

# NSP REVIEW

Engaging with South Africa's National Strategic Plan for HIV, STIs and TB | Edition 4 | October – November 2012

A publication of the Treatment Action  
Campaign and SECTION27

## HUMAN RIGHTS & THE LAW

TB in prisons: What does the Dudley Lee case mean for TB in South Africa?

People before patents: Changes to South Africa's patent laws are long overdue

Ten years since the TAC Case:  
A judgment that saved a million lives



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The Treatment Action Campaign (TAC) advocates for increased access to treatment, care and support services for people living with HIV and campaigns to reduce new HIV infections. Learn more about TAC's work at [www.tac.org.za](http://www.tac.org.za).



SECTION27 is a public interest law centre that seeks to influence, develop and use the law to protect, promote and advance human rights, particularly the right to health. Learn more about SECTION27's work at [www.section27.org.za](http://www.section27.org.za).

This is the fourth issue of NSP Review. We aim to provide quality analysis and monitoring of the implementation of the new NSP. It is our hope that this publication will increase awareness of, and critical engagement with the NSP. We will try to keep it relevant with evidence from new research and feedback from the various district offices of the Treatment Action Campaign as well as organisations with which we work closely. Our vision is a vibrant, evidence-based publication that will help all stakeholders drive a more successful response to HIV, STIs and TB. We encourage you to get in touch with us should you want to contribute to future editions of NSP Review. You can e-mail the editor at [nsptac.org.za](mailto:nsptac.org.za).

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Photo by Susanne Feldt

# EDITORIAL

In 2012 we celebrate ten years since the Constitutional Court delivered a landmark judgment obliging the state to provide treatment for prevention of mother-to-child transmission of HIV.

The court case, which has come to be known as the Treatment Action Campaign (TAC) case, followed a bitter political battle between TAC and the government. In the end, it was the constitution's guarantee of the right to health that determined the legal outcome. Yet, although ten years have passed since that ruling, TAC and other civil society organisations still find themselves going to court to defend the very same constitutionally-guaranteed right to health.

We are now fighting for the rights of prisoners detained in communal cells that often hold up to twice as many people as the legal maximum. Such conditions place both inmates and prison officers at a significantly higher risk of contracting tuberculosis (TB) or drug-resistant TB. Research has found that inmates of Pollsmoor Prison near Cape Town have a roughly 90% risk of contracting TB over a one-year period. But that is not where it ends – prisoners and warders return to their communities carrying these active infections, which then spread to the wider population.

Research shows that the risk of TB transmission can be greatly reduced by implementing national or international cell occupancy standards and active TB case detection. The Department of Correctional Services however has not taken the necessary steps to implement such measures, which could reduce TB transmission risk by up to 94%.

TAC has joined as *amicus curiae* (friend of the court) in the case of Dudley Lee, who contracted TB while awaiting trial in Pollsmoor. John Stephens writes about this important case in more detail starting on the next page.

Apart from prisons, other arenas notable for TB-related human rights violations are our mines, which employ approximately half a million workers. In 2010/2011, 11% of South Africa's gold mine workers were infected with TB compared to a national industry average of 5%. TB is the number one cause of death in South Africa, particularly for people with HIV.

Whereas our 2009 National TB Management Guidelines do not mention mineworkers specifically in regard to the



disease, the National Strategic Plan 2012-2016 (NSP) clearly identifies them as a key population at high risk of infection or re-infection.

The NSP sets out specific interventions to target this key population for maximum impact: "The private sector, all employers and labour unions should ensure that all... employees are tested and screened annually and have equitable access to prevention, treatment and wellness services. Special attention should be given to high-risk workplaces and trades e.g. mines and truck drivers." In addition to the NSP, the 15 member states of the Southern African Development Community (SADC) signed a Declaration on TB in the Mining Sector\* in August 2012. The document identifies areas in need of urgent prioritisation.

But the NSP and the SADC declaration\* are only starting points. We need to transform these high ideals into successful TB programmes in our prisons and mines. TAC will continue to campaign for this and hold government to account.

The only way to beat TB is to address the human rights violations that fuel its spread. These abuses undermine our ability to meet the NSP targets of eliminating new TB infections and stemming the tide of TB-related deaths.

*Vuyiseka Dubula, TAC General Secretary*

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\* For more on the declaration see [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(12\)61698-5/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(12)61698-5/fulltext)



TAC members and other activists gather outside Pollsmoor Prison in Cape Town to draw attention to the Dudley Lee case and to protest against the poor living conditions inside South Africa's prisons. Photo by Susanne Feldt

# TB IN PRISONS:

## WHAT DOES THE DUDLEY LEE CASE MEAN FOR TB IN SOUTH AFRICA?

By John Stephens

On 28 August 2012, the Constitutional Court heard argument in a case that will have major implications for public health and human rights. This case goes to the core of what it means to be human and humane in a TB pandemic that is taking more South African lives than any other cause.

### The National Strategic Plan on TB in prisons:

"Certain populations are at higher risk of TB infection and re-infection, including ... prisoners [and] prison officers and household contacts of confirmed TB patients.... These groups are considered key populations for TB."

Certain groups should be prioritised for TB services including "correctional services staff and inmates....people living...in poorly ventilated and overcrowded environments".

"Respiratory infection control should...be prioritised in prisons."

"Annual risk-assessments should be carried out and 90% of high-risk institutions [including prisons] should achieve a basic infection control standard."

In the Cape Town suburb of Tokai is Pollsmoor Prison, one of South Africa's largest correctional facilities. Pollsmoor consists of five correctional centres, a great hulk of clipped buildings laid out in rows and cut by straight roads like a well-planned city.

66-year-old Dudley Lee entered Pollsmoor in April 2000, charged with fraud, counterfeiting and money laundering amongst other things. The communal cells in which he was placed were at over 200% occupancy. 40 to 60 men crowded on top of one another in each unit. The men were confined to these areas for up to 23 hours a day with little room to move. Lee's cell was so filthy that he sat on his clothes throughout the night to avoid touching the surfaces. Sunlight and ventilation were scarce, and smoke poured from cigarettes. A man coughed. Another sneezed. A third spat on the ground.

The men breathed and rebreathed the air and awaited their trials.

Dudley Lee was healthy when he went into Pollsmoor. In June 2003, he was diagnosed with pulmonary TB. In September 2004—over four years after entering prison—he was acquitted of the charges against him and released. He then sued the Minister of Correctional Services in the Western Cape High Court in Cape Town for negligently causing him to become infected with TB.

Thus began Lee's struggle against the Department of Correctional Services. His legal journey took him through three courts over seven years. The litigation has unearthed disturbing truths about the state of health in South Africa's prisons and how it could affect the health of all South Africans.



Activists were also present outside the Constitutional Court in Johannesburg, where Dudley Lee's case was being heard. Photo by Legogang Mokwela, courtesy of the Treatment Action Campaign Archive

## INHUMAN CONDITIONS

Conditions in Pollsmoor deteriorated over a number of years. In the late nineties medical staff working in the facility began to panic. They wrote to prison authorities describing the collapse of the Pollsmoor health care programme, detailing the risk to health and to their ability to care for patients. Frans Muller, a nurse at Pollsmoor for ten years, wrote a letter to prison authorities in 2000 in which he warned, "We are sitting on a time bomb. Please let us avoid the explosion".

In 2001, Muller sent another report to the authorities pointing out that the "critical shortage of nursing personnel" left the medical staff to cope with "an enormous workload under difficult conditions". He further noted that the "massive overcrowding increases the pressure on our nursing staff and aggravates the poor conditions under which our inmates are detained".

The Department ignored Muller's warnings.

A little over a decade later, a team of academics led by TB and HIV expert Professor Robin Wood of the Desmond Tutu HIV Centre modelled how the conditions of detention at Pollsmoor affect TB transmission.\* The findings were shocking. Wood and his colleagues showed that conditions in Pollsmoor are ideal for the spread of TB, including drug-resistant strains, and result in transmission risks of approximately 90% per annum. In other words, if 100 people go into Pollsmoor prison for a year, 90 of them will probably contract TB.

The Pollsmoor study also revealed that implementing the cell occupancy standards required by South African

prison regulations alone would reduce the likelihood of transmission by 30%. Implementing active TB case finding, as required by law even when Dudley Lee was imprisoned, and combining this with national cell occupancy standards would reduce transmission probabilities by 50%. Finally, implementing active case finding along with international recommendations for cell occupancy would reduce transmission probabilities by a whopping 94%.

When Professor Wood discusses these findings with me he covers a lot of ground in a short time. In the space of just a few minutes he quotes Dostoevsky and explains the basic epidemiology of TB. Wood describes the overcrowding at Pollsmoor, flashing a slide of a communal cell. The image shows men lying on their sides curved into one another in long rows, an occasional sliver of ground visible between two sets of legs like a bulging seam that holds the men together.

Wood outlines simple ways to deal with the TB problem. Increase ventilation by opening cell ventilator grills and using barred instead of solid doors. Let the prisoners outside for longer periods. Test them for TB when they first come to Pollsmoor and actively seek out inmates with symptoms of infection. When you find infectious patients, treat them.

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\* Read more about the findings of Wood and his colleagues at <http://www.samj.org.za/index.php/samj/article/view/5043>

# AN ANCIENT DISEASE

TB is the world's oldest known disease. In 500 BC, the Greek physician Hippocrates, who is known as the founder of western medicine, called it the most prevalent disease of his time. The resilience of TB frustrates scientists. Essentially, the bacterium is protected by a tough outer membrane, which makes killing the pathogen difficult. Professor Valerie Mizrahi, Director of the Molecular Mycobacteriology Research Unit at the University of Cape Town, describes it as “a real tough bastard of a bacteria”.

