

LEGAL AND HUMAN RIGHTS RESPONSES TO THE HIV/AIDS EPIDEMIC

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1 The challenge of AIDS and the role of the law in responding to it

South Africa is experiencing an HIV/AIDS epidemic of devastating proportions. Responsible estimates put the number of South Africans living with HIV or AIDS at between 5.7 million and 6.7 million – the mid-point estimate is 6.29 million.¹ In July 2002 the Constitutional Court opened its judgment in the case the Treatment Action Campaign (“TAC”)² brought to oblige government to institute a national programme to prevent mother-to-child transmission of HIV with a deliberately dramatic statement:

“The HIV/AIDS pandemic in South Africa has been described as ‘an incomprehensible calamity’ and ‘the most important challenge facing South Africa since the birth of our new democracy’ and government’s fight against ‘this scourge’ as ‘a top priority’. It ‘has claimed millions of lives, inflicting pain and grief, causing fear and uncertainty, and threatening the economy’. These are not the words of alarmists but are taken from a Department of Health publication in 2000 and a ministerial foreword to an earlier departmental publication.”³

Tellingly, the Court used its power to order the government to respond properly and effectively within its means to the challenges its own documents had so starkly outlined: its very order instanced the role that the law and legal institutions can play in responding to the crisis.⁴ The interposition of judicial power in the epidemic could be seen as the high point of nearly a decade of jurisprudential development, and came against a background of intense legal and popular activism directed at

achieving equality, non-discrimination and dignity for people living with HIV/AIDS. The Constitutional Court's order in the TAC case thus represented the culmination of a campaign to create a framework within the law for dealing rationally, fairly and effectively with the epidemic.

More generally, the law's response to HIV/AIDS involves critical questions about the nature of South African society. In the negotiations that led in 1994 to the adoption of a Constitution, South Africans chose to embody their democratic aspirations within a framework of legal regulation – at just the time when the epidemic was beginning to take its fearsome hold on the population. Legal values and human rights, as enshrined in the Bill of Rights, became the touchstone of the country's values. The Constitution explicitly committed all institutions to the foundational values of human dignity, the achievement of equality and the advancement of human rights and freedoms, non-racialism and non-sexism, and the supremacy of the Constitution and the rule of law.⁵

One of the questions is whether the law has fulfilled these high promises in relation to the HIV/AIDS epidemic. What role has the law played in practical management of the epidemic? What light does the law's response to HIV/AIDS cast more generally on South Africa's attempts to grapple with the problem? And what do the limitations of the law tell us about our failings in dealing effectively with HIV/AIDS and other social problems? It is these questions I examine in this paper.

2 The context of the law's response in South Africa

From the early 1990s South African lawyers started to focus attention on the possible impact of the disease on our society and the challenge the spread of the epidemic posed for our legal system and our legal values.⁶ Medical science lacks a means to cure HIV infection or any simple way to stop the spread of the virus.⁷ It was widely accepted, however, that the law would necessarily play an important role in attempting to curb the epidemic and to diminish its effects.⁸

Initially many in South Africa demanded that the law be employed to isolate and quarantine persons with HIV and for making AIDS compulsorily notifiable.⁹ Under

apartheid, in line with approaches elsewhere, the government introduced coercive measures for HIV and AIDS. The Regulations relating to Communicable Diseases and the Notification of Notifiable Medical Conditions promulgated in 1987¹⁰ under the previous Health Act 63 of 1977 contained various measures aimed at certain “communicable diseases”. The wide definition of “communicable disease” in section 1 of the Health Act clearly encompassed HIV infection.¹¹ In addition, the Regulations provided for specific coercive measures that were to be applied *mandatorily* to expressly listed communicable diseases. With semantic imprecision, the regulations listed AIDS (which is not communicable), but not HIV (which is).¹² The measures (whether they had to be applied in the discretion of the health authorities or mandatorily) when read to include HIV infection encompassed the following:¹³ authority, under certain circumstances,¹⁴ to close teaching institutions and restrict attendance at them;¹⁵ to prohibit the holding of or attendance of meetings or public gatherings;¹⁶ to place under quarantine any person “suffering” or “suspected to be suffering” from HIV infection;¹⁷ to examine medically persons with HIV or suspected to have HIV;¹⁸ to remove persons with HIV to a hospital or other place of isolation so as to remain there under medical supervision for a period determined in the removal order;¹⁹ to order that a person with HIV not prepare any food, or handle any food or water intended for other persons, or handle a container for such food or water;²⁰ and, in the case of a pupil with AIDS, not to allow such pupil to enter a teaching institution except on the strength of a certificate of admission issued by the health authorities.²¹

