AIDS discourse. This coincided with an overall trend in the SADC countries to adopt new constitutions with a bill of rights. For example, new constitutions were adopted by Namibia in 1990, and by both South Africa and Malawi in 1994.
- Secondly, the legislative frameworks analysed indicate overwhelmingly that in addressing the HIV/AIDS epidemic, and affording protection to the rights of those affected or infected, states elect to respond by introducing policies, codes or guidelines, rather than legislation. This means that government interventions are not legally binding and generally cannot be enforced in the courts. Thus, people living with or affected by HIV/AIDS have few specific enforceable rights. Obligations with respect to human rights are further minimalised by states' reluctance to transform ratified human rights treaties into domestic legislation.
- Thirdly, where legislation does address HIV/AIDS issues, it tends to be limited to the areas of criminal law and labour law. Countries are inclined to promulgate criminal laws that try to "contain" the disease based on a model of "control" over the spread of the disease. Botswana, Namibia, South Africa and Zimbabwe have amended their criminal laws to provide for harsher sentencing of HIV-positive sexual offenders, whilst Zimbabwe has also criminalised the deliberate transmission of HIV. Swaziland and Zambia have declared that they will follow suit in the near future. With the exception of South Africa (in relation to homosexuality), governments have targeted homosexuals and commercial sex workers, groups that are already stigmatised in society, by criminalising their behaviour. In terms of labour legislation, governments have attempted to secure economic stability by focusing on the "economic active," people between the ages of 19 and 45 years, which is the age group that is hardest hit by the epidemic. Mozambique, Namibia, South Africa and Zimbabwe have adopted workplace legislation that outlaws discrimination on the basis of HIV status, prohibits pre-employment testing and secures medical benefits for HIV-positive employees. These efforts with respect

to labour rights are commendable; however, governments' efforts should not end with employment, but rather with an attempt to guarantee human rights in all spheres.

To guide governments toward a more inclusive human-rights-based response, the following steps are recommended:

- Those countries that have not developed a national HIV/AIDS policy to complement the national strategic framework should do so.
- In revising the current strategic frameworks and national policies (usually revised every two or five years), the inclusion of human rights provisions in all spheres/sectors should be a priority. Currently, most frameworks merely mention discrimination and stigmatisation.
- Countries should comply with international and regional treaty obligations and domesticate the provisions of these treaties through national legislation.
- Countries should review and revise national legislation on social assistance and security to provide specifically for AIDS orphans, families caring for people with AIDS, and people living with AIDS. This would avoid the difficulties of interpreting claims in terms of disability grants.
- Countries should develop a separate national policy on voluntary HIV testing, pre- and post-test counselling and factors affecting confidentiality (such as informing an HIV-positive person's partner of his/her status), and avoid the principle of shared confidentiality.
- Countries should develop legislation protecting the rights of volunteers in medical trials testing the effects of new HIV drugs and vaccines. Legislation should also regulate the treatment of HIV-positive patients by private and public health care services, specifically prohibiting discrimination against HIV-positive patients.
- HIV/AIDS-specific legislation prohibiting discrimination on the grounds of HIV status should be developed for all spheres.
- Where countries have not developed HIV/AIDS-specific legislation for the workplace, this must be made a priority, focusing on issues such as non-discrimination against HIV-positive employees, prohibition of pre-employment HIV testing, offering medical benefits that cater for the special needs of HIV-positive employees, and ensuring that employees have access to information and educational programmes on HIV/AIDS.
- Governments should ensure that national strategic frameworks and policies address the needs of the mentally ill and the disabled. Currently, only Botswana has undertaken a programme

to ensure that people with disabilities have access to HIV/AIDS education and information.