South Africa has one of the highest incidence rates in the world. TB is the number one cause of death of South Africans—by a long shot—and has been for many years.

HIV co-infection and the increasing prevalence of drug-resistant TB, which can be incurable, compound the problem. In many cases treatment for drug-resistant TB takes two or more years. It costs a fortune, can involve long periods of isolation and is brutal on the body. For

some patients treatment can even lead to permanent deafness, amongst other serious side effects.

Infection with drug-resistant strains occurs in one of two ways. A person can be infected with drug-susceptible TB, which can then develop into drug-resistant TB. This often happens due to treatment default. Also, drug-resistant TB can be transmitted directly from one person to another. Given that prison conditions are ideal for the spread of infection and that health care is at best sporadic, without serious intervention these institutions are likely to be the wind beneath the rise of drug-resistant TB.

What is more, TB is an airborne communicable disease. The TB that spreads in prison does not stay in prison. Guards, visitors and released detainees carry the bacteria back to their families and communities. Therefore, in order to combat TB effectively in the general population, we must also address it in the prison population.

# PRISONERS HAVE RIGHTS

Prisoners and detainees awaiting trial are endowed with rights enshrined in the Constitution of South Africa. These rights include the right of access to health care services and medical treatment, the right to be detained in conditions consistent with dignity and the right to a public trial in court. In a nation in which not long ago many great visionaries, artists and leaders were jailed for their beliefs, these rights hold special significance.

Moreover, those people at highest risk of TB infection are detainees awaiting trial—people who have not yet had their day in court. The law assigns them the status of “presumed innocent”. This, then, is the question we must ask: what standard of care do we owe people when we take their freedom but have not yet determined if they are guilty of a crime?



Photo courtesy of Treatment Action Campaign Archive

Nelson Mandela, who was detained in Pollsmoor for over six years and suffered from TB whilst there, said this on the subject, “... no one truly knows a nation until one has been inside its jails. A nation should not be judged by how it treats its highest citizens, but its lowest ones”.

# FROM PRISON TO COURT

Dudley Lee won his case in the High Court. The court was plain in its condemnation of the Department of Correctional Services, writing that the Minister had provided no evidence that he took “any steps whatsoever to guard against the spread of TB”. The Minister then appealed to the Supreme Court of Appeal (SCA).

The SCA seemed to recognise the weight of the matter. The judge observed, “Prisoners are amongst the most vulnerable in our society to the failure of the state to meet its constitutional and statutory obligations. It seems to me that there is every reason why the law should recognise a claim for damages to vindicate their rights. To find otherwise would altogether negate those rights.”

The judge also agreed with the High Court that the Minister had failed in his duties. “[T]o the extent that any system existed at all for the proper management of the disease its

application in practice was at best sporadic and in at least some respects effectively non-existent.”

The SCA even reproached the state for litigating the way it had, saying that it had contested “the allegations of an inadequate health-care regime when it must have known that it was defending the indefensible ... By adopting that approach the state forced Mr Lee into a trial that endured for about three weeks, in which he was compelled to take up the time of professional men to prove what was incontestable”.

In spite of these statements, the SCA found against Lee, who then appealed to the Constitutional Court.

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The SCA ruling is online at <http://www.saflii.org/za/cases/ZASCA/2012/23.html>

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## WHY THE SCA RULED AGAINST LEE

To understand why Lee lost in the SCA requires a basic grasp of an area of law known as “delict”. The typical delict case involves a person or entity—in this case the Department of Correctional Services—that has done something wrong, or failed to do its duty, and thereby harmed another person or entity.

The most common delictual claim is a car wreck. For example: Andy fails to stop his car at a red robot and hits Betty’s car, denting her car door. Betty sues Andy for the cost of repairing the dent. Betty’s claim against Andy is a delictual claim.

The question becomes: what is a right without a remedy?

To win a delictual claim one must prove certain “elements”. Most commonly, these are described as: wrongfulness, fault, causation and damages.

“Wrongfulness” refers to a legal obligation to either do or not do something. In the above example, Andy acted wrongfully by not stopping at the red traffic light.

“Being at fault” refers to a failure to comply with the obligation to either do or not do something. In the above example, Andy’s failure to stop at the red robot meant he was at fault.

“Causation” is the element of a delictual claim that was at issue when Lee’s case went to the Constitutional Court. To prove causation you must demonstrate that the wrongful action resulted in, or caused, the harm. Typically, in order to prove this, a court will apply the “but for” test. In the above example, a court would ask whether it is more probable

than not that “but for” Andy having run the red robot Betty’s car would not have been damaged?

“Damages” simply refers to the monetary value required to compensate for the harm suffered. In the above example, the damages would be how much it costs to fix the dent in Betty’s car door. If Betty was injured the damages might include hospital bills as well. In Lee’s case, the harm is TB infection and the damages would be the monetary value that a court determines is necessary to compensate him for being infected with TB.

The SCA found that Lee had proven each of these elements except for “causation”. The Court identified two ways in which he could have proven the causation element.

First, he could have identified the source of his infection and shown a causal connection between it and some specific negligence or omission on the part of prison authorities.

Lee’s second option would have been to show that he would not have been infected with TB if the prison authorities had done everything they were supposed to have done. In other words, Lee would have had to prove that there would have been a zero percent chance of contracting TB “but for” the prison authorities’ negligence.

In the context of TB in prison, both of these methods of proving causation are unrealistic. The first is unrealistic simply because it asks Lee to do the impossible given the limits of science. TB diagnostics do not make it possible to isolate a source of infection and connect it to a specific act of negligence.

# TO THE HIGHEST COURT IN THE LAND

The Treatment Action Campaign, Wits Justice Project (WJP) and the Centre for Applied Legal Studies (CALS), represented by SECTION27, joined Lee's case in the Constitutional Court as amici curiae (friends of the court) in part to bring the above information before the Court. The amici asked the Court to accept evidence in the form of an affidavit from Robin Wood which established that it is not scientifically possible to prove the source of a TB infection for the SCA's purposes.

Wood's affidavit also showed that the SCA's second option for proving causation is equally implausible. One cannot prove that there would be a zero percent chance of contracting TB if the prison authorities fulfilled their duties. Indeed, the legal duty on prison authorities does not intend to altogether eliminate the risk of infection. This was acknowledged by the SCA itself when it wrote, "... whatever management strategies might be put into place, there will always be a risk of contagion".

Thus, the SCA effectively cancelled the possibility of a remedy in this type of case, leaving Lee and others like him without compensation despite the violation of their rights. The SCA ruling also means that the Department of Correctional Services can continue to disregard its obligations. Meanwhile, the lack of incentive to tackle TB in prisons will also have serious consequences for public health.

The constitution requires that common law be developed in order to "promote the spirit, purport and objects of the Bill of Rights". If any circumstances called for it, these are they. TAC, WJP and CALS argued in the Constitutional Court that justice requires the law to be developed in this case in order to give effect to rights specified in the Bill of Rights.

During the hearings on 28 August, the amici drew the Court's attention to the fact that courts around the world had grappled with this question in similar situations. For example, in the United Kingdom the use of asbestos in construction led to workers contracting a hideous disease called mesothelioma. However, workers who sued their employers could not prove that they had contracted mesothelioma due to asbestos exposure at one place of employment or another or even from the environment. Thus, the workers were unable to meet the "but for" test. The courts decided that justice required an adaptation of the test in those circumstances. They ruled that in mesothelioma cases, it was enough to show that the employer's negligence increased the risk of contracting the disease. Courts in many countries have taken a comparable approach when faced with similar facts. The amici argued that the Constitutional Court should do the same in the case of Dudley Lee.



By arguing this point to the Court, these organisations are also asking a broader question of South Africa. In the birthplace of one of humanity's greatest accomplishments, the Constitution of the Republic of South Africa, what kind of country should our prisons reflect? How does the nation's long legacy of resistance relate to the way South Africa treats those whose freedom it sees fit to deny?

Dudley Lee now lives on the breadline in an old age home in Cape Town. He has received no compensation from the state. Today, Pollsmoor is much the same as it was when Mandela was transferred out in 1988 or when Lee was released in 2004.

On 28 August, the Constitutional Court heard argument in Lee's case that will have serious consequences not only for him, but for human rights, public health and prisoners across the country. We now await a judgment from the Court.

We will report on this judgment in a future issue of NSP Review.

*John Stephens is a researcher with SECTION27.*

*Sixty-six-year-old Dudley Lee lives on his R1,200 state pension in St Monica's, a home for the aged in Bo Kaap, near the centre of Cape Town. Most of his pension goes to St Monica's leaving him with very little spending money. Photo courtesy of GroundUp [groundup.org.za](http://groundup.org.za)*

Sources: Johnstone-Robertson S, Lawn S, Welte A, Bekker LG, Wood R, 'Tuberculosis in a South African prison – a transmission modelling analysis.' *South African Medical Journal*, Vol 101, No 11 (2011). <http://www.samj.org.za/index.php/samj/article/view/5043>; Lee v Minister of Correctional Services (10416/04) [2011] ZAWCHC 13; 2011 (6) SA 564 (WCC); 2011 (2) SACR 603 (WCC) (1 February 2011); Minister of Correctional Services v Lee (316/11) [2012] ZASCA 23; 2012 (1) SACR 492 (SCA); 2012 (3) SA 617 (SCA) (23 March 2012)

A close-up, high-contrast photograph of a woman's face, focusing on her eyes and nose. She has dark skin and is looking slightly to the side. The background is blurred, showing some greenery and a blue object.