The Regulations had more bark than bit. It seems they were never applied in respect of HIV or AIDS. They were widely criticised in that many of the measures provided for were totally inappropriate to HIV and AIDS.²² Technically they are however still in force – even though in 1993 draft Regulations intended to replace them were published (these would to a large measure have dealt with the criticism);²³ and even though the South African Law Reform Commission recommended in 1997 that the uncertainty as regards their potential application to HIV/AIDS be cleared up.²⁴ The new National Health Act, 61 of 2003, which came into operation on 2 May 2005, has not yet alleviated this situation since the commencement date of the provisions repealing the sections of the previous Health Act under which the 1987 Regulations were promulgated, has not yet been proclaimed.²⁵

Presumably any regulations dealing with communicable diseases that may be promulgated under the new Act will deal with this uncertainty.²⁶

Also in 1987, the previous government issued Regulations rendering persons with AIDS and HIV “prohibited persons” in terms of the Admission of Persons to the Republic Regulation Act 59 of 1972.²⁷ These were however abandoned when the Aliens Control Act 96 of 1991 came into force.²⁸ The Immigration Act 13 of 2002, which replaced the Aliens Control Act, did not alter the position.

3 A human rights premise

South African lawyers examining the legislative options in addressing HIV/AIDS in the early 1990s warned of the threat that pressure for coercive measures posed to individual rights.²⁹ It was argued that those diagnosed with HIV or AIDS already faced not only physical debilitation and death but severe discrimination: the denial, blame, stigmatisation, prejudice and discrimination that fear of AIDS evokes have been found – and continue to be found – in virtually every society affected by the virus.³⁰

This debate was not unique since at that stage the legal profession world-wide was trying to deal with the impact of HIV/AIDS not only on affected individuals and their relationships with others, but also on society and relations between countries. Several countries were involved in adapting their laws to deal with HIV/AIDS.³¹ What accentuated the debate in South Africa was that a mass heterosexual epidemic was emerging as the country was emerging from a past fractured by racial subordination and injustice.

On the foreground were questions framed as involving the extent to which the community is entitled to protect itself at the expense of the rights of the individual.³² This collective/individual tension becomes acute in the management of diseases where the source of contagion and mode of transmission involve human behaviour. Abstract logic seems to suggest that the risk posed to the community by an epidemic transmitted by individual human action is best countered by isolating or removing individuals whose infection is known to pose a risk to others. Traditional public

health approaches to disease prevention have operated on this premise.³³ The fact that AIDS is incurable, together with early uncertainty about its exact modes of transmission, led some governments to apply the traditional approach of infectious disease control – thus enacting or applying various coercive or punitive efforts to deter infected persons from transmitting the virus to others.³⁴ In invoking the coercive force of the law, direct and indirect coercive measures were called upon.³⁵ These laws included mandatory screening of men having sex with men, sex workers, injecting drug users, foreigners, and others from perceived “risk groups”; isolation, quarantine, compulsory treatment or medical examination of persons with HIV; limitations on international travel; classification of HIV/AIDS as a special or dangerous disease requiring differential treatment; and the requirement that AIDS be listed on death certificates.³⁶

There are however features of HIV/AIDS that distinguish it sharply from other diseases:³⁷

- (i) HIV cannot be transmitted through casual contact.
- (ii) Its major mode of transmission is human sexual behaviour (possibly the most private of human activities).
- (iii) However, only invasive sexual activities (mainly penetrative intercourse) embody a high risk of transmission.
- (iv) HIV infection cannot at present be eliminated (though successful anti-retroviral treatment does reduce infectivity).
- (v) Considerable social stigma still attaches to HIV infection, with the consequence that those unsure about or ignorant of their HIV status often deny or ignore potentially risky behaviour as they have no incentive to ascertain or disclose their HIV status.
- (vi) Unlike many other infectious diseases, which manifest early and have a catastrophic progression, AIDS may take a decade or longer to develop.