- Where legislation does not already exist, states need to legislate on the rights and treatment of orphan children and children in difficult circumstances.
- Governments need to focus on the provision of HIV/AIDS medicines. The focus to date has been on negotiations with pharmaceutical companies for price reductions. The possibility of compulsory licensing and importation (production) of generic substitutes has not received much attention. The exceptions allowed for under the WTO's *Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS)* should be exploited fully.
- Legislation should be promulgated to regulate public and private medical schemes in an effort to ensure that people living with HIV/AIDS are not discriminated against or excluded.
- Governments should investigate ways of addressing the issue of restrictions on HIV-positive persons applying for and being granted life insurance.
- Customary practices that increase the risk of HIV infection in women and men should be addressed through a comprehensive approach, including involving traditional leaders and healers, sensitising communities about the dangers of such practices, suggesting alternatives, and ultimately legislating against harmful (inhuman and degrading) practices.
- Practices that put women in a vulnerable position in society and increase their risk of HIV infection – such as domestic violence and restrictive inheritance laws – should be made a priority and legislation must be adopted to secure women's rights.
- Steps should be taken to decriminalise commercial sex work and homosexuality.
- Only Botswana and South Africa have specific policies on HIV/AIDS and prisons. The other countries in this study have included some guidelines in their national policies or strategic frameworks, but with the special conditions prevailing in prisons that increase the risk of HIV infection, every country should adopt a separate policy or legislation on HIV/AIDS and prisons. Issues that should be addressed include the dissemination of education on HIV/AIDS and STDs, voluntary testing and counselling, non-segregation of prisoners, condom distribution, and access to treatment for opportunistic infections.
- The lack of capacity to develop appropriate legislative frameworks has been invoked by states to explain the legislative impasse. A comprehensive model code on HIV/AIDS should be developed, providing a general framework for states to develop a specific legislative response to the pandemic.
- Heads of state need to take an active lead in the lobbying and reform efforts regionally and internationally.

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ANNEXURE: HIV/AIDS and human rights in SADC – summary of findings

	Botswana	Malawi	Mozambique	Namibia	South Africa	Swaziland	Zambia	Zimbabwe
Form of government	Constitutional democracy	Constitutional democracy	Semi-presidential constitutional democracy	Constitutional democracy	Constitutional democracy	Absolute monarchy with no Constitution	Constitutional democracy	Constitutional democracy
Domestic legal system	English Common law and Roman-Dutch law	English Common law	Civil or Continental law system inherited from Portugal	English Common law and Roman-Dutch law	Roman-Dutch law and English Common law	Roman-Dutch law and Swaziland customary law	English Common law	Roman-Dutch law and English Common law
National HIV/AIDS Strategic Framework (NSF): time frame, human rights provisions	2003-2009 NSF refers to human rights	2000-2004 NSF refers to human rights	2000-2002 National Strategic Plan to Combat STDs/HIV/AIDS makes almost no reference to human rights	1999-2004 National Strategic Plan on HIV/AIDS (MTPH) refers to human rights	2000-2005 HIV/AIDS/STD Strategic Plan for South Africa refers to human rights	2000-2005 Swaziland National Strategic Plan for HIV/AIDS refers to human rights	2002-2005 National HIV/AIDS/STI/TB Intervention Strategic Plan refers to human rights	2000-2004 NSF provides for human rights
National HIV/AIDS Policy: human rights provisions	2002 National AIDS Policy refers to human rights	2002 Draft Malawi National HIV/AIDS Policy. Policy refers to human rights with emphasis on rights based approach.	None	None	None	1998 Swaziland Policy Document on HIV/AIDS and STD Prevention and Control refers to human rights	2002 National HIV/AIDS/STI/TB Policy refers to human rights	1999 National HIV/AIDS Policy refers to human rights
HIV/AIDS jurisprudence	Yes	None	None	Yes	Yes	None	None	None
HIV/AIDS specific legislation¹	Yes. (In realm of criminal law)	None	Yes (Labour law)	Yes	Yes	None	Yes	Yes
Government awareness of UNAIDS guidelines on HIV/AIDS and human rights	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Social security and PLWHA	No specific assistance is provided for PLWHA. Revising the <i>National Destitute Policy</i> to cater for PLWHA and orphans does form part of the NSF for 2003-2009	No special provisions are made to cater for the social assistance needs of PLWHA.	No special provisions are made to cater for the social assistance needs of PLWHA.	Social assistance is provided for PLWHA in terms of a disability grant and a special grant for HIV/AIDS orphans.	PLWHA can qualify for a disability grant in terms of the <i>Social Assistance Act</i> . In August 2002 the <i>National Guidelines for Social Services to Children Infected and Affected by HIV/AIDS</i> were published.	No special provisions, NSF however refers to access to social services for PLWHA.	No special provisions, do qualify for assistance applicable to all Zambians.	No special provisions, do qualify under general <i>Social Security Act</i> .