*A woman living with HIV in Stone Town, Zanzibar. The stigma attached to HIV means that people who are infected with the virus do everything they can to keep their health status a secret. Lydia Martin, courtesy of Photoshare*

# HUMAN RIGHTS & ACCESS TO JUSTICE IN THE NSP

By Umunyana Rugege

The Constitution of the Republic of South Africa says that everyone has the right of access to health care services. This includes access to life-saving medicines and related services such as reproductive health care. This is the basis of the state's obligation to provide sustainable public health programmes.

# THE IMPORTANCE OF INCLUDING HUMAN RIGHTS IN THE NSP

HIV/AIDS and TB are diseases of poverty and inequality. They disproportionately affect people who lack adequate access to education, health care, food and water, sanitation, housing and social security. Through their inability to realise these basic human rights, many living in poverty are made even more vulnerable to HIV and TB infection. The cycle of poverty and disease thus perpetuates itself and restricts people's ability to realise their human rights.

South Africa's commitment to human rights in relation to HIV stems from a number of national and international legal instruments. The Constitution of the Republic of South Africa says that everyone has the right of access to health care services. This includes access to life-saving medicines and related services such as reproductive health care. This is the basis of the state's obligation to provide sustainable public health programmes.

In addition to our own constitution, as a member state of the United Nations South Africa is committed to the Millennium Development Goals (MDGs). Access to health lies at the centre of these goals, which include reducing child mortality, improving maternal health and combating HIV. The MDGs recognise that realising the right to health care and addressing the HIV epidemic are necessary to significantly reduce poverty.

South Africa is also a member of the International Labour Organisation (ILO). As such our country is bound by the ILO legal instruments that prohibit discrimination in the workplace on the basis of HIV status. This is consistent with South Africa's own constitutional protections against all forms of discrimination, including discrimination linked to HIV status. It also aligns with our constitutional rights to human dignity and privacy.

Our legal framework for the protection of human rights is based on laws such as the National Health Act, Labour Relations Act, Employment Equity Act, Medical Schemes Act, the Promotion of Equality and Prevention of Unfair Discrimination Act, the Domestic Violence Act,

the Promotion of Administrative Justice Act and the Promotion of Access to Information Act. The rights that lie at the heart of this framework include equality, human dignity, freedom and security of the person, privacy and many other fundamental socio-economic rights.

Furthermore, South Africa has certain international obligations, among them a requirement to review and reform laws, provide support services, and promote a supportive and enabling environment for the groups most vulnerable to HIV and TB infection.

In fact many laws exist that give effect to these national and international obligations to protect human rights. Yet people living with HIV and TB continue to experience severe prejudice and discrimination in many areas of their lives.

For this reason Strategic Objective 4 ("Ensure protection of human rights and improve access to justice") of the National Strategic Plan for HIV, STIs and TB 2012-2016 (NSP) tries to address shortcomings in the implementation of laws, policies, and public health interventions.



Photo courtesy of Treatment Action Campaign Archive

# WHAT THE NSP SAYS ABOUT HUMAN RIGHTS AND ACCESS TO JUSTICE

During the wide-ranging consultations to develop the NSP, everyone involved—civil society, government departments and technical advisors—accepted that human rights should be central to the NSP and embedded in all aspects of the plan. That consensus will go a long way towards securing safety, dignity and equality for people living with or vulnerable to HIV and TB infection.

As part of this all-encompassing emphasis on human rights, the NSP includes as its fourth strategic objective “Ensure protection of human rights and improve access to justice”. The plan divides this goal into distinct sub-objectives, three of which are:

- Ensure that rights are not violated during the implementation of any NSP intervention. If there are violations, there should be a way to monitor such abuses and deal with them in the appropriate forum.
- Reduce HIV and TB discrimination in the workplace.
- Reduce unfair discrimination in access to services, including health care.

Parties implementing the NSP, including government departments and civil society organisations, must guard against rights violations when they develop interventions to meet the NSP goals. Interventions should aim to protect the dignity of the members of communities that rely on these public services.

## Preventing the violation of people’s rights when implementing NSP interventions

- Health workers who carry out HIV testing without obtaining proper informed consent, or insist on HIV testing before providing other health services, violate the rights of patients.
- If patients with drug-resistant TB are detained under ‘prison-like’ conditions, their rights, including the right to human dignity, are violated.
- When HIV-positive women are denied access to sexual and reproductive health services, their rights are violated. If they are subjected to medical

procedures (such as sterilisation) without their consent, their rights are violated.

- When young men seeking voluntary male medical circumcision services are harmed by untested medical devices or untrained health professionals, this violates their rights.

## Using existing bodies to monitor human rights abuses

Practices such as those described above should be addressed by the relevant government department, private sector or civil society group through policies and programmes. The NSP requires that such rights violations are addressed adequately and appropriately. This can be done using existing complaints mechanisms. These mechanisms should be accessible to ordinary people.

The parties involved in coordinating interventions must review laws and policies and identify potential violations that could form barriers to health care access.

In particular, South Africa must monitor human rights abuses involving people living with HIV. We can do this through existing bodies that have a constitutional mandate to protect and promote human rights. Such institutions already have systems in place to deal with violations. Furthermore, they have well-established relationships with the relevant communities and government departments.

These institutions include the South African National AIDS Council (SANAC), the South African Human Rights Commission, the Judicial Inspectorate of Prisons, the Independent Police Investigative Directorate, the Commission for Gender Equality and the Public Protector.

Where abuses occur, existing legal services organisations should be part of the response. For example, Legal Aid South Africa has a critical role to play in helping people to vindicate their rights. Public interest law centres and pro bono departments of private law firms also have a duty to provide these kinds of legal services. This is especially important where there are violations of human rights in relation to individuals or groups of people living with HIV and TB.



Photo by Legogang Mokwela, courtesy of the Treatment Action Campaign Archive

## REDUCING HIV AND TB DISCRIMINATION IN THE WORKPLACE AND IN ACCESS TO SERVICES

### Workplace discrimination

Despite numerous laws and policies—including the Code of Good Practice on Key Aspects of HIV/AIDS and Employment—discrimination on the basis of HIV and TB status persists in many workplaces. This problem is especially evident in smaller, informal places of employment. The NSP calls for interventions in response:

- Stakeholders such as organised labour, business and government should embark on national campaigns to address HIV- and TB-based discrimination in the workplace.
- Campaigns in small, informal workplaces should include HIV and TB literacy. These programmes should educate employees about the science of HIV and TB, about how the diseases are transmitted and what prevention and treatment services are available. Workplace campaigns should focus on treatment and prevention in the work environment.

### Discrimination in access to health services

During the consultations around the NSP, civil society reported on the barriers that communities confront when they try to access health and other social services. These obstacles range from poor attitudes amongst health workers to insensitivity towards visually impaired patients. By providing health care without sensitivity to a patient's specific needs health workers can discourage people from seeking services such as reproductive health care.

In other words, services must be provided in a manner that is consistent with human dignity. Some interventions suggested by the NSP are:

- Discrimination in access to health services should be addressed by oversight bodies, such as the Health Professions Council and the South African Nursing Council in response to complaints by members of the public.
- Health care providers should be trained to equip them with the skills to respect, protect and promote equality and dignity in their daily role. This would reduce instances of prejudice in service provision.

# WHAT IS MISSING FROM THE NSP?

## Many responsible parties, little accountability

Due to the nature of Strategic Objective 4, no single government department is responsible for implementing the human rights and access to justice aspects of the NSP. This is both a positive and a negative feature.

On one hand, the interdisciplinary approach that involves all departments in conceptualising and carrying out NSP interventions is necessary to keep human rights at the centre of the plan's implementation. In theory, all parties involved in implementing the NSP should carry out their roles with respect for human rights and use available mechanisms to address any violations, should they occur.

On the other hand, no specific organisation or government department is expected to play an oversight role to ensure that interventions, policies and laws are sensitive and responsive to human rights abuses. This may be problematic. Without monitoring there is no direct accountability for carrying out these obligations.

The recognition of human rights and access to justice as central threads of the NSP is a victory in itself. The debate about the human rights concerns facing those affected by or vulnerable to HIV and TB was also an important outcome of the NSP drafting process.

However, in order to make the commitments to human rights real for everyone, institutional partners—SANAC in particular—must be effective at coordinating our HIV and TB response. The South African Human Rights Commission (SAHRC) and other institutions supporting democracy also have a duty to consider the legal and policy framework and take steps to prevent related rights violations. SAHRC has already made a commitment to convene stakeholders in the NSP in order to deal with human rights issues that may arise.

## Costing of the NSP

A key criticism of the previous NSP was the failure to properly cost and budget proposed interventions supporting human rights, access to justice and stigma. It has been argued that the state has a legal duty to devise a transparent budget for the NSP that is approved and implemented by government. Adila Hassim, Head

of Litigation and Legal Services at SECTION27 notes that “not having a proper budget is unlawful and unconstitutional”.

Interventions for human rights and access to justice are costed in the new NSP. Human rights interventions have been costed at one of the lowest rates of all the interventions. The costing was done at a broad level because there was insufficient information to accurately detail the cost of such interventions. Also, costing is carried out on the basis that certain interventions and programmes will become institutionalised. However it is not certain that this will in fact happen. Consequently it is possible that in future such interventions may be underfunded.