These features challenged the traditional coercive approaches. A cogent consideration against the traditional public health model was that HIV prevention and care programmes based on coercive measures resulted in reduced public participation and increased alienation of those at risk of infection.³⁸ Further, where confidentiality, informed consent and non-discrimination were not guaranteed, individuals did not come forward for early education, counselling, testing and treatment - instead they remained beyond the reach of public health services, thus posing far greater risk to the community at large.³⁹

These considerations suggested that coercive measures not only infringe upon people's civil and individual rights, but do nothing to advance understanding of the HIV/AIDS epidemic and may be counter-productive in slowing it.⁴⁰

More recent thinking about optimal strategies for disease control has also significantly influenced legal approaches to the epidemic. Efforts to confront some of the most serious global health threats, including cancer, cardiovascular disease and other chronic diseases, injuries, reproductive health and infectious disease increasingly emphasise the role of personal behaviour within its social setting.⁴¹ Following general public health trends, AIDS policymakers therefore broke with the traditional model of disease control by adopting a non-coercive approach to public health - a phenomenon dubbed "AIDS exceptionalism".⁴² As a result, over the past two decades policies that recognise and try to attain harmony between human rights and public health have emerged. This suggests wherever possible a voluntaristic approach: measures that value autonomy, cooperation and consent protect individual rights while improving community welfare. This approach excluded contact tracing, isolation and quarantine, even when the behaviour of an infected individual was believed to pose a threat to others, and stressed education rather than coercion.⁴³

The premise is that there is no public health rationale for discriminatory and coercive measures based solely on HIV infection. This has been repeatedly affirmed by the public health specialists world-wide, including those at the World Health Organisation and the United Nations.⁴⁴ Internationally this premise radiates from the International Guidelines on HIV/AIDS and Human Rights (adopted by United Nations bodies in 1996 at an international consultation in which South Africa was a participant⁴⁵); in the International Partnership against AIDS in Africa (forged in 1999 between 20 African countries, including South Africa, and certain UNAIDS⁴⁶ co-sponsors to intensify the response to AIDS in Africa);⁴⁷ and the United Nations General Assembly Special Session (UNGASS) Declaration of Commitment on HIV/AIDS (adopted in 2001 at the 26th special session of the General Assembly to secure a global commitment to enhancing co-ordination and intensification of national, regional and international efforts to combat HIV/AIDS in a comprehensive manner).⁴⁸ The importance of human rights in dealing effectively with HIV/AIDS is also recognised by the Department of Health in its HIV/AIDS/STD Strategic Plan for South Africa 2000-2005.

The Plan includes human rights and legal issues as one of the five 'key priority issues'.⁴⁹

Legal responses elsewhere benefited South Africa as it grappled with rising prevalences. Lawyers accepted that the debate about individual rights and public health did not exclude an important role for the law in HIV prevention. Only coercive measures trenching on civil liberties and human values have been shown to be counterproductive.⁵⁰ By contrast, as a means of securing peoples' rights and protecting them from discrimination - in furnishing a shield rather than acting as a bludgeon - it was emphasised that the law might yet prove an important ally of public education in combating the crisis.⁵¹

The central point is that the protection of individual rights and the preservation of the common good, far from being antithetical, are in fact complementary.⁵² Here it was suggested that every measure that involves limitation of rights must be tested against criteria of rationality and ethical values: whether a particular measure does actually achieve its object in combating the spread of HIV; if it does, whether the measure invades a more crucial and fundamental human right; and, if so, whether it is the least restrictive way of attaining its objective.⁵³ The late Mr Justice Ismail Mahomed supported this approach in 1992, during South Africa's constitutional negotiations. He cautioned the South African legal fraternity that informed and rational debate is crucial to determining adequate responses to HIV/AIDS. Such measures, he said, should be scientifically and sociologically effective, ethically and politically coherent, and legally and jurisprudentially defensible.⁵⁴