¹ None of the eight countries that formed part of the study have a comprehensive HIV/AIDS specific law in place. This section was answered in reference to sections of existing or new legislation that included specific reference to HIV or AIDS.

	Botswana	Malawi	Mozambique	Namibia	South Africa	Swaziland	Zambia	Zimbabwe
Constitutional protection of the right to health	None	Equal access to basic health services is incorporated in the right to development, section 30(2) of the <i>Constitution</i> .	Article 94 of the <i>Constitution</i> guarantees the right to health subjected to the law in place.	Article 95 of the <i>Constitution</i> refers to public health but as a matter of state policy and not as a fundamental right.	Article 27(1)(a) of the <i>Constitution</i> .	<i>Constitution</i> is suspended, the drafting of a new <i>Constitution</i> is underway.	The right to health care is provided for under the <i>Directive Principles of State Policy</i> incorporated in Part IX of the <i>Constitution</i> . ²	None
HIV/AIDS as a notifiable disease	No	No, although it is foreseen in the draft <i>National HIV/AIDS Policy</i> of 2002.	No	No	No	Yes	Yes	No
Rights of HIV positive patients	No HIV specific guidelines exist currently within the health profession, according to Bonera ³ a policy is in the pipeline.	No special protection exists currently but it is foreseen in the draft <i>National HIV/AIDS Policy</i> of 2002.	Ethical guidelines for health workers are foreseen in the <i>2000-2002 National Strategic Plan</i> .	HIV specific guidelines and a <i>Namibian Charter on HIV/AIDS</i> exist. (non-binding)	Protected by the 2001 HPCSA guidelines on the <i>Management of Patients with HIV Infection or AIDS</i> and the <i>SAMA Guidelines on Human Rights, Ethics and HIV</i> .	None	No special provisions.	Provisions within the (non-binding) <i>Patient's Charter</i> .
Constitutional and legislative protection of equality and non-discrimination	Section 15 of the <i>Constitution</i> lists grounds for non-discrimination (non-exhaustive list). HIV is not a listed ground. No special legislation addressing discrimination exists.	Section 20 of the <i>Constitution</i> lists grounds for non-discrimination (non-exhaustive list). HIV is not a listed ground. No special legislation addressing discrimination exists.	Section 66 of the <i>Constitution</i> lists grounds for non-discrimination (exhaustive list). HIV is not a listed ground. Law no 5/2002 deals specifically with discrimination against employees and candidate employees and HIV/AIDS is covered by the law.	Section 10 of the <i>Constitution</i> lists grounds for non-discrimination (exhaustive list). HIV is not a listed ground. Section 107(1) of the <i>Labour Act</i> lists grounds of non-discrimination in employment. Although it does not include HIV status, see the Labour Court ruling on exclusion. ⁴	Section 9(3) of the <i>Constitution</i> lists grounds for non-discrimination (non-exhausted list). HIV is not a listed ground. Specialised legislation on non-discrimination: <i>Promotion of Equality and Prevention of Unfair Discrimination Act</i> no 4 of 2000, section 34 provides for the possibility of including HIV status as a ground for non-discrimination.	Swaziland does not have a <i>Constitution</i> although negotiations around the drafting of a <i>Constitution</i> with a bill of rights are being considered.	Section 23 of the <i>Constitution</i> lists grounds for non-discrimination (exhausted list). HIV is not a listed ground. No special legislation addressing discrimination exists.	Section 23 of the <i>Constitution</i> lists grounds for non-discrimination (exhausted list). HIV is not a listed ground. <i>Statutory Instrument</i> 202 of 1998 prohibits discrimination on the basis of HIV status in the workplace.

2 The Directive Principles of State Policy are not in themselves binding and are subject to the availability of funds under article 110.

3 Botswana Network on Ethics, Law and HIV/AIDS.

4 *Haindongo Nghidipohamba Nanditume v Minister of Defence* Case No. LC 24/98.

