THE RIGHT OF THE HIV/AIDS PATIENT TO TREATMENT

by

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"This project is an original piece of work which is made available for photocopying, and for inter-library loan. Signed..........................".
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SUMMARY

The objective of this treatise is to establish whether a right to social security exists in South Africa, which would entitle HIV positive persons in South Africa citizens to medical care.

A study was made of various articles in journals and on the Internet to determine the South African government's policy on a right to social security and to providing medical treatment.

It was found that South Africa lacks an integrated, holistic approach to social security and does not guarantee the right to social security, merely the right to have access to social security. The same was found with the right to medical care. Although there seems to be a general right to medical care which extends to and includes HIV-positive patients, the state merely guarantees the right to apply for medical treatment but does not guarantee the granting thereof. It is submitted that the Department of Health’s refusal to implement a vertical transmission prevention programme and the failure to offer treatment as an alternative, for whatever reason, is "penny wise and pound foolish". In the long run more money is spent dealing with pediatric AIDS.

It was further found that although the government attempted to lay a groundwork with the formulation and acceptance of the national AIDS plan, the successful implementation thereof is seriously hindered due to the lack of inter- and intra-departmental collaboration, essential health services and funding.
CHAPTER 1
A GENERAL OVERVIEW

1. INTRODUCTION

HIV (Human Immune Deficiency Virus) is a life-threatening condition, transmitted in clearly established and known ways. HIV can be transmitted in three ways:

(i) Sexual contact;

(ii) Contact with infected blood;

(iii) During pregnancy and via breastmilk.

There is no convincing evidence that the virus is spread through contact with saliva, sweat, tears or urine.\(^1\) In common with other viruses, HIV can only replicate inside cells. Once it enters the body, HIV infects a large number of cells and replicates extremely rapidly.

HIV is characterized by a gradual deterioration of the body’s immune system which normally defends the body against a multitude of invaders. After about eight to ten years, a person becomes particularly vulnerable to many conditions that define AIDS (Acquired Immune Deficiency Syndrome).\(^2\)

Relevant to any discussion concerning a right to treatment or a potential state obligation to provide care to the infected person are the statistics of infected persons in South Africa. The estimated number of HIV-infected persons by province in 1996 can be illustrated graphically as follows:\(^3\)

\(^1\) Regensberg "HIV and AIDS – an Overview" (1999-06) Modern Medicine of South Africa 51.
\(^2\) Regensberg Modern Medicine of South Africa 52.
<table>
<thead>
<tr>
<th>Province</th>
<th>Total</th>
<th>Babies</th>
<th>Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>Western Cape</td>
<td>27 216</td>
<td>465</td>
<td>26 751</td>
</tr>
<tr>
<td>Eastern Cape</td>
<td>229 912</td>
<td>5 622</td>
<td>224 290</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>22 457</td>
<td>423</td>
<td>22 034</td>
</tr>
<tr>
<td>Free State</td>
<td>213 542</td>
<td>5 050</td>
<td>208 492</td>
</tr>
<tr>
<td>KwaZulu Natal</td>
<td>746 684</td>
<td>17 615</td>
<td>729 069</td>
</tr>
<tr>
<td>North West</td>
<td>367 122</td>
<td>9 035</td>
<td>358 087</td>
</tr>
<tr>
<td>Gauteng</td>
<td>466 176</td>
<td>9 528</td>
<td>456 648</td>
</tr>
<tr>
<td>Mpumulanga</td>
<td>199 189</td>
<td>4 840</td>
<td>194 349</td>
</tr>
<tr>
<td>Northern</td>
<td>175 941</td>
<td>4 499</td>
<td>171 422</td>
</tr>
<tr>
<td>TOTAL RSA</td>
<td>2 448 239</td>
<td>57 077</td>
<td>2 391 162</td>
</tr>
</tbody>
</table>

HIV and Aids levels differ substantially between provinces, it also impacts differently between age groups and between men and women as HIV infection among men tends to peak at an older age than among women.⁴

South Africa has the fastest growth rate of HIV infection in sub-Saharan Africa. Up to 1 500 people are estimated to be infected by the virus daily, one in ten of all South Africans. Sub-Saharan Africa is a region in which four-fifths of all AIDS deaths occurred in 1998.⁵

The sheer number of Africans affected by the epidemic is overwhelming. The Southern part of the African Continent holds the majority of the world’s hard-hit countries. In Botswana, Namibia, Swaziland and Zimbabwe, current estimates show that between 20% and 26% of people aged between 15 – 49 are living with HIV or AIDS.⁶

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⁶ UNAIDS Material on HIV/AIDS 3.
According to Regensberg the development of new and effective antiviral drug combinations make it possible to treat the disease actively. HIV is therefore no longer a death sentence and it should now be regarded as a manageable chronic disease.\textsuperscript{7}

In developed countries where the epidemic is no longer out of control. For example, the death rate for AIDS in the United States in 1997 was the lowest in a decade – almost two-thirds below rates recorded only two years earlier.\textsuperscript{8} However, in developing countries where treatment is not received, millions of people, specifically the economically active part of the population are worst effected.

In South Africa, mining operations attract workers from rural and neighboring areas, resulting in millions of migrant workers living in single-sex dormitories. In Carletonville, for example, it is estimated that 60% of the workforce are migrants. Around 22% of adults in Carletonville are infected with HIV, as a survey of sex workers in this area found that over three-quarters of them to be infected, while one in five mine workers is thought to be infected.\textsuperscript{9}

This holds direct negative consequences for South Africa’s already fragile economy because the disease could lead to a shortfall in much needed skilled labour, lower productivity and extra pressure on resources. In Tanzania and Zambia, large companies have reported that AIDS related illnesses and deaths cost more than their total profits for the year, if the indirect costs associated with mounting sick and compassionate leave, recruiting and training replacement staff, protracted negotiations with workers on AIDS related issues are taken into account, as well as the drop in sales turnover that results from a higher mortality rate.\textsuperscript{10}

The issue of access to expensive AIDS drugs such as Zidovudine (hereinafter referred to as AZT) in developing countries remains an area of deep concern

\textsuperscript{7} Regensberg \textit{Modern Medicine of South Africa} 51.
\textsuperscript{8} UNAIDS \textit{Material on HIV/AIDS} 6.
\textsuperscript{9} UNAIDS \textit{Material on HIV/AIDS} 4.
for health activists. The South African government’s decision in February 1999 not to provide the AZT drug free of charge to pregnant HIV-positive women who are too poor to afford it, has caused a wave of outrage among people living with HIV and Aids.

There are various reasons for this lack of access. Worldwide, the most important reason is affordability since drugs cost more money than what are available to pay for them. Drug prices are influenced by many factors, but one of the most important is whether the drugs are proprietary (still new and under patent) or generic (not under patent) and therefore sold at a price nearer to the production cost.

The question of costs is obviously always paramount in deciding whether or not medical care can be provided – also to the HIV patient where the cost of treatment may be prohibitively expensive. In this article it will be submitted that this argument cannot be supported with reference to pregnant HIV-positive women as the administration of AZT during the last four weeks of pregnancy and during labour will prevent costs that would have been incurred during the long-term treatment of children born from HIV-positive mothers.

We can hardly afford not to intervene in the control of the disease, as Aids is life threatening and ultimately fatal. The right to life is a basic fundamental right and as such entails the obligation on the state to take all reasonable and appropriate measures to protect life.

In discussing the state’s possible obligation and ability to provide medical care to HIV infected individuals, the right to social security will firstly be considered as social protection is also a fundamental human right and its ultimate objective is the social protection of all citizens.