4 The response

4.1 Initiating change: The National AIDS Coordinating Committee of South Africa ("Nacosa")

In South Africa the first hope of an effective national response to the epidemic began in August 1994, when the ANC Government adopted a National AIDS Plan (the NACOSA AIDS Plan) to prevent the spread of HIV and reduce its impact.⁵⁵ NACOSA was established in October 1992 following an agreement between the

former government and the ANC. Despite the breakdown in constitutional negotiations that the Boipatong killings caused in June 1992, the two negotiating parties agreed that HIV/AIDS demanded coordinated supra-partisan action. The Plan was the product of a nationally inclusive process of participation and consultation and proposed a holistic and multi-sectoral response to the epidemic - including education and prevention, counselling, health care and research.⁵⁶ The Plan focused particular attention on law reform and human rights principles. Since unfair discrimination was a particular danger, priority was given to ensuring respect for the rights of those living with HIV/AIDS to provision for monitoring and enforcing human rights in specific areas.⁵⁷ This approach endorsed the complementarity premise in understanding the relationship between human rights and public health.⁵⁸

For various reasons however the social and programmatic substance of the NACOSA Plan was never significantly implemented.⁵⁹ But its legal ideas were a significant exception. They found fertile soil in the new constitutional dispensation. In promising law reform and the recognition of human rights, the recommendations of the South African Law Reform Commission between 1997 and 2001 played a signal role in addressing the most pressing issues relating to HIV and the law.⁶⁰

4.2 Law Reform: Recommendations of the South African Law Reform Commission

The South African Law Reform Commission published five reports dealing with reform of aspects of the law relating to AIDS between 1997 and 2001 in an extensive investigation that started in 1993 at the request of the Department of Health.

The Commission's work started with the publication of a discussion document in 1995, containing preliminary recommendations addressing unfair discrimination on the basis of HIV infection.⁶¹ Public comments on the discussion document reflected strong differences of opinion about the preliminary conclusion that HIV/AIDS-specific anti-discrimination legislation was warranted. The Commission based its recommendation on the facts that at the time the law dealing with HIV/AIDS was not known, it was difficult to locate or unclear and there was a great degree of ignorance regarding the disease, with resultant discrimination.⁶²

This initial work, together with the public response on it, laid some foundation for the discussion papers and interim reports that followed after 1996 when a new Commission was appointed, and the project committee dealing with HIV/AIDS was itself reconstituted.⁶³ The underlying general premise of the Commission's work throughout was to find solutions to HIV/AIDS-related legal problems that would serve to protect the rights of persons with HIV/AIDS while at the same time accommodating and balancing the major concerns of opponents of such reform.⁶⁴

The new project committee's⁶⁵ *First Interim Report* – adopted by the Commission and published in February 1997 – covered specific health-related issues the committee considered non-controversial, but which required urgent legislative intervention. These included -

- (i) recommendations to limit the use of non-disposable syringes, needles, and other hazardous material in health care settings;
- (ii) implementing universal precautions⁶⁶ in the work place in occupational legislation;
- (iii) the statutory implementation of a national compulsory standard for condoms in accordance with international standards;
- (iv) promulgating a national policy on testing for HIV infection; and
- (v) amending, finalising and promulgating the Draft Regulations relating to Communicable Diseases and the Notification of Notifiable Medical Conditions 1993⁶⁷ (which, as we explained earlier, would have descheduled AIDS as a communicable disease in respect of which coercive measures would apply).