Since Cabinet's approval of the NSP document in December 2011 there has been further work towards costing human rights measures in provincial operational plans. However, some provinces have simply failed to cost such interventions. Others have not planned human rights measures tailored to the needs of their provinces beyond the broader national initiatives. This remains a hugely deficient aspect of the NSP.

## Sex work

During the consultation process for the new NSP, civil society called for more concrete steps that would lead to the decriminalisation of sex work. This is an important issue because sex workers are particularly vulnerable to HIV. However, despite the strong views expressed by sections of civil society the final NSP document did not go far enough. The plan acknowledges that sex workers are a vulnerable group in need of services and protection but it provides no guidance on how South Africa might progress towards the decriminalisation of sex work. The NSP only states that debate should continue until the issue is finally resolved.

Sources: Sections 10, 12, 14 and 27 of the Constitution of the Republic of South Africa; Hassim, A. 'The Cost of Rights: is there a legal right to transparent and efficient budgeting?' SECTION27 Review (2010 – 2011).



# A LONG WAIT FOR JUSTICE

By Sibongile Nkosi

In 2011 while Oscar Mabela, a former Treatment Action Campaign (TAC) employee, was conducting treatment literacy training at Dr C N Phatudi Hospital in Limpopo, he was approached by a mother and her daughter. The woman was worried about sores in her child's vagina.

Mabela asked if the daughter, Tsakane (not her real name)\*, could be tested for sexually-transmitted infections at the clinic. Nurses there discovered that she had been raped several times. Tsakane was then able to reveal that the rapist was her stepfather. Mabela referred both mother and daughter for counselling at ProGroup Foundation, an organisation that partners with TAC in Mopani.

Soon after, a charge of rape was laid against Tsakane's stepfather at the Tzaneen police station and he was arrested.

TAC Mopani decided to follow up on the case and mobilised the local community to do the same. It became a theme for the branch's door-to-door campaign. "This was a human rights issue and it was in our focus," says Cedric Nukeri, the TAC Mopani District Manager. The case was also a chance for TAC to advocate for a more effective justice system in the district.

On 18 February 2010 the accused appeared at Ritavi Magistrates Court, where he was refused bail. Around 100 TAC members picketed outside the court to support Tsakane and her mother but also to raise broader awareness about gender-based violence.

"We wanted justice and we wanted the perpetrator to get [the] maximum sentence. We are tired of...men that

rape our children [being] let off easily," says Jeniffer Milambo, the District Mobiliser for TAC Mopani.

The case was postponed until 15 June 2010, when TAC members picketing outside the court heard that Tsakane's attacker had received bail of R500.

Campaigners were concerned and contacted the media. Soon the case was all over local newspapers as well as on the radio. "The media is a powerful weapon to bring attention from those in power," notes Moses Makhomisane, Capacity Builder at TAC Mopani.

In November 2010 TAC held another picket outside the court. This time, more than 200 people gathered to demand that the magistrate withdraw the option of bail for the accused. But Tsakane's stepfather remained free on bail and the case was subsequently postponed numerous times.

In 2011, proceedings appeared to have reached a dead end. Milambo requested meetings to find out what was happening and wrote to the prosecutor pushing for the trial to continue.

Finally, on 1 March 2012 the magistrate ruled on the case. A group of TAC members wearing the organisation's familiar T shirts attended court proceedings and saw Tsakane's stepfather sentenced to 25 years in prison.

"Although we met with a lot of challenges...like getting permission for a picket, TAC did not pull out. We persisted in the fight against gender-based violence," remembers Milambo.

(\* Some details in this article have been changed to protect those involved.)



## Ana's story

*Due to domestic violence and unfaithfulness of my husband I decided to run away from my marital home of 16 years in Tembisa to look for freedom and some peace of mind. I was traumatised time and time again and although he said he would kill me and even though I reported him to the police, he was never arrested.*

*On Sunday 4 April I left my place in Tembisa with two kids and moved to Hillbrow to my close friend's place at a hotel. My friend explained how she earned a living at the hotel. I agreed to the idea to sell sex since there was no other alternative for me to earn a living at that moment in time.*

*Being a once-married woman, it was tough at first to work as a sex worker but after two weeks I made up my mind not to blame myself for what I was doing because surely I had to pay the bills and buy something to eat. I had to support myself.*

*The ...problem at the hotel is that the security guards and the management really abuse me and force me to have sex with them without paying like other clients. This really bothers me because if I don't agree they will chase me away at night and this means that my room will be given to another person. The police as well – they are a major threat since they continuously raid the hotel and upon arrest I have to pay a fine of R300. The police scare away clients and put my life at risk.*

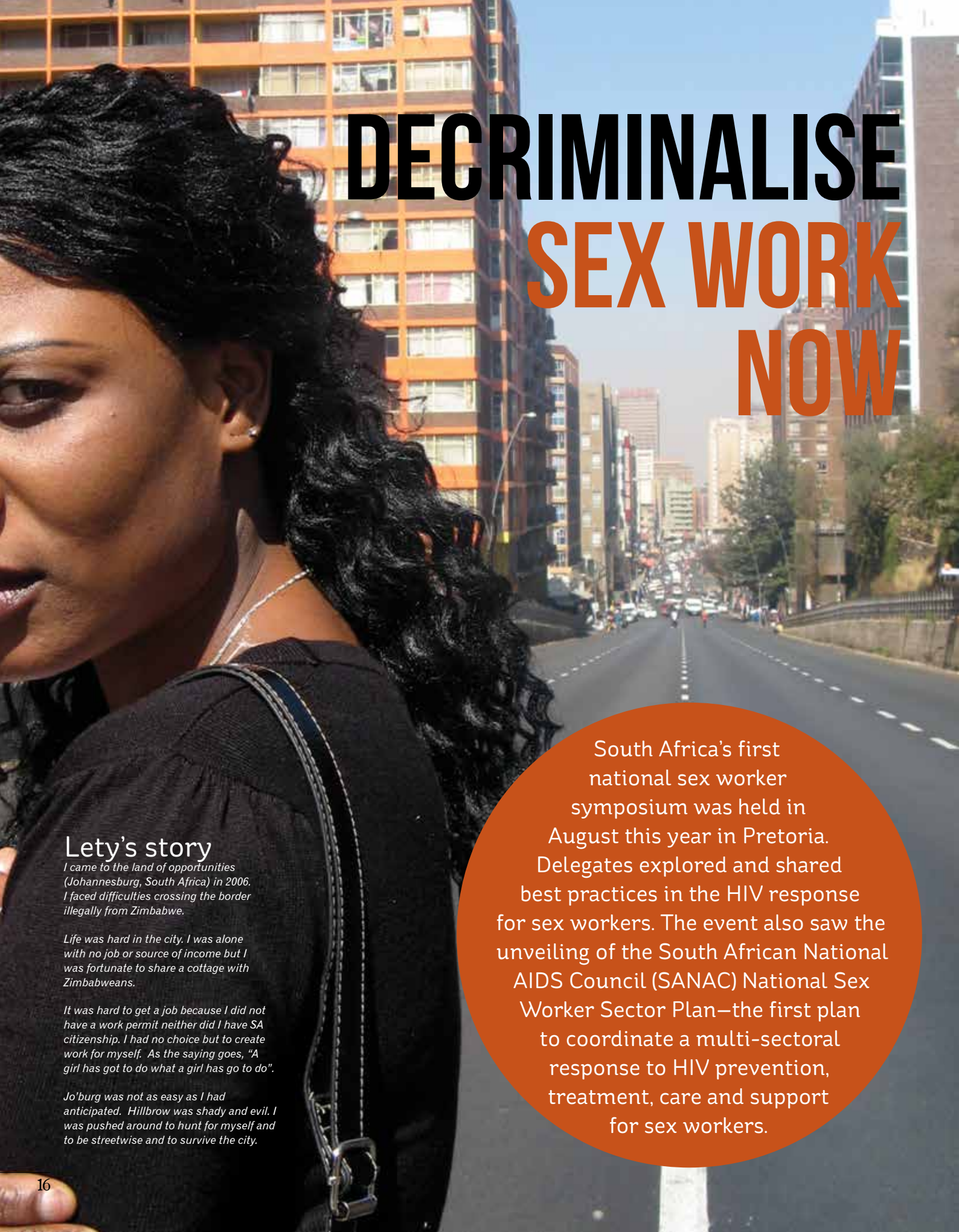


A dirty building where people sell their produce along Abel Street in order to earn a living. This image reflects the lack of adequate selling spaces for vendors in Hillbrow.



These are some of the beautiful places where parents go with their kids in Hillbrow. This actually reminds me of good moments with my kids.

These pictures and stories (including page 16) were taken by participants during a photo project titled, "Working the City: Experiences of Migrant Women in Inner-City Johannesburg". It was a collaboration with the Market Photo Workshop, Sisonke Sex Worker Movement, and the African Centre for Migration and Society at Wits University. For more information see <http://workingthecity.wordpress.com>.

A woman with dark, curly hair is shown from the chest up, looking back over her right shoulder towards the camera. She is wearing a dark top and a thin necklace. The background is a bright, sunny city street with tall buildings and a clear blue sky.