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11 UNAIDS Material on HIV/AIDS 11.
12 Ekambaram "Health before Profits" (1999-08) Women’s Health Project Newsletter 11.
13 UNAIDS "Access to Drugs" Technical Update 3.
14 Transmission can be reduced by 50% according to Prof E Coetzee at a lecture on HIV during May 1999.
15 s 11 of Act 108 of 1996.
Thereafter the right to treatment will be discussed in order to determine the right of the HIV-positive patient to treatment. It is necessary to consider the right to treatment generally, since it cannot be argued that HIV-positive patients have a right to treatment if others in the country do not enjoy such a right.17

Besides entertaining an overview of the current social security system in South Africa and the treatment of HIV and AIDS, some problem areas identified in tackling the HIV/AIDS epidemic will also be highlighted and possible measures to address these problems will be considered.

2. SOCIAL SECURITY PROVISIONS, PRIVATE INSURANCE AND THE HIV/AIDS INFECTED PERSON

In this paragraph a broad overview of the existing social security system in South Africa, is provided as the HIV/AIDS epidemic will profoundly influence South Africa’s current social assistance scheme.

Regard will be had to some of the major problem areas identified in combating the HIV/AIDS epidemic, upon which we will formulate a possible response to some of the challenges identified in introducing effective interventions. It is submitted that due to the uneven nature of the existing social security cover we are experiencing a patchwork social security system, particularly for those who cannot afford to purchase additional protection.

Social security can be defined as the body of arrangements shaping the solidarity with people facing (the threat of) a lack of earnings or particular costs.18 Social security is thus a generic term which encompasses such terms as a “social safety

16 s 27 of Act 108 of 1996.
17 Leech "The Right of the HIV-positive patient to Medical Care: An Analysis of the costs of providing Medical Treatment" (1993) SAJHR 49.
net against destitution” and “social provisions following the occurrence of social risks”.19

The right to social security is a fundamental human right20 and the purpose of social security is to guarantee an income to those who, for one reason or other, are no longer able to earn a living, alleviate deprivation, or insure against adversity.21

The White Paper on Social Welfare22 defines social security as covering a wide variety of public and private measures that provide cash or “in-kind” benefits or both, first, in the event of an individual’s earning power permanently ceasing, being interrupted, never developing, or being exercised only at an unacceptable social cost and such person being unable to avoid poverty and, secondly, in order to maintain children.

The right to social security is part of the central protective function of the state because as soon as development enables a state to provide a form of protection which people need, but cannot provide for themselves, this protection is recognized as a citizen’s right and the responsibility of the state.23 The ultimate objective of social security is the social protection of all citizens. Any form of physical protection or safety policy is doomed to failure if it is not based on one or other form of social protection.

2.1 Social Security Provisions

The most well-known techniques utilized by social security at present are social assistance and social insurance. In the case of social insurance, contributions are paid, voluntarily or obligatory, for and/or by the members, so that when a member is affected by a social risk, he/she can be provided with a
social benefit. In a free society, all citizens are expected to contribute to the community, each according to their own means. In return, they hope to be looked after, should they be affected by a social risk.

The private sector contributes to short and long term insurance as well as pension and retirement schemes. An insurance system redistributes the cost of losses, by collecting a premium from every participant. Insurance companies play a crucial role in covering health costs for much of the population.

Insurance companies, state legislatures and AIDS activists have been engaged in heated debates over the measures insurance companies should be allowed to take to limit their exposure to claims arising from “high risk” groups. Insurance companies operate on a profit basis, so by excluding “high risk” applicants, they are bound to remain profitable.

Applicants for life insurance whose health is sub-standard, are handled in one of three ways: they are either accepted with a premium loading, postponed or the application is denied.24 The foundation of life insurance is that all medical conditions giving rise to death should be covered. The insurance industry however argues, that it has the right to exclude certain risks from coverage, as the insurance policy is a contract and the parties to the contract may include whatever terms they choose as long as they are valid and not contrary to public policy.25

AIDS, therefore poses a major threat to life offices in South Africa. The life insurance industry bases life cover premiums on mortality statistics and with the advent of the HIV/AIDS epidemic, life expectancy, for the first time in many years, would begin to decline.26

25 Swanson 9 SAJHR 147.
26 Booth ”The Insurance Industry and AIDS – An Insider's Perspective” (1993) 9 SAJHR 151.
Life insurance, is a long-term business and it became clear that the threat posed by AIDS could not be ignored. Insurers, must respect the rights not only of those with HIV, but also of those who are not infected. This entails that life offices have an obligation to existing policy-holders, to take all reasonable steps to protect life funds.

Should they fail to take effective measures, they’ll run the risk of an insolvent life fund within a short period of time. AIDS activists hold that insurers are only excluding HIV-related care and are not doing the same with other diseases, and that this amounts to arbitrary discrimination as they are denied a right to share in a part of the country’s resources.27

By screening applicants for HIV before their proposals are accepted, health offices are running the risk of breaching confidentiality, discrimination and of providing inadequate counseling to those who test positive.28

The Medical Schemes Act,29 (hereinafter referred to as MSA) was recently enacted to regulate and reform private health care insurers and providers, as many health insurance plans operate on the insurance principles of risk and exclusion or limitation. The MSA will try to equalize access to health care. This entails that if a person can afford the premiums associated with health insurance, an insurer may not exclude him or her from cover. Interestingly enough, the MSA prohibits insurers from unfairly excluding people with HIV/AIDS. Statistics, indicate however that only 10% of black people belong to private health insurance schemes, compared to 72% of white people.30

The private sector provides good but expensive care and is therefore out of reach of the majority of South Africans. The majority must rely on the care provided by the already over-burdened public sector. We are therefore, more concerned with the operation of social assistance schemes as they represent

28 Swanson 9 SAJHR 146.
the most significant mechanisms of poverty alleviation and income redistribution in South Africa.\textsuperscript{31}

In any society, it is inevitable that some of its members cannot adequately care for themselves or their dependants because they have insufficient means to do so. Medical care, sickness and invalidity benefits are just a few of the social risks listed in the I.L.O. Convention no. 102, against which individuals should be protected.

In order to identify social risks in a particular community one needs to look at what it is in society that makes people behave in certain ways that puts them at risk and we need to identify particular susceptible groups.

Once this has been done interventions can be targeted to prevent the spread of the HIV/AIDS epidemic. At first glance some of these interventions may seem to have little to do with HIV. It will become clear that the HIV/AIDS epidemic does not “belong” to any specific segment of society, as a successful plan of action calls for a multi-sectoral response.

3. PROBLEM AREAS IDENTIFIED

The following has been identified as factors hampering the effective targeting of the HIV/AIDS epidemic

(i) Poverty

Poverty is fertile ground for HIV infection. The United Nations has described HIV/AIDS as a new force of impoverishment in sub-Saharan Africa\textsuperscript{32} as a larger amount of household income will be spent on health care due to adults and children becoming ill because they are HIV infected.

\textsuperscript{31} Ekambaram (1999) *Women's Health Project Newsletter* 11.

\textsuperscript{32} The Namibian (1997-06-12) 11.
The death of a breadwinner may lead to loss of income and benefits for remaining members of the family, as HIV/AIDS related causes of death are not always covered by medical or life insurers. Some may even have to give up paid employment to nurse sick family members and because this role will fall particularly on women, it reinforces gender inequalities.

(ii) Treatment

Large numbers of pregnant women infected with HIV are dependent on the public health system and are unable to access treatment (such as AZT) that reduce the risk of mother-to-child transmission. This results in HIV-positive babies being born into already poor and over-burdened families.

(iii) Testing

Access to confidential and voluntary HIV testing poses a major problem especially in townships and rural areas where there is insufficient clinics and health care facilities. Very little regard is given to confidentiality and privacy. This results in already poor people having to face discrimination and rejection.

Fortunately, civil case law in South Africa has established a positive set of legal precedents, in regard to confidentiality of HIV information and access to treatment. In the Kruger-case the Appellate Division upheld the patient’s right to confidentiality of his medical information with regard to his HIV status.

In this case, a medical practitioner disclosed his HIV status, without the patient’s consent, to two other medical practitioners during the course of

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a social outing. According to Figueira\textsuperscript{36} confidentiality forms the very basis of the relationship between a doctor and his or her patient.