Response was not immediate, and even now not all these recommendations have been implemented.⁶⁸ But this first Report resulted in –

- (i) the adoption of a national policy on testing for HIV in 1999,⁶⁹
- (ii) the inclusion in the 2001 Regulations for Hazardous Biological Agents of the Commission's recommendations with regard to non-disposable syringes, needles, and other hazardous material in health care settings;⁷⁰ and
- (iii) the adoption in 2001 of universal precautions applicable to the workplace.⁷¹

Although not explicitly included in the recommendations contained in the first report, the Commission's work in the course of developing them also led to the amendment of the legislation relating to disclosure of HIV/AIDS-related information on death

certificates to protect privacy.⁷² The amendment was designed to secure the collation of reliable and accurate statistics relating to death from HIV-related causes, while protecting the families of deceased persons from social stigma.

The Commission's *Second Interim Report* on AIDS, published in April 1998, recommended the adoption of a legislative ban on pre-employment testing for HIV. Was statutory intervention necessary? Despite wide acceptance that testing cannot eliminate HIV/AIDS from the workplace, and gives rise to gross unfairness and irrational decisions, widespread reports and evidence indicated that testing was indeed taking place in both the public and private sectors, and that employers discriminated against employees and job applicants testing positive for HIV.⁷³ Our law contained no specific statutory prohibition on pre-employment testing for HIV. There was also no clarity as to the circumstances under which an employer could require an applicant for employment to take an HIV test. Widely-phrased 1996 al and legislative prohibitions on unfair discrimination in general might have been thought sufficient to prevent irrational pre-employment testing for HIV. But neither the 1996 Constitution nor the Labour Relations Act 66 of 1995 conferred unqualified rights. A review of comparable legal systems, together with a scientific assessment in the light of ethical, social and economic considerations led the Commission to conclude that legislative intervention was necessary.⁷⁴ This aimed to attain the twin objectives of maintaining otherwise healthy persons with HIV in productive employment, and protecting the rights of persons with HIV/AIDS in the workplace.⁷⁵

The Commission's principles for legislative intervention on pre-employment testing for HIV were aimed at balancing seemingly conflicting interests – on the one hand, the need for statutory intervention to prohibit pre-employment HIV testing; on the other, the negative repercussions this may have in terms of AIDS exceptionalism and possible costs.⁷⁶ These principles were ultimately embodied in the Employment Equity Act 55 of 1998,⁷⁷ though the draft statute the Commission prepared was not adopted. The measures as enacted complied with reform advocacy going back to 1991,⁷⁸ though the ambit of the ban they imposed on workplace testing without labour court authorisation initially gave rise to controversy (as we discuss under the heading 'Employment Equity Act' below), until labour court decisions made it clear that voluntary employee-initiated testing did not require judicial authorisation.

The *Third Interim Report*, published simultaneously with the Second in 1998, covered HIV/AIDS and discrimination in schools. It followed the well-publicised crisis when Nkosi Johnson (an eight-year-old boy with AIDS) applied in early 1997 to be admitted to a public school in Johannesburg.⁷⁹ His admission was resisted even though the South African Schools Act 84 of 1996 had just been passed. The Act gave effect to both the spirit and letter of the 1996 Constitution by protecting learners from unfair discrimination and guaranteed them the right to a basic education and to equal access to public schools. The reaction of some members of the public and the apparent absence of a national education policy on the AIDS issue underscored the need for intervention. The Report recommended that the Minister of Education should exercise ministerial power under the National Education Policy Act 27 of 1996 to determine a national policy on HIV/AIDS in schools.⁸⁰ The Report contained a fully detailed draft national policy for HIV/AIDS in public schools,⁸¹ setting out broad constitutional guidelines from which schools' governing bodies could not deviate.⁸²

The Department of Education adopted the Commission's recommendations in full in August 1999 when it promulgated a National Policy on HIV/AIDS for Learners and Educators in Public Schools, and Students and Educators in Further Education and Training Institutions.⁸³ The Commission's recommendations also led to certain tertiary educational institutions protecting students with HIV/AIDS.