# DECRIMINALISE SEX WORK NOW

## Lety's story

*I came to the land of opportunities (Johannesburg, South Africa) in 2006. I faced difficulties crossing the border illegally from Zimbabwe.*

*Life was hard in the city. I was alone with no job or source of income but I was fortunate to share a cottage with Zimbabweans.*

*It was hard to get a job because I did not have a work permit neither did I have SA citizenship. I had no choice but to create work for myself. As the saying goes, "A girl has got to do what a girl has got to do".*

*Jo'burg was not as easy as I had anticipated. Hillbrow was shady and evil. I was pushed around to hunt for myself and to be streetwise and to survive the city.*

South Africa's first national sex worker symposium was held in August this year in Pretoria. Delegates explored and shared best practices in the HIV response for sex workers. The event also saw the unveiling of the South African National AIDS Council (SANAC) National Sex Worker Sector Plan—the first plan to coordinate a multi-sectoral response to HIV prevention, treatment, care and support for sex workers.

Rough estimates place the HIV prevalence rate among sex workers between 44% and 69% and suggest that one in five new HIV infections are related to sex work. Although the links between sex work and vulnerability to HIV have been recognised since the earliest days of the epidemic, surveys indicate that workers still lack adequate access to HIV prevention services. To date, South Africa's HIV response has devoted insufficient resources to addressing this problem.

The law compounds this failure by criminalising sex work. This pushes the industry underground, and facilitates the abuse of sex workers by police, clients and

pimps. Speaking at the symposium, the Deputy Minister of Police, Maggie Sotyu said, "The unnecessary use of force...by police is criminal," and noted that sex work should be recognised as work. "Freedom in 1994 is freedom for all," she observed. "You can't be harassed by police officers and say you are free."

Criminalisation also places a burden on the country's overstretched police services. Sex work activists argue that enforcing the laws that criminalise sex work absorbs significant resources that, given South Africa's high crime levels, would be better deployed elsewhere.

## STOP HARASSING US

A recent study by the Women's Legal Centre (WLC), Sisonke (a sex worker organisation) and the Sex Workers Education and Advocacy Taskforce (SWEAT) found that seven out of ten surveyed sex workers reported some form of abuse by police officials. Many experienced more than one violation.

The study, titled "Stop harassing us! Tackle real crime! A report on human rights violations by police against sex workers in South Africa", draws on interviews with 308 sex workers in Johannesburg, Cape Town, Durban, Pretoria and Limpopo Province. Its findings indicate that police may be the primary abusers of sex workers. Indeed, the researchers suggest that the existing legal framework encourages police corruption and abuse.

The study found:

- Nearly one in six workers who approached the WLC had been sexually or physically assaulted, and one in three harassed, by the police.
- Among the 45 percent of sex workers that had been arrested, more than 85 percent of arrests had been carried out by a police officer not wearing proper identification.
- Almost half of those who had been arrested were held beyond the 48-hour maximum permitted by law. Nearly 70 percent had been denied access to food or water whilst in detention.
- Just under half of all sex workers who were arrested and 40 percent of those who were fined, said that police did not follow the formal procedures required.

(NOTE: This study relies on a relatively small sample that might not be representative of the experience of all sex workers. Even so, the results are alarming and raise serious questions.)

The report outlined the following recommendations:

- Laws prohibiting the selling and buying of sex should be repealed to facilitate increased access to health and other social services. This would honour the international treaties that South Africa has signed and ratified protecting women against violence.
- The Commission for Gender Equality and the Human Rights Commission should investigate the human rights violations that sex workers endure. The state must be held accountable for its violations.
- Police commissioners should immediately issue directives prohibiting staff from harassing and arresting sex workers for ulterior purposes. Senior officers should enforce compliance with the Western Cape High Court interdict of 2009, which bans the arbitrary arrest of sex workers. (See <http://www.saflii.org/za/cases/ZAWCHC/2009/64.html> )
- Law enforcement leaders together with sex workers should establish guidelines for the conduct of police officers when interacting with sex workers, and establish mechanisms for dealing with unlawful conduct by police.
- Sex workers should receive services in the form of legal advice, legal representation and health care.

Sources: [www.sweat.org.za](http://www.sweat.org.za), [www.sanac.org.za](http://www.sanac.org.za)



# PEOPLE BEFORE PATENTS

## CHANGES TO SOUTH AFRICA'S PATENT LAWS ARE LONG OVERDUE

By Catherine Tomlinson

As it currently stands, South Africa's intellectual property (IP) legislation arguably fails to uphold our government's constitutional obligations to realise the right to health for its citizens. According to Section 27 of our constitution, government must take reasonable legislative and other measures to progressively achieve the right of access to health care services.

For over a decade, government has failed to uphold this constitutional duty. It has neglected to adopt many provisions and flexibilities that are allowed in the Agreement on Trade-Related Aspects of Intellectual Property Rights ('the TRIPS agreement') to protect health. Adopting these provisions into our national law falls within what the constitution means by 'reasonable legislative measures'. There can be no doubt that adopting these provisions would help South Africans to

progressively realise their right to health by dramatically increasing access to life-saving medicines.

However, recent moves by government indicate some willingness to remedy this failure. During 2011, the Department of Trade and Industry announced it was developing an IP policy for South Africa. The outcome of this process would be substantive amendments to South Africa's IP legislation.

Recognising a potentially significant opportunity to adopt pro-public health IP legislation in South Africa, the Treatment Action Campaign and Médecins Sans Frontières launched a campaign in November of 2011 calling on government to "Fix the Patent Laws". Specifically, TAC and MSF have proposed a number of amendments to South Africa's Patents Act 57 of 1978.

# WHAT IS A PATENT?

A patent is an exclusive right granted to a company or individual by government that protects that company or person's intellectual property. Patents are granted for new or inventive discoveries. However, what constitutes 'new' and 'inventive' can differ from country to country. Patents granted in one jurisdiction are often rejected in another.

During the period of patent protection, the patent holder is able to sell the patented product free of competition from other companies. Because of this, the company will generally keep the cost of its product extremely high in order to maximise profits. This practice can block access to life-saving medicines, by keeping the cost of these products artificially high.

## IP AND THE NSP

In drafting the current National Strategic Plan for HIV, STIs and TB 2012–2016 (NSP), civil society recognised the barrier that South Africa's patent laws would create to achieving the NSP targets.

Third-line ARVs, as well as many improved first- and second-line antiretroviral medicines remain under patent

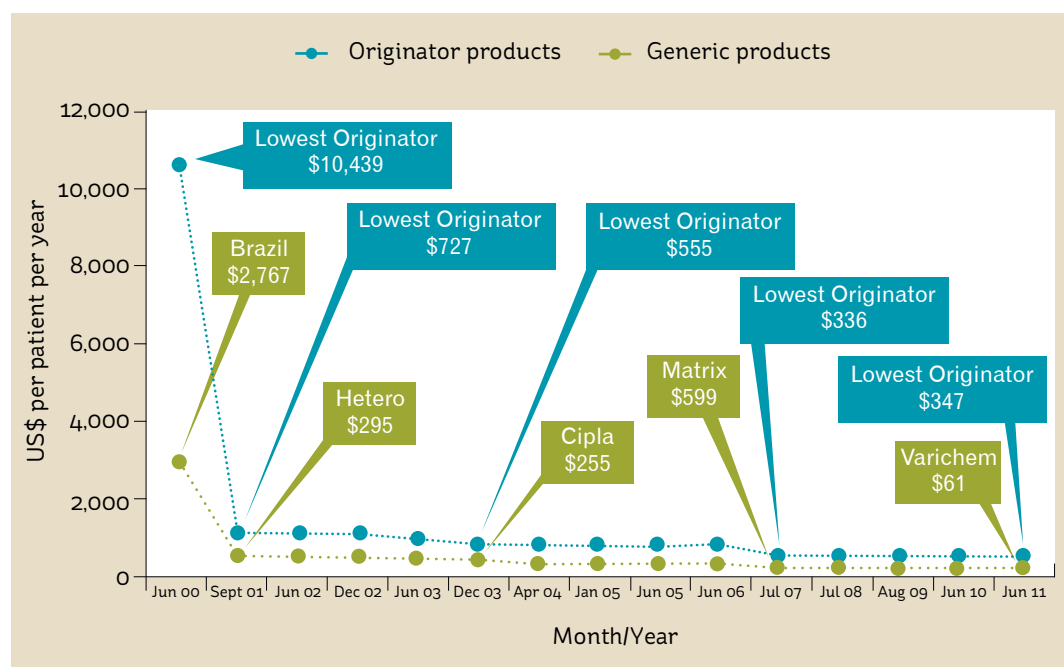
and are costly. Such drugs are therefore not provided through the public sector. Additionally, after decades without new TB medicines, innovative drugs now in the pipeline show significant potential for improved treatment of drug-resistant TB. It is essential that access to these new medicines is not blocked by patents.

In the final version of the NSP that was submitted to cabinet, SANAC had recommended reforming the Patents Act, "to the extent that various provisions – including but not limited to sections 4, 25, 56, 61 and 65 – may unconstitutionally limit access to medicines by providing patent protection in excess of what is required under international trade law, thereby preventing the market entry of generic competition necessary to bring medicine prices down and ensure sustainability of supply." This recommendation was originally included in the human rights section of the NSP.

However, a number of commitments on human rights, including amendments to the Patents Act, were removed by Cabinet. The plan was finalised without explicit commitments to reform our patent laws.

Nevertheless, reform remains critical to achieving the right to health in South Africa. The IP Policy for South Africa, developed by the Department of Trade and Industry, thus provides a critical opportunity to achieve pro-public health reform of South Africa's IP legislation.