A breach of that confidentiality on the part of the doctor clearly constitutes an invasion of the patient’s right to privacy. Any wrongful disclosure of a patient’s HIV status constitutes an unlawful act for which compensation may be sought and awarded. A person’s HIV status can only be disclosed to a third party without the patient’s consent, where there is a serious and identifiable risk to the specific individual.

\textbf{(iv) Opportunistic diseases and access to drugs}

Living with advancing HIV infection is complicated by a variety of opportunistic diseases. Many can be treated with drugs, but access to even the most basic drugs is seriously lacking in many parts of the world. Effective intervention against opportunistic diseases requires not only the appropriate medical treatment, but also the infrastructure necessary to diagnose the condition, monitor the intervention and to counsel patients.

Access to drugs does however not pose the only hurdle, but the costs involved in obtaining the necessary drugs poses the greatest single challenge to individuals and healthcare systems. Adequate distribution systems run by trained personnel goes hand-in-hand with the availability and accessibility of these drugs. Proper use of drugs requires training and information for all involved – doctors, patients and carers.\textsuperscript{37}

\textbf{(v) Status}

People infected with HIV is believed to be morally blameworthy for indulging in high risk lifestyle habits. People do not wish to become

\textsuperscript{35} \textit{Vuuren v Kruger} 1993 (4) SA 842 (AD).
\textsuperscript{36} Figueira “AIDS, the Namibian Constitution and Human Rights – An Overview” (1993) 9 \textit{SAJHR} 32.
involved in AIDS programmes for fear of being regarded as supporting morally unacceptable individual lifestyles.\textsuperscript{38} Prostitution, promiscuity and homosexuality are not themselves, the causes of HIV transmission but unsafe sexual conduct, such as unprotected intercourse, even in a heterosexual relationship poses a great danger of becoming infected. There is always the discomfort of dealing with sexual behavior without offending individual sensitivities.

\textbf{(vi) Fear}

Misconceptions about the facts of HIV can lead to unjustified fear and ignorance. People furthermore assume that only certain groups of people can acquire the virus, which makes it that much easier to place oneself a cut above the rest. Focusing on high risk groups, rather than on high risk activities, may lead to punishing those who practices safe sex but not those in the “ordinary” heterosexual majority. Those diagnosed with HIV/AIDS faces not only physical debilitation and death but also severe social discrimination. According to Cameron and Swanson AIDS is viewed as the modern day equivalent of leprosy.\textsuperscript{39}

It is however impossible to prevent people having their own private prejudices and attitudes. We need to start at the source of the problem – the minds of those irrationally discriminating against individuals infected with HIV.

\textbf{(vii) Children and young people}

HIV is increasingly contributing to rising child mortality rates. It is estimated that 61 in every 1 000 infants born in South Africa will die due to HIV infection, before the age of one year, between 2005 – 2010.\textsuperscript{40}

\begin{flushleft}
\textsuperscript{37} Heywood 1999 Aids Law Project 7.  
\textsuperscript{38} Heywood 1999 Aids Law Project 9.  
\textsuperscript{39} Cameron and Swanson “Public Health and Human Rights – The AIDS Crisis in South Africa” (1992) 8 SAJHR 201.  
\end{flushleft}
Women will have to take control in order to prevent becoming infected in the first instance and secondly, should be afforded intervention measures that could reduce mother-to-child transmission.

Young people are also disproportionately affected by HIV and AIDS. Around half of new HIV infections are in people aged 15 – 24, the range in which most people become sexually active. Young people are vulnerable to HIV for many reasons – they either do not know about HIV or sexually transmitted diseases or they do know about them but do not know how to avoid infection. What is more, adolescence is a time when many people experiment – not only with different forms of sex but also with needle-sharing drugs. In Lithuania, over half of HIV infections registered in injecting drug users are people under 25.

(viii) Stigma

Due to the stigma and discrimination that accompanies HIV infection, a self-imposed silence is not uncommon. Where shame rules, people simply do not want to know whether they are HIV infected. People that care for HIV infected patients cannot prepare themselves adequately when they are unaware that a loved one is suffering from a fatal disease.

Besides identifying the general problem areas as discussed supra the HIV/AIDS epidemic will have three broad effects that must also be considered namely:

(i) Demographic consequences

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HIV/AIDS will affect the population in a number of ways. There will be increased mortality and many of these people may be in their reproductive years, which could reduce fertility rates.

However, the epidemic is unlikely to stop population growth and the idea that Aids is the solution to the population problem is unfounded. It might however slow the rate of population growth and alter the structure of the population. The number of children orphaned is of great importance as they will have special needs, especially as the numbers grow and the extended family is no longer able to cope with the increased burden of care.

(ii) Economic Implications

At the household level the effect of HIV infection is obvious as it may result in poverty on a grand scale as a family’s resources are consumed to care for the sick and dying. If the infected person is an income earner then production and income, savings and even investments will be reduced. It is uncertain exactly what the impact of HIV holds for national economies, other than to invest in prevention strategies and to plan for the impact of the epidemic.

Because HIV/AIDS is only one of a number of pressing problems faced by policy makers in developing countries, the significance people attach to the risk of infection is influenced by a complex matrix of social factors. Amongst people most at risk becoming infected is just another burden in an endless struggle for survival.

(iii) Development consequences

In South Africa, the need to develop the economy and provide houses, education, health and employment have all been seen as more
important than effectively combating the HIV/AIDS epidemic. However, life assurer Metropolitan, has startled the business community by suggesting that listed companies should be compelled by law to alert shareholders to the impact of the AIDS epidemic as it is likely to have crippling effects on their future earnings.\(^44\) The association fears that AIDS will severely harm the operation and profitability of virtually all South African companies.

The fact that AIDS will have a greater impact in South Africa than on its more developed competitors will also add to the strain of local companies battling to be globally competitive. It is estimated that by 2005, direct AIDS-related costs in the form of increased contributions for medical aid, group life and disability cover could add 15% to the remuneration budget of a typical manufacturing company. This being in a company where 80% of the staff are blue-collar workers and the employer is fully responsible for contribution increases.

This figure could increase by another 10% if the indirect costs associated with mounting sick and compassionate leave, recruiting and training replacement staff, are taken into account. There will be a drop in turnover that will result from a higher mortality rate and a fall in disposable incomes.\(^45\)

If it is accepted that development involves more than economic growth, and includes things such as longevity, standard of living, infant and child mortality and distribution of income, then it is here that the impact of the epidemic will be felt first and worst.

Life expectancy at birth is one of the key measures that policy-makers look at to assess human development. Because of the extra deaths from AIDS in children and young adults, this indicator raises alarm. It is

\(^{44}\) Financial Mail (1999-06-25).
estimated that life expectancy will fall by 17 years. Instead of a rising life expectancy reaching 64 years, by 2010-2015, life expectancy will regress on average to 47 years.46

In South Africa, there is a drive to produce policy papers that will lead to action but no consideration is given to the effect that HIV/AIDS is having on the demand for services, the ability to supply them or the ways in which the demand may change.47

For example, provision of affordable housing is a national priority. A White Paper has been produced, but nowhere is there any mention of the effect that AIDS will have on the population. Maybe there will be fewer people wanting houses. AIDS may affect the banks and financial institution's decision whether to grant loans in order to buy these houses. The extra financial burden imposed on families to care for AIDS sufferers may lead to a situation where people are unable to afford even the most basic housing.48

From this discussion it is clear that the HIV/AIDS epidemic has a number of important effects that occur at various levels in the society and economy. HIV infects individuals who fall sick and die. Thus the worst effect of this disease is felt by the person who falls ill, and his or her family. Indirect effects then spread like a ripple through the household, community and the country as a whole. The epidemic therefore requires a multi-sectoral and imaginative response.

4. RESPONSES TO THE EPIDEMIC

The need for a rational and comprehensive response becomes more acute the longer we are unable to find a cure. The possible responses to the epidemic are well documented. Risk of transmission can be reduced by use

48 Heywood 1999 AIDS Law Project 5.
of condoms, and/or cutting down on partners, and treating sexually transmitted diseases. Blood and blood products can be made safer through screening of both the donors and their blood. Drug users can be encouraged to sterilize or exchange needles. Work on developing means of reducing mother-to-child infection must be engaged in as a matter of urgency.