	Botswana	Malawi	Mozambique	Namibia	South Africa	Swaziland	Zambia	Zimbabwe
HIV/AIDS and the workplace: discrimination and pre-employment testing	Labour legislation does not address discrimination on the ground of HIV status and there are no legislative provisions on pre-employment HIV testing.	Labour legislation does not address discrimination on the ground of HIV status and there are no legislative provisions on pre-employment HIV testing.	Law no 5/2002 outlaws discrimination on the ground of HIV status in employment and prohibits pre-employment HIV testing.	Guidelines were promulgated in terms of section 112 of the Labour Act for the implementation of the <i>National Code on HIV/AIDS in Employment</i> and for application of relevant provisions of the <i>Labour Act</i> in respect of HIV/AIDS. The guidelines outlaw discrimination on HIV status and pre-employment testing for HIV.	Article 6 of the <i>Employment Equity Act</i> no 55 of 1998 lists HIV status as a ground for non-discrimination. HIV testing of an employee is prohibited by section 7(2) unless justifiable by the Labour Court in terms of section 50(4).	Labour legislation does not address discrimination on the ground of HIV status and there are no legislative provisions on pre-employment HIV testing.	Labour legislation does not address discrimination on the ground of HIV status and there are no legislative provisions on pre-employment HIV testing. The Defence Force requires HIV tests and do not recruit HIV positive candidates.	<i>Statutory Instrument</i> 202 of 1998 prohibits discrimination based on HIV status in the workplace and states that pre-employment testing should not be required except where fitness for work is a precondition to the offer of employment. <i>Labour Relations Amendment Bill</i> of 2001 includes HIV status as a ground for non-discrimination.
Legislative protection of PLWHA in medical schemes	No	No	No	No, although the 2002 <i>Health Plan</i> provides policy protection in terms of the Aid for AIDS benefit scheme.	Yes	No	No	No
HIV/AIDS and insurance policies	No legislative regulation, policies for PLWHA determined by companies at higher premiums or not at all.	Currently no legislative protection, the issuing of policies is up to the private company (no granting of life insurance to HIV positive people).	No legislative regulation of the insurance industry, life insurance policies do not cover PLWHA.	No legislative regulation of the insurance industry.	No legislative regulation of the insurance industry. The Life Office's Association's <i>HIV Testing Protocol</i> clearly states that life insurance will not be granted to people who test HIV positive. Those companies that do offer special packages do it at higher premiums or limit the amount of insurance.	No legislative regulation of the insurance industry.	No legislative regulation of the insurance industry.	No legislative regulation of the insurance industry.
Existence of cultural practices that enhance spread of HIV	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Legality of commercial sex work	Illegal	Illegal	Illegal	Illegal	Illegal	Illegal	Illegal	Illegal
Legality of same sex relationships	Illegal	Illegal	Illegal	Illegal	Legal	Illegal according to common law offence of sodomy, last case tried in 1983. Lesbianism seems legal according to 1992 judgment. ⁵	Illegal	Illegal