Both the *Fourth and Fifth Interim Reports* resulted from public pressure for the government to take appropriate action regarding deliberate transmission of HIV infection against the background of the high rate of rape and other sexual offences, the high prevalence of HIV infection in South Africa, and the knowledge that mostly women and young girls are at risk of deliberate exposure to HIV.⁸⁴

The *Fourth Interim Report*, published in November 2000, contained innovative and somewhat daring proposals for legislative intervention to provide a speedy and uncomplicated mechanism by which the victim of a sexual offence could apply to have a person arrested on suspicion of the offence tested for HIV and to obtain confidential access to the test result.⁸⁵ In general, our law provides for HIV testing only with the informed consent of the person concerned. And every person is entitled to privacy regarding medical information. No general legislation, public health law or criminal procedure allows for disclosure of such information to victims or alleged victims of crime. The Commission concluded that intervention is necessary in the

light of women's undoubted vulnerability to widespread sexual violence amidst a nationwide epidemic of HIV/AIDS and in the absence of adequate institutional or other victim support measures.⁸⁶ It found that these circumstances provide a compelling argument for limited – and strictly regulated – curtailment of an arrested suspect's rights of privacy and bodily integrity to enable his accuser to know speedily whether he has HIV.

The benefit to alleged victims is not only immediately practical – in that the knowledge enables them to make life decisions and choices for themselves and people around them – it is also profoundly beneficial to their psychological state to have even a limited degree of certainty regarding their exposure to a life threatening disease. That the arrested person's rights are infringed must be acknowledged. The Commission therefore recommended that procedural and substantive safeguards be built into the new process.⁸⁷ On 23 October 2002, Cabinet approved the draft legislation, which was due to come before the next sitting of Parliament.⁸⁸

The proposed draft legislation received attention during the 2003 Parliamentary legislative programme but has not yet been enacted.⁸⁹

The *Fifth Interim Report*, published in April 2001, counselled against express statutory intervention against harmful (i.e. unacceptable) consensual sexual activity by persons with HIV or AIDS that could transmit HIV or expose others to HIV. The Commission pointed out that existing common law crimes (murder, attempted murder, assault and assault with intent to commit grievous bodily harm) generally cover harmful HIV-related behaviour. The only gap is that South African criminal law has no crime of negligently inflicting injury and/or negligently or intentionally endangering another. To remedy this gap would entail creating an offence targeting in particular negligent behaviour by persons with HIV or AIDS.⁹⁰ The Commission concluded that legislative intervention is neither necessary nor desirable and recommended that the current legal position be maintained. It found that there was no scientific, empirical or even informal evidence that such behaviour is occurring to such an extent that intervention is necessary; that enactment of a new statutory offence would have no or little practical utility and would be largely symbolic in view of the existing array of common law crimes;⁹¹ and that the intrusion into sexual privacy inherent in any HIV-specific statutory offence is not justified.

More significantly, the Commission found that the social cost of creating an offence targeting *negligent* HIV-related behaviour was too high. Negligence in the HIV/AIDS context envisages an individual unaware that he or she has HIV and who in ignorance unknowingly transmits HIV or exposes another to HIV. The negligence would consist in failing to ascertain HIV status and in failing to take appropriate precautionary measures. The Commission concluded that since the overwhelming majority of persons in South Africa who have HIV are unaware of their HIV status and since there are insufficient resources for the widespread HIV testing that would be required to change this, it is not just and right that persons ignorant of their health status (but who ought perhaps ideally to know that they are infected), should be punished. In effect such individuals would be punished for their failure to know their HIV status – a matter that may lie outside their control and beyond realistic choice.⁹²

The Commission's recommendations were tabled in Parliament on 13 September 2001. In tandem with these recommendations, the Commission gave voice to the urgent need for government departments to develop practical mechanisms to utilise effectively existing common law crimes in cases of unacceptable HIV-related behaviour; and to encourage a culture of responsibility regarding HIV status.⁹³ The Commission's conclusion accords markedly with the latest UNAIDS policies on criminal law and HIV/AIDS.⁹⁴