It is relatively easy to implement these “technical” responses, but changing behaviour to ensure people use condoms, reduce partners and to have their sexually transmitted diseases treated has proven to be more difficult. Although we know what we have to respond to the epidemic, we have generally not succeeded in dramatically altering its course. This points to the key issues above, in trying to understand what make people behave in the way they do, and to try and alter this.

### 4.1 Responses in South Africa: The National AIDS Plan

The National AIDS Plan has been formulated as a possible response to the HIV/AIDS epidemic but will only be considered in broad terms in order to highlight the difficulties experienced in implementing the different components of the Plan. The National Aids Convention of South Africa (herein after referred NACOSA) was convened in 1992. NACOSA wanted to develop a national AIDS strategy, and the NACOSA Plan was developed with technical assistance from WHO (World Health Organisation). The six components of the National AIDS Plan include:

(i) Education and prevention;

(ii) Counselling;

(iii) Health care;

(iv) Human rights and law reform;

(v) Welfare; and
Education and prevention includes the prevention of the spread of HIV through changing behaviour, treating sexually transmitted diseases and by providing condoms. Such activities include:

**Raising awareness through media and community campaigns**

The AIDS plan includes a mass communication campaign using the electronic media (TV and radio) through the employment of advertising agencies. It also emphasize the active involvement of the press in communicating with the public.

The implementation of this section of the plan was not without problems. The relationship between the press and the national programme deteriorated over the Sarafina debacle. Few provinces has the capacity to budget for small media products, for example pamphlets, posters and stickers. There seems to be a lack of a holistic approach on mass communication and how to employ these campaigns. Local community events are not well documented or evaluated, which makes it difficult to evaluate the effectiveness of public awareness and education campaigns.

**Educational programmes**

(i) *Life skills programmes in schools*

The concept of life skills programmes has been adopted by various Departments, although the focus varies in each Department. The life skills programme covers a wide range of issues but emphasis is placed on sexuality education. The Life skills policy is implemented by Provincial Health Department. It is however difficult to assess how many youths are exposed to sexuality training at this stage.

(ii) *Community education through NGOs*
The NACOSA plan identifies the need to support NGOs in mobilising society around HIV prevention and care. NGOs account for a major part in implementing HIV/AIDS prevention, but their activities are seriously inhibited due to a lack of funding.

(iii) Outreach projects for special groups

These groups will include sex workers and prisoners. Although there has been an increase in specialized projects, these groups need to be supported in a more organized manner.

Workplace education

Companies can limit the negative impact of the disease through effective AIDS education campaigns, restructuring employee benefits and careful human resources planning. If they wait until AIDS begins to hammer productivity, it will be too late. Although HIV/AIDS poses a great threat to future profitability for businesses, it is uncertain how many companies face this problem head-on.

Control of sexually transmitted diseases

This programme is based on making effective sexually transmitted diseases treatment accessible through all primary care services and promoting its public awareness. Although there has been an improvement in the quality of care, this varies across provinces.

Supplying condoms

This plan envisages the provision of free condoms to the public. KwaZulu-Natal, Gauteng and Mpumalanga received 70% of condoms supplied nationally, with low distribution in the other provinces.
Reducing blood spread

It is essential to ensure a safe blood supply as it has been reported that haemophiliacs have contracted AIDS from blood transfusions even where the plasma was stored for months as a dry flaky powder. It is therefore necessary that effective methods for screening blood and blood products are to be implemented as a matter of urgency.

Reducing transmission from mother-to-baby

The lack of clarity on policy results in an uncoordinated mix of practices. National government has basically shunned the implementation of a national vertical transmission prevention programme, even in the face of proven cost saving and effectiveness of such a programme. By contrast, the Western Cape, using its own provincial health budget, has started implementing a pilot programme to provide medical intervention to HIV-positive pregnant women.49

Addressing the socio-economic factors contributing to the spread of HIV through the RDP and supporting women’s movement

The Plan also envisages reducing the impact of the epidemic through providing comprehensive, co-ordinated care services, building acceptance and support of people with AIDS and providing welfare support. Such activities include:

- Developing hospital care and Tuberculosis services

In the absence of a national policy, the medical care of people with AIDS relies heavily on local initiatives and remains dominated by hospital care. There is insufficient access to services that provides dedicated care as these institutions are being overwhelmed by demand. There are further insufficient services for terminal care.

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49 Gray "Denying effective antiretroviral drugs to HIV-positive pregnant women – the National Government’s flawed decision" (1999) 89 SAMJ 621.
- Developing counselling services

This plan emphasize counselling as an essential component of care, not only in dealing with the fact that one is HIV-positive but also to inform individuals on how to prevent infecting others. Hospitals still commonly test for HIV without pre-test counselling. This contributes to post-test counselling problems faced by counsellors.

- Fighting discrimination and building support groups

The National AIDS strategy emphasise the human rights of people with AIDS and the importance of them being involved in planning and development programmes. People with AIDS still face rejection, dismissal, isolation and violation of confidentiality issues.

- Providing welfare support, especially for affected children

Welfare services face a range of immediate problems with children, involving the care of HIV infected children in institutions and a disproportionately high rate of HIV infection among abandoned babies.

These babies are difficult to place and have special needs. Some of the problems that adults are faced with include: unemployment, homelessness and delays in accessing disability grants.

AIDS workers are struggling to prioritize AIDS programmes in the face of general restructuring and other competing priorities. AIDS workers need in-depth training in every aspect, as insufficient familiarity with aspects of AIDS policies pose yet another hurdle to overcome.

Although the National AIDS Plan outlines the most important areas to bring about behavioural changes in society, it is clear that there are special
difficulties in implementing such an AIDS programme. An AIDS programme will only be successful if every component of civil society, including schools, churches, clubs and communities play their part in addressing the HIV/AIDS epidemic.\textsuperscript{50}

This approach supports the notion of a multi-sectoral response to the epidemic. Even though the AIDS plan has laid a groundwork for the response to the epidemic, it seem that it is lacking a comprehensive, integrated approach and implementation. For example, it is difficult to assess how many individuals are exposed to sexuality training as awareness programmes are not always documented or evaluated.\textsuperscript{51} Discrimination remains a fundamental problem and undermines access to support and health services. In the absence of a national policy on AIDS care, several provinces are undertaking individual initiatives. However, most provinces have insufficient capacity to do this. The scale of services needed for the AIDS epidemic is large and services have developed in an uncoordinated way. People with AIDS are therefore not always aware of the services available to them.

The decision of the Department of Health’s not to implement a national vertical transmission prevention programme, made South Africa the target of international criticism, as South Africa has a unique opportunity to act as an effective platform for improving the health of the whole of sub-Saharan Africa.\textsuperscript{52} The Department’s concerns of cost and cost effectiveness in support of this decision does not hold water as it has been demonstrated that very short courses of antiretroviral drugs can significantly reduce vertical transmission, and thereby save costs in the long run.\textsuperscript{53}

HIV/AIDS is probably the biggest risk facing South African businesses but the extent of the crisis is not reflected in the 2000/1 budget. Despite a moderate

\textsuperscript{50} Heywood 1999 AIDS Law Project 12.
\textsuperscript{51} Regensberg Modern Medicine of South Africa 54.
\textsuperscript{52} Gray SAMJ 621.
\textsuperscript{53} Ibid.
Overall rise, expenditure on HIV/AIDS takes up a negligible 0.02% of the total health budget and 0.047% of the total national budget.\textsuperscript{54}

Expenditure on HIV/AIDS prevention and treatment amounts to 0.018% of South Africa’s total GDP. Money is not the only answer to the problem. How it is spent is equally important. For this reason the allocations within the total HIV/AIDS budget are also disturbing. The budget for the government’s AIDS Action Plan has rocketed from R43.5 million last year to R74.4 million this year – an increase of 73%. Given the many shortcomings of this plan and its predecessors, this does not seem to have been earned.