5 Mngomezulu case discussed on http://www.mask.org.za/SECTIONS/AfricaPerCountry/ABC/swaziland/swaziland_index.html.

	Botswana	Malawi	Mozambique	Namibia	South Africa	Swaziland	Zambia	Zimbabwe
HIV education in schools: non-discrimination in schools	HIV/AIDS education (for pupils and teachers) is provided for in the 1998 <i>Policy on HIV/AIDS Education</i> , the <i>National Strategic Plan</i> and the <i>National Policy on HIV/AIDS</i> .	HIV/AIDS education is included in formal primary and secondary school curricula. This effort is expanded upon in the NSF and <i>National HIV/AIDS Policy</i> .	NSF sets forth the policy on education in schools whilst also declaring that implementation has been delayed. ⁶	<i>National Teachers Union Policy on HIV/AIDS</i> (2000) together with the <i>National Policy on HIV/AIDS</i> for the education sector (4th draft) 2002 provides for HIV education in schools and non-discrimination.	1999 <i>National Policy on HIV/AIDS for Learners and Educators in Public Schools, and Students and Educators in Further Education and Training Institutions</i> . The <i>South African Schools Act</i> protects learners from unfair discrimination.	NSF provides for integration of HIV education in pre-schools, schools and institutions of higher learning and provides for training of teachers.	HIV/AIDS education is integrated in the school curricula. No special training is provided for teachers. No specific policy on non-discrimination in schools exist.	AIDS education was introduced in schools in 1993. HIV/Life Skills Desk in Ministry of Education trains teachers and coordinates HIV teaching in schools. <i>National Policy on HIV</i> includes provisions on non-discrimination in schools.
Criminal legislation on HIV/AIDS	Harsher sentencing for HIV positive rapists in terms of the <i>Penal Code (Amendment) Act No 5 of 1998</i> .	No HIV/AIDS specific provisions in the Malawi criminal law rather the 2002 <i>National HIV/AIDS Policy</i> aims to promote the use of generic criminal law and not HIV specific criminal codes and to apply HIV status only as a mitigating or aggravating factor.	No HIV/AIDS specific provisions in Mozambique criminal law.	Harsher sentencing for HIV positive rapists provided in the <i>Combating of Rape Act of 2000</i> .	<i>Criminal Law Amendment Act of 1997</i> provides for harsher sentences for HIV positive rapists. <i>Criminal Procedure Second Amendment Act</i> – more difficult to obtain bail in rape cases involving HIV positive accused. New <i>Sexual Offences Bill</i> and <i>Compulsory HIV Testing of Alleged Sexual Offenders Bill</i> tabled in 2003.	No HIV/AIDS specific provisions in Swaziland criminal law although the <i>Public Health Bill</i> envisages penalties for knowingly transmitting HIV.	No HIV/AIDS specific provisions in Zambian criminal law. Rape carries life sentencing in the <i>Penal Code</i> regardless of HIV status. <i>National AIDS Policy</i> recommends criminalising of wilful HIV transmission.	<i>Sexual Offences Act No 8 of 2001</i> , harsher sentencing for HIV positive rapists and criminalizing of deliberate transmission of HIV.
HIV/AIDS and prisons: education, testing, condoms and separation	The following policies are in place; <i>National Policy on HIV testing and education in prisons</i> , the <i>Health Care Delivery Policy</i> , a <i>Policy on HIV/AIDS/STD for inmates</i> and a <i>HIV/AIDS Policy and Procedure Manual for Prison Staff and their families</i> .	No official policy on HIV/AIDS in prisons the only reference to prisons is found in the 2002 draft <i>Malawi National HIV/AIDS Policy</i> . Addressing issues such as voluntary testing and counselling, non-segregation of prisoners and the distribution of condoms.	No official policy on HIV/AIDS in prisons guidelines are however included in the <i>National Strategic Plan on HIV/AIDS</i> . Prisoners have access to education on HIV/AIDS and condoms. Prisoners are not separated.	No official policy on HIV/AIDS in prisons. Non-separation of HIV positive inmates. Condoms are not distributed. AIDS campaign training inmates to counsel fellow inmates exist, voluntary testing is provided.	2002 <i>Policy on Management Strategy of HIV/AIDS in Prisons</i> : 1) Voluntary testing, counselling and education. 2) Non-segregation. 3) Condoms are distributed.	The <i>Swaziland National Strategic Plan on HIV/AIDS</i> and the <i>Policy Document on HIV/AIDS</i> set forth guidelines on prisons on education, non-separation and voluntary testing and counselling. Condoms are not distributed.	No official policy on HIV/AIDS in prisons exist. Condoms are not distributed in prisons, prisoners are not separated.	Prisons are addressed in the <i>National Policy on HIV/AIDS</i> : 1) Voluntary testing and counselling together with education is provided. 2) Condoms are not distributed. 3) HIV positive prisoners are not separated.

The table above is not conclusive as to all the findings of the study for certain areas analysing access to essential HIV/AIDS drugs, the rights of volunteers in HIV/AIDS medical trials, condom distribution or discussions around legislation and policies protecting women and the most

vulnerable in society could not be comparatively tabled. For a discussion on these areas the individual country reports should be accessed.



The University of Pretoria established the Centre for the Study of AIDS in 1999 to 'mainstream' HIV/AIDS through all aspects of the University's core business and community-based activities. Its mission is to understand the complexities of the HIV/AIDS epidemic in South Africa and to develop effective ways of ensuring that all the students and staff of the University are prepared both professionally and personally to deal with HIV/AIDS as it unfolds in South African society.

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