It should be noted that the Commission's recommendations covered only consensual adult sex. Transmission of or exposure to HIV can also occur during non-consensual sexual acts such as rape. The need for further measures in sexual offence cases was dealt with by a separate Commission investigation into sexual offences.⁹⁵ There a separate committee recommended, and the Commission accepted, that the definition of rape should be expanded to include certain acts committed under false pretences or fraudulent means. It was recommended that the latter should include circumstances where a person intentionally fails to disclose that he or she is infected by a life-threatening sexually transmissible infection in circumstances where there is a significant risk of transmission of such infection to another.⁹⁶ These recommendations are currently under consideration by Parliament.⁹⁷ Women's groups and organisations dealing with HIV/AIDS have however expressed themselves strong opposition to the proposals on the ground that they would increase the stigma associated with HIV, and unjustly target vulnerable women (the

very sector the proposed steps aim to protect); others consider that a new offence may prevent people from having tests for HIV to avoid prosecution.⁹⁸

Other jurisdictions seem to show a tendency to enact legislation to target harmful HIV-related behaviour.⁹⁹ Reports of prosecutions or convictions for such behaviour are also increasing – whether under legislation specially enacted¹⁰⁰ or under ordinary common law or existing statutory offences.¹⁰¹ In South Africa the common law has increasingly been used recently to deal with harmful HIV-related behaviour (see *infra*).

4.3 Legislation

As indicated earlier, in its 1995 Working Paper 58, the Law Reform Commission preliminarily proposed the adoption of specific anti-discrimination legislation addressing HIV/AIDS. Provisions addressed HIV testing without consent; disclosure of HIV-related information; and discriminatory practices in the work place, the school environment, prisons, and the health care setting. The Commission in addition preliminarily proposed a general prohibition on unfair discrimination on the ground of HIV.¹⁰² Legislation has since then addressed many of these issues - some more general and other legislation HIV-specific.

The Constitution,¹⁰³ the Employment Equity Act¹⁰⁴ and the Promotion of Equality and Prevention of Unfair Discrimination Act¹⁰⁵ in general now comprehensively address unfair discrimination on the ground of HIV/AIDS.

4.3.1 *The Constitution, 1996*

The most important legal development impacting on HIV/AIDS has without doubt been the new constitutional order adopted in 1994, today embodied in the 1996 final Constitution.¹⁰⁶ Previously discussions on the law applicable to HIV/AIDS were primarily within the common-law. Now, the Constitution – although it does not expressly refer to HIV or AIDS – has laid a new foundation for the entire debate.¹⁰⁷

The Bill of Rights contains the most significant constitutional protections. Those affecting persons with HIV or AIDS include the rights to equality,¹⁰⁸ dignity,¹⁰⁹ life,¹¹⁰ privacy,¹¹¹ freedom of trade, occupation and profession,¹¹² fair labour practices,¹¹³ an environment that is not harmful,¹¹⁴ health care,¹¹⁵ education,¹¹⁶ and information,¹¹⁷ and specific rights for children.¹¹⁸

Two important premises underlie these rights. First, they are not absolute - their boundaries are set by the rights of others and by the legitimate needs of society.¹¹⁹ In ascertaining whether it is justified to limit the constitutional rights of a person with HIV or AIDS, the Constitutional Court has emphasised proportionality: "The level of justification required to warrant a limitation upon a right depends on the extent of the limitation. The more invasive the infringement, the more powerful the justification must be".¹²⁰ The second premise is that the constitutionally entrenched rights of a person with HIV or AIDS apply not only against the State (vertically) but also against fellow citizens (horizontally). The Bill of Rights thus protects individuals not only against the state but also, in certain circumstances, against abuses by other individuals. Horizontal application implies that individuals are accorded rights, but that in certain circumstances they have duties imposed on them to respect the rights of others.¹²¹

4.3.2 *The Employment Equity Act, 1998*

Neither the Constitution nor the Labour Relations Act specifically address HIV or AIDS. The first legislative measure in South Africa to offer protection specifically and expressly to persons with HIV was enacted in 1998. The Employment Equity Act 55 of 1998 (aimed at the equitable representation of blacks, women and people with disabilities in the workplace) expressly protects against unfair discrimination on the ground of HIV status in the workplace.¹²²

The 1998 statute's protection is not absolute. The Act allows an employer to "distinguish, exclude or prefer any person on the basis of an inherent requirement of a job".¹²³ This confirms that HIV and AIDS are to be treated like any other comparable medical condition - suitability or capacity to do the job, rather than HIV status per se, is determinative.¹²⁴