## GENERIC COMPETITION AS A CATALYST FOR PRICE REDUCTIONS



The graph shows the drop in price of an antiretroviral first-line regimen, as a consequence of generic competition. In 2000, an antiretroviral regime consisting of stavudine (d4T), lamivudine (3TC) and nevirapine (NVP) cost over US\$10,000 per patient per year (more than R75,000). Today, generic versions of these medicines are widely available for under 1% of their original price (less than R1,000 per patient per year).

Adapted from a graphic produced by Médecins Sans Frontières

The fall in the price of first-line combination of stavudine (d4T), lamivudine (3TC), and nevirapine (NVP), since 2000.

# LIFE-SAVING LAW REFORM

TAC and MSF have identified a number of key amendments that South Africa should make to its intellectual property laws in order to fulfill the constitutional requirement to progressively realise the right of access to health care services. We will be pushing for these amendments in the current policy process. If unsuccessful we will consider taking the matter to court.

1

## Set stricter standards for granting patents

Patentability standards differ widely from country to country. So, for example, it is comparatively easy to secure a patent on a pharmaceutical product in the United States, while it is much more difficult in India.

These differences are consistent with international law. According to the TRIPS agreement, countries have considerable flexibility to set their own standards of patentability. This is because although countries must grant patents on products that are 'new' and 'involve an inventive step', they have the right to determine what is meant by 'new' and 'inventive step'.

A number of developing countries (including India, Argentina, Peru, Bolivia, Columbia and Ecuador) have used this flexibility to set high patentability standards. This is in part a recognition that the patent system should only grant exclusivity rights in return for meaningful innovation. It is also partly a response to abuse of the patent system through tactics such as evergreening.

Evergreening is a method by which pharmaceutical companies try to extend their market exclusivity on a product by patenting new versions of existing drugs. This is usually done by applying for 'new use' and 'new formulations' patents on existing medicines. A new use patent is an additional patent that is granted on an existing medicine found to be effective in treating a different illness than the one for which it was initially registered. A new formulation patent is an additional patent that is granted for making minor changes to an existing medicine or chemical entity.

**In order to curb evergreening, a number of countries now explicitly exclude 'new uses' and 'new formulations' of existing medicines from patentability in their national laws. South Africa should follow suit to prevent abuse by pharmaceutical companies. In this way we could ensure that patents are only granted on products which are truly 'new' and 'involve an inventive step'.**

2

## Require that all applications undergo examination to ensure that they meet patent standards

South Africa currently has what is called a depository patent system. This means that when someone applies for a patent the validity of that patent is not examined against the patentability criteria described in the previous section. As long as you fill in all the application forms correctly, pay the very low fee, and as long as your application appears to be credible, you will be granted a patent. This is different from the examination systems in most developed, and some developing countries. Under examination systems all patent applications are scrutinised and tested against the country's patentability criteria.

Because South Africa has both weak standards of patentability and no substantive examination of applications, the country grants an excessively high number of patents compared to other developing countries. For instance, South Africa granted 2,442 pharmaceutical patents in 2008 alone, while Brazil granted just 278 between 2003 and 2008. (Correa, 2011)

Furthermore, a recent study by the University of Pretoria found that if South Africa used the examination system 80% of existing patents would not have been granted. (Pouris, 2011)

Introducing an examination system in South Africa would dramatically reduce the number of weak or frivolous patents. This would make for an altogether more robust patent system. In addition, far from being costly, examination systems typically provide a source of income for government in the form of patent examination fees.

**South Africa should review its system for granting patents. A proper examination system will ensure that patents are only granted for real innovations, thus considerably reducing the number of patents granted. Examination can be phased in, focusing initially on applications that have an impact on public interest.**

### 3 Allow for opposition to patents by third parties

In addition to granting patents without examination, the Patents Act currently contains no provisions for third parties, such as civil society organisations or manufacturers of generic drugs, to oppose patent applications or to appeal against existing patents through an administrative process.

As a result of this shortcoming, the only way to challenge a patent in South Africa is through lengthy and expensive court proceedings. This severely limits who is able to challenge patents. As a result many patents of poor quality simply go unchallenged.

Hand-in-hand with a patent review system, South Africa could also set up a system of procedures for patent opposition. This would allow anyone to oppose an application simply by submitting evidence to the patents office about why the patent should not be granted. Botswana recently amended their laws to allow opposition to patent applications. Currently, India allows opposition while a patent is pending and for one year after it is granted.

Indian activists have successfully used these procedures to oppose a number of low quality patents on medicines, including paediatric formulations and fixed-dose combinations of antiretroviral medicines.

**South Africa should amend its Patents Act to allow for both pre- and post-grant opposition of patent applications. This should be coupled with disclosure requirements to allow third parties to monitor patents that are pending or granted.**

### 4 Amend the grounds and procedure for granting compulsory licenses

The fundamental aim of the patent system is to serve the public interest by encouraging innovation. However, as all major patent systems since the late 1800s recognise, it is essential to build into the patent system mechanisms that can balance public interest against the business needs of patent holders.

The most important of these balancing mechanisms is a compulsory license. Essentially, most legal systems set up terms and procedures that allow for a patent to be overridden in the public interest. So for example, if a life-saving medicine is prohibitively expensive, the state could step in and allow generic manufacturers to make the medicine at a lower cost.

South Africa's Patents Act does technically provide for compulsory licenses. However the terms and procedures for granting these licenses are overly restrictive and do not utilise flexibilities in international law. It is thus not surprising that South Africa has never issued a compulsory license on a pharmaceutical medicine. A number of other developing countries have streamlined their intellectual property legislation and utilised compulsory licenses to improve access to affordable medicines.

Even though it is allowed under international law, South Africa's Patents Act does not explicitly provide for compulsory licenses to protect health or in cases when the cost of medicines is too high. Also, the procedure and conditions for issuing a compulsory license in South Africa are unclear and overly complicated. Applications can only be made through expensive and time-consuming legal procedures. Also, critical issues such as timelines and royalty rates remain unclear in our laws.

**South Africa should amend its laws to allow for compulsory licenses to protect health. It should also establish a simple, swift administrative procedure with clear guidance for granting compulsory licenses.**

See the website  
[www.fixthepatentlaws.org](http://www.fixthepatentlaws.org)  
for updates on the  
policy process and the  
Fix the Patent Laws  
campaign.

*Catherine Tomlinson is a senior researcher  
with the Treatment Action Campaign.*

Sources: Correa C. 'Pharmaceutical Innovation, Incremental Patenting and Compulsory Licensing', Research paper 41, South Centre (2011); Pouris A, Pouris A. 'Patents and economic development in South Africa: Managing intellectual property rights', S Afr J Sci.;107(11/12), Art. #355, 10 pages (2011), <http://www.sajs.co.za/index.php/SAJS/article/view/355>.



Photo by Zackie Achmat, courtesy of Treatment Action Campaign Archive

# TEN YEARS SINCE THE TAC CASE

## A JUDGMENT THAT SAVED A MILLION LIVES

By Brian Honermann and Mark Heywood

“The magnitude of the HIV/AIDS challenge facing the country calls for a concerted, co-ordinated and co-operative national effort in which government in each of its three spheres and the panoply of resources and skills of civil society are marshalled, inspired and led. This can only be achieved if there is proper communication, especially by government.”

On 5 July 2002, 10 years ago this year, the Constitutional Court delivered the words on the left as part of its judgment in *Minister of Health and Others v Treatment Action Campaign and Others* (the TAC Case). After a bitter political dispute between TAC and the government it upheld the constitutional right of all HIV positive pregnant women to access health care services to prevent mother to child transmission of HIV (PMTCT).

This decision came despite the best efforts of former President Thabo Mbeki and then Health Minister Dr Manto Tshabalala-Msimang. It came despite lackey

Health MECs, such as Sibongile Manana and later Peggy Nkonyeni, trying to use their gate control over Provincial hospitals and clinics trying to deny and delay access to such services in the public health system.

Thanks must go to young women with HIV like Sarah Hlahlele and Charlene Wilson, who literally gave up their lives in this struggle. We must also acknowledge brave doctors such as Haroon Saloojee, Ashraf Coovadia and Keith Bolton who formed an organisation called Save Our Babies to take the issue to Court.

The TAC decision ushered in a new era in the response to HIV in South Africa and the world. Before this, the doors to HIV care and treatment had been closed. Immediately after the decision, health workers able to deliver the antiretroviral (ARV) Nevirapine in the public health care system were freed to do so.

By April 2003, the Department of Health was including PMTCT programmes in their budgets. In November that year Cabinet resistance to a national ARV programme was broken. By April 2004, the public health system began rolling out treatment to people with HIV.

Now, according to recent estimates by actuary Leigh Johnson and others, in the 10 years since this decision, 327,000 children have not contracted HIV as a result of having access to PMTCT because of the TAC case.

HIV care and treatment has come a long way in the past decade. In 2002, an HIV positive mother would pass on HIV to her baby about 30% of the time. With access to Nevirapine the transmission rate was cut in half. Now, with better drug regimens being used, transmission of HIV from mothers to babies happens in only about 3% of cases during or shortly after birth. The latest National Strategic Plan (2012-2016) aims to reduce this rate to below 2% by 2016. At the same time, we're now treating nearly 2 million people with ARVs.