At the same time, the budget allocation for NGOs, who have done virtually all of the real HIV/AIDS prevention work, dropped by 43%. The message that government is not taking AIDS seriously is clear and this is reflected in the budget allocation for 2000/01.\textsuperscript{55}

It would appear that while efforts have been made by the government in the field of AIDS prevention, that is, by education and awareness programmes, not much is being done to provide people with AIDS access to faculty-saving drugs. Essential health services, complementary services and funding seems to pose the greatest stumbling blocks in the successful implementation of the national AIDS Plan.

In the following chapter the focus is placed on establishing whether a general right to treatment exists in our law and if so, whether this right is extended to HIV-positive patients.

\textsuperscript{54} Statement issued by the Democratic Party Health Spokesperson – S Kaylan during May 1999.

\textsuperscript{55} Ibid.
CHAPTER 2
THE RIGHT TO TREATMENT

Having considered the inherent difficulties embedded in successfully implementing a national AIDS plan, it is clear that the measures of public health and private law in response to an epidemic such as AIDS must be consistent with the legitimate needs of a democratic society. This holds that a legal right available to one person depends on a legal duty that binds others. The right to treatment will be a hollow one, unless there is a person (juristic or otherwise) against whom the right is enforceable.

1. A General Right to Treatment

The duty to “safeguard” health and wellbeing had to be borne by individuals and their families at first. They had to create their own safety net in the face of medical or other risks, by employing their own resources.

The notion of state responsibility for public health services was initially founded in the Public Health Act.\(^{56}\) The historical evolution of social security from the social charity era (when people in need were helped by private charity or by way of public relief to the poor) on to the current stage (which has been described as the social protection era) see a growing need, especially in developing countries to strive for the provision of an integrated, comprehensive and holistic approach in extending cover to all those at risk.

With the more liberal, human-rights oriented approach the state has become more actively involved in the provision of health care. Although there is no mention of a \textit{right} to treatment in the Health Act,\(^{57}\) it is submitted that the ultimate duty to provide health care rests upon the Department of National Health and Population Development, as “it is the function of the Department to

\(^{56}\) Act 76 of 1919.
\(^{57}\) Act 63 of 1977.
co-ordinate health services … and to provide such additional health services for the population of the Republic of South Africa". 58

Leech suggests that the Health Act contains an implicit right to treatment in that it is founded on the premises “to promote the health of the inhabitants of the Republic so that every person shall be enabled to attain and maintain a state of complete physical, mental and social well-being”. 59

Leech 60 further holds that should this matter come up for interpretation by our courts, the conclusion reached will favour a right to treatment for the following reasons:

(i) The conclusion appears to be implicit within the language of the Act itself;

(ii) There are repeated references to the fact that every person shall be “enabled to attain” complete physical well-being; and

(iii) There appears to be a duty cast on the various authorities involved to ensure that all citizens have access to health care facilities. 61

This right is not absolute, as both the pecuniary costs (the costs of prevention, diagnosis and treatment of illness) and the non-pecuniary costs (costs to bring about behavioural changes to avoid contracting or transmitting AIDS and the costs of pain and suffering of family and friends when a loved one dies of AIDS) are factors requiring consideration when regard is had to the limitation of the right to treatment. 62

Having established a right to treatment generally, the issue we now turn to is to establish whether this right is also enjoyed by the HIV-positive patient. If

58 Leech (1993) SAJHR 45.
not, whether there is justification for denying them the right due to their particular illness.

1.1 Does the HIV-positive Patient have a Right to Treatment?

The answer to this question is not as obvious as it at first seems, as the HIV/AIDS epidemic is firmly embedded in our country and is decimating the population on a grand scale. During 1998, some 2.5 million people died of AIDS-related illness. By the end of that year, more than 33 million people were living with HIV/AIDS. Enormous death and loss due to AIDS is now a reality for many developing countries in Africa.

Arguments against a right to treatment are generally rejected. It must be accepted, however, that the disease is different from other diseases. AIDS threatens human life and is ultimately fatal. It is a new epidemic. AIDS was first recognized in 1981 and it was not until 1984 that the cause, and a test to detect it, was identified. It has a long incubation period, and persons infected by the virus may have productive normal lives, although they can infect others during this period. There is further no effective cure and the infected person will, at the end of the incubation period, experience periods of sickness, increasing in severity, duration and frequency, until he/she dies.

Many HIV-positive patients are regarded as being morally culpable for their plight, as HIV is mainly sexually transmitted. The infection of someone by this illness is thus frowned upon by society, suggesting that they do not deserve treatment. It is sometimes perceived as too costly to waste money in treating HIV-infected patients, since they will die soon anyway.

It must be pointed out however, that medical professionals should not judge the moral accountability of patients in determining whether or not a patient is entitled to medical care. Although the disease is mainly transmitted through

64 Cameron & Swanson SAJHR 228.
intimate or personal contact, children under five and the heterosexual community is increasingly infected, reducing the moral argument in any event.67

The question as to the costs involved in treating HIV-patients are paramount in deciding whether to provide medical care, given that the treatment thereof is so prohibitive. A number of factors are closely interrelated to the actual cost. One such factor is what it would cost the country not to provide the treatment. The disease is such a long suffering one with a varied number of costly opportunistic infections, most notably tuberculosis, which holds further implications for public health.

Living with advancing HIV infection is complicated by a variety of symptoms and medical conditions, many of which is manageable with drugs. A number of drugs have been approved for the treatment of HIV infection. The first group interrupt an early stage in viral replication. AZT is a good example of this group. These drugs should not be used on their own, except in the prevention of vertical transmission from mother-to-child.

Indinavir, is a good example of a second class of drugs which interrupt replication at a later stage. Nevirapine, may be combined with both groups, resulting in highly active antiretroviral therapy, also known as HAART or “triple therapy”.68 While “ideal” therapy such as HAART is unlikely to become available to the majority of infected people, less costly therapy does exist.

While the costs of treating HIV and AIDS will be high, specific antiretroviral drugs, may for example only be employed for the benefit of unborn babies, since the right to health care is not absolute but limited by resources.

A starting point in this regard is the consideration of the cost of a comprehensive vertical transmission programme to prevent the transmission

67 Olivier 259.
of the virus from mother-to-child. Glenda Gray\textsuperscript{69} concluded in their study that antiretroviral intervention is cost effective and that low cost antiretroviral regiments were almost as effective as high cost ones.

This study was applied to the Soweto community, a black urban, working class population of about 1 million people, located south west of central Johannesburg.\textsuperscript{70} This community is served mainly by a single public hospital the Chris Hani Baragwanah hospital. The study objective was to compare the likely cost effectiveness of different intervention strategies such as:

(i) Substitution of breast feeding with formula feeding;

(ii) The administration of antiretroviral agents to mother and child around the time of birth;

(iii) Caeserean section instead of natural delivery;

(iv) The use of vaginal antiseptics before delivery; and

(v) The administration of vitamin A.

Many factors need to be taken into account when considering the cost effectiveness of methods to prevent the vertical transmission of HIV from mother-to-child. Some of these factors are outlined as:

\textit{Benefits of intervention}

(i) Lives saved;

(ii) Morbidity averted and quality of life improvements;

(iii) Prevention of costs of future health care related to HIV infection; and

\textsuperscript{69} Gray (1999) SAMJ 622.
\textsuperscript{70} söderlun@icon.co.za.
Decreased burden of care on families.\textsuperscript{71}

\textbf{Adverse effects of intervention}

(i) Stigma attached to HIV positive status and the social consequences thereof;

(ii) Spread of recommendation to formula feed beyond mothers known to be infected with HIV;

(iii) Abuse of antiretroviral drugs; and

(iv) Increased anxiety associated with HIV positive status.\textsuperscript{72}

\textbf{Costs\textsuperscript{73} of intervention}

(i) Costs of screening and counselling;

(ii) Costs of health worker training;

(iii) Cost due to loss to follow up;

(iv) Poor compliance with intervention;

(v) Cost of drugs for antiretroviral regimens; and

(vi) Mortality, morbidity and healthcare costs associated with formula feeding in HIV negative infants.

\textsuperscript{71} \textit{Ibid.}
\textsuperscript{72} \textit{Ibid.}
\textsuperscript{73} All costs are expressed in US dollars (converted at the South African rands at the 1998 rate of R6 to $1 and $1.5 to £1).
The effectiveness of interventions was measured in terms of discounted life years saved and deaths averted. The study concluded that the ACTG076 regimen is the most effective antiretroviral regimen but also the most costly as 80% of the costs are due to expenditure on antiretroviral drugs and their administration.

The costs of administering each of the interventions were estimated for 20 000 pregnancies over a 1 year period. According to the above study, the counselling and screening per pregnant woman will amount to $7.30 or £4.86. Antiretroviral drugs such as ACTG076 will cost from $400 (£267) to $89 (£59) for the PETRA regimen. Formula feeds and bottles will cost $60 (£40) for a 6 month supply.

The above study established that the administration of a low cost antiretroviral regimen would save lives, and in many cases save money as well. It has been estimated in 1998 that the cost of running such a programme will be R80 million per annum. This amounts to 1 per cent of the annual health budget and this sum includes HIV counselling, testing, AZT and infant formula.74 Given the scenario where the estimated increase of HIV in babies will rise to approximately 100 infants daily between 1998 and 2008,75 in the absence of medical intervention, we realize that we are faced not with the question of whether we should act, but rather how we should respond to this pandemic.

The Department of Health decided in October 1998 to reject a national vertical transmission prevention programme by arguing that it is not cost-effective and that the money will be better spent on a public education campaign.76

As discussed above, perinatal prevention programmes have shown that a national programme would probably be cost-effective and cost-saving because of the enormous costs of caring for HIV-infected children.77

75 Ibid.
There is further no evidence that public education campaigns approach the effectiveness of antiretrovirals, especially when one has regard to the lack of credibility that followed the Sarafina 2 campaign.

The Western Cape, using its own provincial health budget, has started implementing a pilot programme to provide AZT to HIV-positive pregnant women. In so doing it joins a growing number of African countries poorer than South Africa, including Uganda, which have decided to implement antiretroviral regimens for HIV-positive pregnant women.78

South Africa has much to learn from Ugandan President Yowere Museveni who has advanced efforts in his country to stem HIV transmission and to expand care for those infected. Museveni established the nation’s first AIDS control programme.79

With UNAIDS launching a drug access initiative between pharmaceutical companies and government, access to HIV/AIDS related drugs are being improved. The initiative’s co-ordinator, Joseph Saba, explained that “this programme will provide the information we need to determine whether HIV/AIDS related drugs can be obtained and distributed effectively in developing countries”.

Once a state has access to this information, it will be easier to lobby the necessary resources to treat infected individuals.

This programme was initiated as a long-term plan, spanning 5 years. Numerous factors need to be taken into account before launching the initiative such as:

(i) Political and social stability;

77 Ibid.
78 The Sunday Times (2000-10-01) 12.
(ii) High HIV prevalence;

(iii) Existing healthcare infrastructure;

(iv) The presence of an active national AIDS programme; and

(vi) The capacity to implement and evaluate the pilot phase and to collect clear, unbiased results.

South Africa has much of what is needed to implement such a pilot programme, and could only gain from deciding on such an initiative as it has been proved that antiretroviral drugs can be successfully introduced into resource limited settings. In fact, infected people will benefit from any type of intervention offered.

According to Cameron\textsuperscript{80} discrimination in the allocation of resources is the most debilitating discrimination. By denying persons with AIDS or HIV access to a fair share of national resources and wealth results in violating that person’s humanity. To deprive that person of the means to remain healthy, to fight off illness and to live or die in reasonable comfort and dignity, is the most critical human rights issue before us.

One of the duties of the state is however to protect and promote the highest attainable standard of health for the population as a whole. By implementing a particular public health policy, which in itself may promote public health, the rights of individuals may be infringed. Such infringements must be justifiable in economic terms and must not be motivated by any consideration other than what is in the best interests of the community at large.

As there appears to be a general legal right to medical treatment as provided by legislation, this right extends to and includes the HIV-positive patient. The

\textsuperscript{79} Zuniga "Uganda and UNAIDS Advance a Bold Experiment" (1999) \textit{International Associations of Physicians in AIDS care} 49.
right is limited, and not absolute as cost and effectiveness or treatment are issues of paramount importance to be considered by the state.


It appears reasonable and economically viable that the state should at least provide medical intervention to prevent vertical transmission from mother-to-child.

Having established a right to treatment, one must consider the enforcement of such a right. Central to the discussion of the treatment of AIDS sufferers, is the realization that AIDS is life threatening and ultimately fatal. The right to life is a fundamental right\textsuperscript{81} and entails that the competent authorities should undertake all appropriate measures to protect human life. The Constitutional Court of South Africa provides a platform from which an individual can enforce his/her basic human rights.

The unreported \textit{Biljon}-decision\textsuperscript{82} dealt with the rights to adequate health care and access to antiretroviral therapy of prisoners living with HIV. In this case, the court dismissed the prison authorities’ claim of budgetary constraints and upheld two of the four prisoners’ rights to access to treatment at the expense of the prison authorities. (This judgement is specific to prison settings.)

In the early 90’s in the \textit{Schmidt}-case\textsuperscript{83} it was held that people with AIDS has rights no different from others and that they may approach the courts for appropriate relief in case of infringement.

This judgement serves as an important indicator for individuals wanting to enforce his/her basic human rights. Our human rights principle of non-discrimination requires us to ensure that adequate resources are committed to caring for people with AIDS. The law requires that people with HIV/AIDS

\textsuperscript{81} See \textit{Makwanyane} 1995 960 BCLR 665 (CC).
\textsuperscript{82} \textit{Biljon v Minister of Correctional Services} 1997 (4) SA 441 (C).
\textsuperscript{83} \textit{Schmidt v Administrator of the Transvaal}, WLD 3 April 1992, case no 7937/92 unreported.
receive the best care the country can afford, no more but certainly no less, than other terminally ill persons.

Thus far, the duty of the state to provide health care was tested in the Soobramoney-case. In this case the applicant was suffering from chronic irreversible renal failure and sought access to “health care” and continued, indefinite kidney dialysis. His kidneys failed and his condition was diagnosed as irreversible.

The hospital had a policy of only providing renal dialysis to patients who could be cured or who were eligible for a kidney transplant. The court held that emergency medical treatment must be interpreted in the context of the availability of health services.

The relevant provincial health department did not have sufficient money and had overspent its budget for 1997.

The court held that it will refrain form interfering with budget decisions where those decisions are made in good faith and are rational. The Constitutional Court upheld the state’s budgetary constraints argument for not providing the patient with continued and indefinite kidney dialysis. The judgement confirms that the courts are increasingly reluctant to intervene and alter state budgetary decisions, even where this amounts to the non-provision of treatment or health care.

In concluding the discussion of the HIV patient’s right to treatment it is important to consider Van Oosten’s views regarding the patient’s right to health care and emergency treatment. This include:

84 Soobramoney v Minister of Health 1997 (12) BCLR 1696 (CC).
(i) The status and content of the patient’s right are anything but clear and may ostensibly vary from rights to prohibitions to non-rights depending on whatever;

(ii) Financial constraints are a relevant consideration in determining whether or not there was civil or criminal negligence on the part of a State hospital;

(iii) The following considerations are relevant in determining the patient’s right to health care or emergency treatment: financial resources, the State’s obligation to provide other services in the promotion of fundamental rights, in HIV/AIDS cases, the fact that the patient is a prisoner, the competing interests of patients, the nature of the patient’s condition: whether or not the patient’s condition is acute or chronic, the benefit to be gained from the health care service claimed: whether or not the patient’s condition can be remedied or is irreversible.