It's not often that we are able to quantify the effect of a judgment—even one of this import. It's not often that a court has the opportunity to order the government to open the barriers to public health interventions and 10 years on, it's possible to calculate what this judgment has meant for the people who have benefited from its wise ruling.

**It is not clear how much government has learned from this decision.**

Currently, the Department of Justice and Constitutional Development (DoJCD) is carrying out an assessment of the decisions of the Constitutional Court and the Supreme Court of Appeal in order to—in the words of the DoJCD's Terms of Reference—"assess the evolving

jurisprudence on socio-economic rights with a view to establishing its impact on eradicating inequality and poverty and enhancing human dignity."

Many people have expressed fear about this 'assessment', particularly in the context of statements attacking the constitution from senior ANC leaders such as Ngoako Ramathlodi. This is perhaps not surprising: at the time of judgment in the TAC case Ramathlodi was one of Mbeki's trusted lieutenants and the Premier of Limpopo, a province that played its part in denying women access to medicines.

Civil society, on the other hand, has grown wiser. We have learned the limits of what any judgment from any court is able to accomplish when that judgment is not backed by a movement dedicated to ensuring that its rights and the rights of others are upheld. Despite the fact that the Constitutional Court provided the mechanism by which HIV care and treatment were legally able to gain entry to the public health system in the country, it has been the work of civil society, health workers, and the dedication to make resources available for HIV treatment that have ensured that the judgment did not remain mere words on paper.

Unfortunately, despite the possibility demonstrated by the TAC case, access to courts for the poor and pro-poor organisations remains restricted by the lack of resources directed to providing public legal services. This results in a jurisprudence that is primarily shaped by the disputes of the wealthy. While such cases are legitimate and may form good constitutional law—the cases are not generally designed to promote the realisation of socio-economic rights and equality put forward by the constitution. Nor are they backed by the movements necessary to give life to the judgments.

The TAC case has shown us that it is not the Constitutional Court that has stood in the way of "eradicating inequality and poverty and enhancing human dignity". What is really needed to fulfill this noble mission is respect for the rule of law, an active civil society addressing more than just health care, effectively resourced pro-poor legal organisations, and a government willing to put the constitution at the forefront of all policymaking decisions.

*Mark Heywood is executive director of SECTION27. Brian Honermann is a former researcher at the AIDS Law Project.*

Civil society, health workers and the dedication to make resources available for HIV treatment have ensured the judgment did not remain mere words on paper

# HIV & THE LAW

## IS SOUTH AFRICA IMPLEMENTING THE RECOMMENDATIONS OF A MAJOR UNITED NATIONS REPORT?

By Metumo Shilongo

“The law alone cannot stop AIDS. Nor can the law alone be blamed when the HIV responses are inadequate. But the legal environment can play a powerful role in the well-being of people living with HIV and those vulnerable to HIV.”

The law plays a major role in South Africa's response to social problems, including how we deal with the HIV epidemic. As well as enabling access to tangible goods like life-saving treatment the law can also facilitate access to less tangible social goods like an environment in which the dignity of people with HIV is protected.

But the law can also harm those affected by HIV. It can criminalise an intimate part of their lives, creating fear and stigma, which in turn obstruct access to treatment. Laws can also perpetuate power imbalances and social customs that make people more vulnerable to HIV infection.

### What is the **Global Commission** on HIV and the Law?

The United Nations Development Programme's Global Commission on HIV and the Law ('the commission') is an independent body made up of leading experts and advocates in HIV, public health, law and development. South African Constitutional Court Judge Justice Edwin Cameron is a former commissioner. Jonathan Berger, formerly of SECTION27, is part of a technical task team that supports the commission's work.

### A **landmark** report

The commission recently published a flagship report titled *"HIV and the Law: Risks, Rights & Health"*, which aims to understand how the legal environment can affect a country's response to HIV. The publication makes recommendations in several areas that we will discuss in this article.

The report is a valuable instrument in our fight against HIV. It gives South Africa an opportunity to measure its own response to HIV against the best-practice identified in the document. More specifically, we can use this report to decide whether our National Strategic Plan on HIV, STIs and TB 2012-2016 (NSP) meets requirements when it comes to HIV and the law. As we will see below, in some respects we are doing well, and in others we are lagging behind.



Photo by Legogang Mokwela, courtesy of the Treatment Action Campaign Archive

## DISCRIMINATION

Discrimination and stigma remain significant barriers to a truly effective HIV response. Yet over 123 countries have legislation that prohibits HIV-based discrimination and makes provision for protecting people who are vulnerable to the disease. South Africa is one of these countries. Our laws and policies are pretty strong on fighting discrimination, but their implementation is weak. A combination of bigotry, inadequate resources and a lack of political will lie behind this problem.

The commission recommends several ways to combat discrimination, calling on countries to create legal environments that protect and promote human rights and access to justice. The report urges nations to explicitly outlaw discrimination on the basis of HIV status. Countries are encouraged to guarantee legal

protection for people with HIV as well as for key populations (see below). Furthermore, the authors appeal to civil society, the private sector and the international community to hold governments to account for their commitments to human rights.

The mood of these recommendations is echoed in the NSP's Strategic Objective 4 (SO4). The NSP recognises that discrimination and stigma can undermine South Africa's response to HIV. The plan calls on government as well as private partners to put in place mechanisms to prevent discrimination. Where discrimination does occur, the NSP requires us to ensure access to justice for those whose rights are infringed.

Sources: Global Commission on HIV and the Law, 'Risks, Rights and Health' (2012), <http://www.hivlawcommission.org/index.php/report>; Section 6(1) of the Employment Equity Act, 55 of 1998 and Section 34(1) of the Promotion of Equality and Prevention of Unfair Discrimination Act, 4 of 2000; S v Nyalungu 2005 JOL 13254 (T) and South African Law Reform Commission, Project 85, 'Fifth Interim Report of certain aspects of the law relating to AIDS' (2001).

# CRIMINALISATION OF HIV TRANSMISSION, EXPOSURE AND NON-DISCLOSURE

Chapter 2 of the report deals with the thorny issue of criminalising HIV transmission, exposure and non-disclosure. In more than 60 countries it is still a crime—under either HIV-specific statutes or general criminal laws—to expose a person to HIV or to transmit the virus. South African law does not specifically criminalise deliberate transmission, exposure or non-disclosure of HIV between two consenting adults in a sexual relationship. However, in principle such behaviour falls under the scope of common law crimes that range from attempted murder to assault.

The report argues that applying such laws to HIV exposure is counterproductive. Firstly, criminal sanctions discourage people from getting testing or treated for HIV. If people know that they could be punished for exposing others to the virus, they might choose not to investigate their HIV status. Of course, the irony is that an HIV-positive person on effective treatment poses a lower transmission risk than someone who has not been diagnosed.

Secondly, there are many practical difficulties in applying these laws. For example, the near-impossibility of proving the source of an HIV infection means that criminal sanctions often focus on exposure to HIV. The end result is that laws tend to punish people for merely having sex if there is a risk of transmission.

Finally, criminalisation also tends to punish vulnerable populations—HIV-positive women in particular—who may lack

the power to negotiate safer sex. Such laws foster a destructive view that some people with HIV deserve punishment while others deserve public sympathy and treatment.

The commission proposes limiting criminalisation to the rare instances in which a person maliciously and intentionally exposes another individual with the deliberate goal of causing harm. The commission recommends the repeal of laws that explicitly criminalise HIV transmission, exposure or failure to disclose HIV status.

The NSP does not address criminalisation directly. However, the call for criminalisation remains an issue in South Africa. In fact, politicians like the Democratic Alliance leader Hellen Zille have argued in favour of criminalisation, sparking a fierce debate in the media.

Also, certain principles of South African criminal law could be used to criminalise HIV transmission or exposure, even in cases where there is no malicious intent. While there have been very few successful prosecutions of such cases, this by no means reflects government policy. South Africa needs to adopt a clear position on the criminalisation of HIV transmission that acknowledges how counterproductive a specific criminal law can be for our HIV response.

## KEY POPULATIONS

In the report, 'key populations' refers to groups of people who are at a particularly high risk of HIV infection, such as sex workers, migrants, and lesbian, gay, bisexual and transgender (LGBT) individuals. The commission recognises that these populations face stigma and discrimination, often at the hands of state agents. These violations can leave people even more vulnerable to HIV while also acting as barriers to treatment. Some countries further compound the problem by treating key populations as criminals.

The commission calls for an end to police brutality against key populations and for support programmes to reduce the stigma and discrimination that they suffer. The authors also recommend an approach to key populations that focuses on public health as opposed to punitive criminal law. This would allow access to health services for drug users; sex workers and their clients; men who have sex with men; transgender persons; prisoners and migrants. In addition, the report recommends that migrants receive the same health services as citizens.

The NSP recognises the plight of key populations and tailors interventions for each strategic objective to their needs. The UNDP report however goes further. While the NSP is at best ambiguous about criminalising certain groups, for example sex workers and drug users, the report calls for the decriminalisation of these key populations. It points out that criminalisation is incompatible with a public health and human rights approach to dealing with HIV.



## WOMEN AND GIRLS

HIV disproportionately affects women and girls. In Africa, females make up 60% of the HIV-positive population. Many of these women are denied property rights or subjected to violence, forced abortion and sterilisations. Furthermore, traditional customs often perpetuate the oppression of women and increase HIV risk through practices such as female genital mutilation and widow inheritance.

The commission recommends that states prohibit all forms of violence against women and ban cultural practices that make them more vulnerable to HIV. The report also calls for all women and girls to have access to sexual and reproductive health services.

These recommendations are in line with the NSP. In Strategic Objective 1, the NSP identifies gender inequality as one of the social factors that fuel the HIV epidemic. Sub-objective 1.3 specifically deals with interventions to address gender inequities and gender-based violence.

## INTELLECTUAL PROPERTY LAW AND THE GLOBAL FIGHT FOR TREATMENT

The commission found that a growing body of international trade law and intellectual property (IP) protections is limiting the production of low-cost generic drugs. This bottleneck restricts access to HIV treatment and other life-saving drugs.

The report concludes that current laws do not promote the access and innovation that serve the medical needs of the poor. The authors encourage countries to make full use of existing flexibilities in international law to advance access to medicines. Despite our high disease burden South Africa has failed to use the most important of these flexibilities.

Some drafts of the NSP contained specific commitments to reforming South Africa's intellectual property laws in line with the commission's recommendations. However, at the last moment these commitments were cut from the document. Even though the current NSP does not mention reform of these laws, a policy process is now underway that may lead to changes in South Africa's IP laws. (Read more about that policy process on page 18.)

## CHILDREN AND YOUTH

The commission recognises that although children are vulnerable, they can also be powerful agents for change in the fight against HIV and stigma. However, the authors found that governments continue to ignore the reality of the lives—and sexual lives—of young people. This is certainly true in South Africa.

Many children, especially girls, are left to run households at the expense of their education. This harms their economic prospects and compounds their vulnerability to HIV. The authors recommend that countries take measures to reduce harm to young people, ensure access to age-appropriate sex education, and offer them comprehensive reproductive and HIV services. To do this would curb the rates of HIV and other sexually-transmitted infections (STIs).

SO1 of the NSP recognises the vulnerability of young people to HIV infection and commits to tackling the conditions that give rise to it. The NSP however does little to address the controversial reality that many young people are sexually active but lack the knowledge or means to protect themselves from HIV. The plan also says nothing about the problematic aspect of criminalising sex between young people.

## Why the report **matters**

1. The report draws on a wide range of practices from many countries. It thus reflects a wealth of experience about what works and what doesn't.
2. Thanks to the independence of the commission, its report offers a frank assessment of various HIV responses. The document is free of political concerns and therefore makes bold recommendations. A few contrasts with the NSP make this clear. For example, it is evident that the decriminalisation of key populations is the only policy consistent with a public health approach to HIV. The NSP is alive to this fact. Yet, South Africa's plan falls short of calling for the decriminalisation of sex work. Instead, it deflects the issue, calling for 'continued public deliberation'.
3. The document can serve as a neutral reference point on some of the more difficult topics. Where the NSP is silent on critical issues such as intellectual property law or the criminalisation of HIV transmission or exposure, the report can be used to put these concerns back on South Africa's HIV agenda.
4. Because the NSP had to narrow its focus in order to function as a strategic plan, its content is necessarily limited. The report's wider perspective can thus serve as a useful complement to the NSP.

*Metumo Shilongo is a researcher with SECTION27.*

# NO JUSTICE FOR SEVEN-YEAR-OLD

By Simonia Mashangoane

The Treatment Action Campaign (TAC) in Volksrust, a small town in Pixley Ka Seme Municipality in Mpumalanga Province, has campaigned against sexual violence for many years. TAC members have worked hard to ensure that this gross violation of human rights is taken seriously by the justice system.

In February 2010 a Volksrust man was arrested for allegedly raping his neighbour's seven-year-old son. The accused lured the victim into his back yard with the promise of sweets and chips and then allegedly raped the boy. The victim told his grandmother what had happened to him. She took him to hospital where medical staff confirmed that the child had been raped.

Siphesihle Shabangu, a Community Health Advocate (CHA) from TAC was alerted to this violation by the victim's mother. Shabangu helped her to open a case and have the alleged rapist arrested. In the process it emerged that the accused had been recently released from prison after serving time for a similar crime.

In July 2010 during his bail hearing TAC branch members picketed outside court demanding that the man be denied bail. A memorandum outlining the reasons for opposing bail was handed to the prosecutor in charge of the case. The memorandum stated, "The interests of justice will be prejudiced if the accused is granted bail as we believe that [he] has a propensity to commit the crime with which he is charged and also that he might intimidate and threaten the witness and the complainant".

The TAC branch began to mobilise and educate the local community about the problem of sexual violence. The CHA became involved with the Community Policing Forum to enable the two organisations to work together on such cases.

In October 2011 to her surprise the CHA ran into the accused on the street. Neither she nor the victim's family knew why he had been released.

Shabangu accompanied the boy's mother to a meeting with the case investigator, who notified them that due to a lack of evidence the charges against the accused had been dropped. This angered TAC members who wrote to the prosecutor in charge of the case seeking clarification. Their letters went unanswered.

Meanwhile, the accused had allegedly been intimidating and threatening the victim whenever he saw him. As a result the child's mother sent him to live with his grandmother on the other side of the township.

Shabangu points out, "What's worrying...is that this was not the first offence of the accused. The case has been ongoing since February 2010 and to this day the accused is still free while the victim has to live his life in fear." She notes an upswing in reports of rape in the Volksrust area and says that not enough is done to protect victims and their families.

The local branch of TAC continues to pursue the case and advocate against sexual violence. They now also work with organisations assisting orphaned and vulnerable children. Shabangu remains active in the CPF, to which she reports all rape cases. Together, TAC and the CPF monitor these cases and carry out door-to-door campaigns to help community members deal with the problem of sexual violence.



Photo by Simonia Mashangoane

# AL JAZEERA: HIV-POSITIVE WORKERS NOT WELCOME HERE

Foreigners make up 94% of the workforce in Qatar. Yet they have few rights.

## The state of Qatar discriminates against HIV-positive people

Qatar is one of only five countries which deny visas to foreign nationals based on HIV status. If a foreign national is found to have HIV after he or she has already entered Qatar, the Minister of the Interior is empowered to order the deportation of that person. If deportation is not immediately possible, the Minister of the Interior is allowed to detain the foreign national pending deportation. This means that all HIV-positive people will effectively be barred from attending and participating in the 2022 FIFA Soccer World Cup to be held in Qatar, and COP18 to be held at the end of this year.

## Al Jazeera humiliates and fires HIV-positive employees

"MR" is a senior journalist from South Africa and former leader in the struggle for South Africa's freedom. He accepted a job as a Senior Editor with Al Jazeera in October 2010 and relocated to Doha, Qatar. He was subjected to HIV testing without his informed consent and was not informed of the results of the HIV test, nor offered counselling or support services. However, others were informed of his test results.

MR was detained and deported solely as a result of his HIV status and Al Jazeera was actively complicit in the detention and deportation of MR. During his detention he was subjected to severe breaches of his privacy and cruel, inhuman and degrading treatment. Al Jazeera also terminated his contract of employment solely as a result

of his HIV status and no accommodation was made to allow MR to work from outside Qatar. However, an employee who was appointed to MR's position after his dismissal was allowed to perform his duties from London.

This case has importance beyond MR. Foreign workers make up 94% of the workforce in Qatar. Yet they have few rights and are often treated abysmally. This case is an opportunity to shine a light on and change this unacceptable situation. The International Trade Union Confederation (ITUC), representing tens of millions of trade unionists worldwide, has demanded MR's reinstatement, but Al Jazeera refuses to even apologise or admit that it is at fault.

## Link between Al Jazeera and the Qatari Government

Al Jazeera is owned by the Qatari government through the Qatar Media Corporation. Despite this close link, Al Jazeera has delivered high-quality journalism and received critical acclaim for their coverage of the Arab Spring uprisings. But there is still no democracy in Qatar.

Much of Al Jazeera's success has been ascribed to the leadership of Wadah Khanfar. In 2011, Khanfar was replaced at the head of Al Jazeera by Sheikh Ahmed bin Jassim al Thani, a member of Qatar's ruling dynasty. It is feared that this appointment may signal an attempt by the state to exert greater control over the network. Al Jazeera has also been criticized for failing to turn the spotlight on human rights abuses within Qatar itself—or as in the case of MR, within Al Jazeera itself.

## WE DEMAND

that Al Jazeera offers a public apology for the violations of MR's rights and of the rights of all others victimised by Al Jazeera because of their HIV status.

**UNAIDS, the WHO and the ILO must publicly condemn and work to end employment-related HIV testing in Qatar and other countries.**

**Major international events like the 2022 FIFA World Cup and COP 2012 must be taken away from Qatar and should instead be held in countries that respect the human rights of HIV-positive people.**

# DID YOU KNOW

## MEDICAL CIRCUMCISION **REDUCES** A MAN'S RISK **OF GETTING HIV**



But you still have to use a condom.  
There is still a risk of getting HIV even if you are circumcised.

### DO NOT USE



### THE TARA KLAMP

Circumcision also reduces the risk of a man getting the human papillomavirus which can cause throat cancer. If a man transmits this virus to a woman, she is at greater risk of developing cervical cancer.

### **MOST MEN REPORT BEING HAPPY WITH THEIR CIRCUMCISIONS.**

Some KZN clinics and hospitals are offering circumcisions.

If you have a circumcision, demand that it be done surgically. Some hospitals are using a dangerous device called the Tara KLamp. A study showed that this device can cause unnecessary complications and is much more painful than a standard circumcision. Say no to the clamp.

**If you are a sexually active heterosexual male over the age of 18 we recommend that you have a circumcision, but no-one can force you to have this surgery.**