The South African law does not guarantee an absolute right to care. According to Leech\textsuperscript{86} there are no studies to date which show that South Africa is incapable of bearing the costs of treating HIV infected patients. Therefore, all HIV-positive patients should be given suitable care until it becomes clear that the impact of HIV treatment on the economy is such that South Africa is unable to maintain comprehensive health-care facilities.

The overriding need in developing countries is primary health care. The object of primary health care in these countries is to make the maximum use of available resources of personnel and equipment.

\textsuperscript{86} Leech (1993) \textit{SAJHR} 54.
CHAPTER 3
CONSTITUTIONAL PROVISIONS RELATING TO THE HIV/AIDS-INFECTED PERSON

The Constitution\textsuperscript{87} is the Supreme law of South Africa.\textsuperscript{88} It not only entrenches our common-law rights, but for the first time introduced democracy, equality, it recognizes the past injustices and promises a future of reconciliation and reconstruction.

The Bill of Rights forms a cornerstone of democracy in South Africa and enshrines the rights of all people in our country. It further affirms the democratic values of human dignity, equality and freedom. These commitments are particularly reflected in the socio-economic rights included in the Bill of Rights, for example the right to health care, food, water and social security.

The Constitution therefore establishes a perfect platform for HIV-infected individuals from which to demand that they be treated equally, fairly and without being arbitrarily discriminated against.

In this chapter we will give particular consideration to section 27 which provides for the right of everyone to have access to health care services, sufficient food and water and social security.

This section also prohibits anyone from refusing a person emergency medical treatment. Section 27(1) reads as follows:

“Everyone has the right to have access to –

(a) health care services, including reproductive health care;

(b) sufficient food and water; and

\textsuperscript{87} Act 108 of 1996.

\textsuperscript{88} s 2 of Act 108 of 1996.
Section 27(2) provides that:

“the state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of these rights”.

Traditionalists who see a Bill of Rights as a shield and not a sword – as a protective mechanism against state interference in the lives of individuals, usually hold that such rights merely place a duty on the state to refrain from interfering with the rights of individuals. In other words, they see a Bill of Rights as merely placing a duty on the state to respect the enumerated rights.89

South Africa’s Constitution rejects this notion as it obliges the state in section 7(2) to respect, protect and fulfil the rights contained in the Bill of Rights. There is, therefore a duty on the state to act positively. This entails that the state is under a positive obligation to take steps to ensure that the enjoyment of the right is effective.

This general obligation includes the obligation to have in place laws and regulations that grant individuals the legal status, rights and privileges required to ensure the proper protection of their rights.

Despite this positive duty being placed on the state certain internal limitations contained in this section provides an acknowledgement that the state cannot fulfill all the rights contained in the Bill of Rights immediately and completely. The following four internal limitations contained in section 27(1) and 27(2) can be identified:90

(i) Firstly, the right which the Constitution entrenches is not a right to health care, food, water and social security, but the right to have access to

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90 De Vos SAJHR 83.
health care, food, water and social security. This holds that citizens have a right to apply for socio-economic rights but that the granting thereof is not guaranteed.

(ii) Secondly, the state must take reasonable measures within its available resources, to achieve the progressive realization of these rights. The state need therefore not undertake every conceivable measure, only appropriate ones, depending on the extent, duration and nature of the rights.

(iii) Thirdly, the available resources referred to in this section refers to the prerogative of government to decide whether certain social risks will be recognized or not. The inclusion of this phrase reflects the practical economic and political reality that it is the state of the country’s economy that most vitally determines the level of its obligations. The prerogative will be exercised differently as social and economic conditions change and governing policies are adopted accordingly.

(iv) Fourthly, the progressive realization of these rights imply that their enforcement will only be realized gradually, as financial, administrative and educational measures needs to be implemented in a transparent plan of action.

Whether socio-economic rights are generally acceptable, will depend on the way courts, tribunals and forums interpret the rights as contained in the Bill. Section 36 states that:

“[w]hen interpreting the Bill of Rights, a court, tribunal or forum must promote the values that underlie on open and democratic society based on human dignity, equality and freedom; must consider international law; and may consider foreign law; when interpreting any legislation, and when developing the common or customary law, every court, tribunal of forum must promote the spirit, purport and objects of the Bill of Rights ...”

The innovative approach of the Constitution in placing a specific duty on the state to take positive measures in order to give effect to the rights contained in
the Bill of Rights, implies that the rights contained in section 27 are capable of enforcement, subject to the limitation clause as contained in section 36 of the Constitution. It is however, of the utmost importance that it has to be recognized that the longer it takes to make progress with the realization of socio-economic rights (such as access to primary health care) the more endemic poverty and AIDS will become in our society.91

91 De Vos SAJHR 94.
Despite the founding mythology upon which the new South Africa is based, that is talk of an “African renaissance” and “rainbow nation” the country continues to be divided by misunderstandings and disputes, especially between AIDS activists, experts and the government.92

Despite acknowledging that the HIV/AIDS epidemic is firmly embedded in our nation, the government's perceived inability to communicate their stance on the link between HIV/AIDS with any clarity and their decision to take the advice of medical conspiracy theorists have endorsed the impression that the South African government is clearly unable to deal with this catastrophe.

Whenever the question of whether HIV leads to AIDS is raised one notices a clear divide with President Mbeki and the ANC on the one side and AIDS activists, non-governmental organizations, the media, the political opposition and the western world on the other. This us-versus-them mindset sparked a small war between the “traditional” and “dissident” scientists and their supporters as to the true cause of AIDS.

It all started when Thabo Mbeki asked scientists to explain how the disease had come to blight Africa at the AIDS advisory panel’s first meeting during May this year. Their opposing views on this controversial issue will now be considered. Most orthodox scientists from bodies like the local Medical Research Council, the Centre for Disease Control in the US and organizations such as WHO and UNAIDS say that:

(i) AIDS is caused by the human immuno-deficiency virus that is spread by unprotected sex, by sharing needles with an HIV-infected person and by infected pregnant women to their babies;

(ii) HIV causes AIDS and that evidence in support of this contention is overwhelming because evidence of HIV infection is easily found in patients with AIDS and the virus has been isolated and grown in pure culture from people with the disease. Studies of AIDS infection resulting from blood transfusions have documented the transmission of HIV to previously uninfected people, who have subsequently developed the disease;

(iii) tests for HIV are reliable;

(iv) anti-retroviral drugs can be used to slow down the pace of infection and cut down transmission of the virus from mother to child.

Dissident scientists on the other side however holds the following views:

(i) HIV is not the cause of AIDS, although people are dying and AIDS causes a breakdown of the immune system;

(ii) AIDS has been caused in Europe and the US by recreational anti-retroviral drugs and in the developing world by poverty, malnutrition and poor living standards;

(iii) Statistics used to cite the disease is not accurate;

(iv) Tests used to detect HIV is not trustworthy.

The dissident’s theory has caused ripples in the previously calm pond of popular thought that there is an accepted causal nexus linking HIV to AIDS.
The dissident view claims that the popular theory of HIV causing AIDS, although accepted, cannot be proven scientifically.

They argue that it is impossible to prove that HIV causes AIDS because it has not been proved that a human immuno-deficiency virus exists at all. This is because HIV has been classified as a retrovirus, and the only scientifically acceptable method of isolating and identifying retroviruses has never successfully been used in the study of HIV. This method apparently involves culturing cells, isolating suspected retroviral particles (HIV) and then studying these isolated particles.

In the initial study where HIV was identified, a purified cell culture was studied and not the required isolated retroviral particles. The dissidents continue to support their view that HIV should not be classified as a retrovirus by stating that the observed particles do not carry the usual characteristics of a retrovirus.

A retrovirus is spherical in nature, have diameters of 100 – 120 mm and are covered in “knobs”, whereas the particles identified as HIV were not spherical in nature, they were considerable larger (±120-240 mm) and smooth. The dissidents further supports this view by stating that it is characteristic for a retrovirus to leave the host cell intact after replication, whereas the HI virus destroys the host cell. Of particular significance is the dissidents’ claim, that without scientifically isolating and identifying HIV as a retrovirus, it is impossible to identify an HIV specific antibody.

Antibodies are produced by the body’s immune system in response to infectious agents. HIV testing involves identifying the presence of HIV-specific antibodies in the blood. The traditional theory holds that if these antibodies are present, then it is accepted that the individual is HIV-positive.

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The dissidents however claim that unless the nature of HIV is scientifically proved, it is impossible to say that HIV causes AIDS. The basis of the origin of the HIV-specific antibody test. This HIV-specific antibody test is used to prove the existence and infection of HIV in the blood. Scientists have agreed that the only way to prove that an antibody is specific to one infectious agent is to first isolate the infectious agent and then to identify the antibodies that are always present when this specific infectious agent is present. It is thus apparently impossible to prepare specific antibodies before the infectious agent to which they are specific has been isolated.95

Of particular significance now is the dissidents’ claim that it is impossible to identify an HIV-specific antibody without first establishing that the infectious agent is indeed a retrovirus. It would appear that the dissidents’ claim that unless the nature of HIV is scientifically proved, it is impossible to say that HIV causes AIDS.

The dissidents even suggests that the cause of AIDS may in itself not even be a virus. They state that it is well known that viruses cannot survive outside of a host cell for more than a few hours, yet haemophiliacs have been known to contract AIDS form blood transfusions where the plasma was stored for months as a dry, flaky powder in which a virus could apparently not survive.

It is clear that whenever the question of whether HIV leads to AIDS is raised with Mbeki or his office no straight commitment will be forthcoming. Many of the issues raised by Mbeki regarding HIV/AIDS for example that poverty exacerbate rampant disease in Africa and that a lack of resources leads to poor medical services are noteworthy but it is the lack of clarity from him and his advisors and their apparent confusion on the link between HIV and AIDS that leaves one with the impression of a shifty, evasive, leader who has seen it fit to rather take the advice of medical conspiracy theorists than to accept established and irrefutable evidence.

This creates the impression that this constitutes yet another ploy by the government in delaying the ultimate – to make a clear stance and to tackle the issues head on.

The vague undertakings by the state to combat the HIV/AIDS pandemic creates little comfort for the millions of HIV and AIDS infected persons who are dying daily of this disease. It has been proved that low-cost antiretroviral regimens can be introduced into resource limited areas successfully. In fact, any kind of treatment will be better than none at all.96

CHAPTER 5
CONCLUSION

The HIV/AIDS epidemic is here to stay and will therefore affect everyone. The responsibility of caring for those who are living with HIV/AIDS cannot be left to the few experts in the field. Everyone will have to become knowledgeable about the condition, its diagnosis and its management.

In establishing a right of access to social security, be it social insurance or social assistance, I came to the conclusion that HIV/AIDS really highlights the lack of a comprehensive, integrated social security system in South Africa. In not only excludes large sectors of the community which results in gender and racial discrimination but also lacks a holistic approach.

It is suggested that a general right to medical treatment is held by all within South Africa. It will be morally and ethically wrong to deny an HIV infected person treatment solely on the basis of his HIV status. This also means that HIV infected people will not receive preferential treatment but that treatment should be available to all, no matter what the need. The decision to treat an HIV-infected person must also take into account the value of the treatment for other people, those not infected. Treating Tuberculosis, for example holds the value to society as a whole. It benefits people affected by HIV and Tuberculoses, it is also effective and low costing, given the number of people reached.

Central to the discussion of a right to treatment as envisaged by section 27(1) of the Constitution, is the limitation of this right. Section 36 of the Constitution permits the limitation of the right. Before the right to have access to health care services can be limited, the limitation must be contained in a law of general applications, and it must be reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom. Cognisance must be taken of the nature of the right and of the limitation and the purposes of the limitation.
It is important to note that the right that the Constitution guarantees is the right to have access to health care services. This means that the Constitution guarantees each citizen an opportunity to apply for health services but does not guarantee the granting of such health services.

Section 27(3) specifically protects an element of the general right to have access to health services, namely, the right not to be denied emergency medical treatment. The purpose of this section is to ensure that no one is denied the medical treatment essential to preserve life. The right to access to health care services formed the subject matter of the *Soobramoney*-case, as discussed *supra*.

In outlining the national AIDS plan and its shortcomings, it is clear that government will have to expand its friendship ties and form partnerships if they want to take control of this epidemic. We need to form alliances with international as well as non-governmental organizations in order to learn from each other and to formulate an effective, strategic plan to confront the challenges posed by HIV and AIDS. UNAIDS suggests that the following principles must be agreed upon to meet the physical, social and economic needs of people living with HIV/AIDS:

(i) Respect, that is having regard for human rights and individual dignity;

(ii) Accessibility and availability includes appropriate care provided at the local level;

(iii) Equity entails the provision of care to all persons living with HIV/AIDS regardless of gender, age, race, sexual identity, etc;

(iv) Efficiency and effectiveness refers to efficacious care provided at reasonable societal costs as demonstrated through ongoing monitoring and evaluation; and
(v) Coordination and integration to ensure a continuum of care across providers and levels of care.

With specific regard to expanding access to antiretroviral drugs, the WHO suggests minimum requirements that healthcare systems must meet before introducing interventions. This include the following:

(i) Reliable and inexpensive HIV tests;

(ii) Access to voluntary and confidential counselling and testing;

(iii) Functional laboratories to monitor the adverse reactions to antiretroviral treatment;

(iv) Training for clinicians and nurses;

(v) Reliable, long-term supply for drugs; and

(vi) Joint decision-making between physician and patient on antiretroviral treatment.

In South Africa, it would not be impossible to satisfy the above requirements, and so set the stage for a strategic, national plan of action on how to combat the HIV epidemic.

Treating HIV is a good policy and the responsibility lies not only with governments, pharmaceutical companies or medical doctors, but all citizens have a moral and social obligation to make war against AIDS, and not against people with AIDS.

It is however specifically the government's inability to communicate their stance and commitment to effectively address the disastrous consequences of the AIDS pandemic that leaves desperate people clutching at straws and a nation being decimated while the epidemic continues to rage on.
BIBLIOGRAPHY

Books


Discussion Papers/Articles

Booth Clem "The insurance industry and AIDS – an insider’s perspective" 1993 9 SAJHR 151.


Figueira Michaela "AIDS, the Namibian Constitution and human rights – an overview" 1993 9 SAJHR 32.

Gray Glenda "Denying effective antiretroviral drugs to HIV-positive pregnant women – the national government’s flawed decision" 1999 89 SAMJ 622.

Leech Bruce "The right of the HIV-positive patient to medical care: An analysis of the costs of providing medical treatment” 1993 9 SAJHR 49.
Swanson Edward "Life assurance, health insurance and AIDS: Lessons from the United States" 1993 9 *SAJHR*.


Zuniga "Uganda and UNAIDS advance a bold experiment" 1999 the *journal of the international association of physicians in AIDS care* 49.

**Legislation**

Compensation for Occupational Injuries and Diseases Act 130 of 1993.
Medical Schemes Act 131 of 1998.
Public Health Act 36 of 1919.
The Health Act 63 of 1997.
Unemployment Insurance Act 30 of 1996.
Workmen's Compensation Act 30 of 1941.

**Case law**

*Biljon v Minister of Correctional Services* 11778/96 C.P.D. High Court.

*Makwanyane* 1995 960 BCLR 665 (CC).

*Schmidt v Administrator of the Transvaal* WLD 3 April 1992 case no. 7937/92 unreported.

*Soobramoney v Minister of Health (KwaZulu-Natal)* 1998 (1) SA 765 (CC).

*Vuuren v Kruger* 1993 (4) SA 842.
Websites

http://www.hri.cq/alp/about/index.shtml#l.
söderlun@icon.co.za.