As mentioned earlier, a further significant provision prohibits employment-related HIV testing unless authorised by the Labour Court.¹²⁵ Where the court authorises testing, it may make an order that it considers appropriate in the circumstances.¹²⁶ Job applicants are included in the protection.¹²⁷

The extent of the prohibition however became the subject of controversy after the courts initially interpreted the prohibition on employer-instigated HIV testing as covering even cases where employers offer *voluntary* tests to present and future employees.¹²⁸ This broad interpretation caused confusion since it implied that prior approval of the Labour Court is always necessary – even if the employee consented to the testing.¹²⁹ . The Labour Court brought clarity to the issue in two more recent decisions holding that if an HIV test will not result in unfair discrimination, testing is not prohibited.¹³⁰

The Act also provides for Codes of Good Practice to be adopted. A Code dealing with HIV/AIDS was adopted in 2000. This provides for appropriate practical workplace-related measures to inhibit unfair discrimination against employees with HIV and AIDS.¹³¹ These include the development of HIV/AIDS policies and programmes; the introduction of mechanisms to promote acceptance and openness in relation to HIV/AIDS; promoting support for all employees with or affected by HIV and AIDS; and establishing grievance procedures and disciplinary measures to deal with HIV-related complaints.

The Act has brought much-needed clarity to the position of employees with HIV and AIDS. It clearly signals that discrimination against employees with HIV will be deemed unfair unless an employer can prove otherwise.¹³² Moreover, the court is now the gatekeeper against employer abuse in that discretion for HIV testing has been removed and given to the Labour Court.¹³³ This allows the Labour Court to develop standards for testing that are consistent with the Constitution and other international human rights instruments. The Act also has symbolic value in that it embraces persons with HIV and AIDS as an integral part of the workforce and signifies South Africa's disapprobation of HIV-related discrimination. The statute may also sensitise society at large to the rights of persons with HIV and AIDS.¹³⁴

4.3.3 *The Promotion of Equality and Prevention of Unfair Discrimination Act, 2000*

In addition to the Constitution, the Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000 provides protection, albeit general, to persons with HIV and AIDS. The Act aims to fulfil the Constitution's requirement that government enact national legislation to prohibit or prevent unfair discrimination, in particular discrimination practised by individuals or institutions other than the state.¹³⁵ For this purpose it prohibits unfair discrimination on any one of a list of specific grounds.¹³⁶

Although HIV and AIDS are not expressly listed, discrimination is prohibited generally on "any other ground" where it causes or perpetuates systemic disadvantage, undermines human dignity or adversely affects the equal enjoyment of a person's rights and freedoms in a serious manner that is comparable to discrimination on one of the listed grounds.¹³⁷ The Act moreover expressly directs the Minister of Justice and Constitutional Development to give special consideration to the inclusion of HIV/AIDS status in the list of prohibited grounds.¹³⁸ It further refers to discrimination solely on the basis of HIV/AIDS status as part of an illustrative list of unfair practices in the insurance services.¹³⁹ For purposes of the Act, HIV/AIDS status includes actual or perceived presence of HIV or AIDS in a person's body, as well as adverse assumptions based on this status.¹⁴⁰

In considering whether someone has been unfairly discriminated against on the basis of any "other ground", the Constitutional Court has held that the right to equality is violated whenever a person is treated "differently" in a way that results in unfair discrimination. And more specifically, when such "different" treatment might seriously harm the person's sense of dignity, or otherwise affects him or her in a serious way.¹⁴¹ Even though HIV status is not listed separately in the 2000 Act, there is little doubt that people living with HIV or AIDS face barriers and discrimination similar to those that face persons on the basis of certain of the listed grounds - in particular on the ground of disability.¹⁴²

4.3.4 *The National Health Act, 2003*

The new National Health Act 61 of 2003, which came into operation on 2 May 2005, expressly recognises the state's positive obligations to realise the right of access to health services within accessible resources.¹⁴³ Although not directly addressing HIV/AIDS, the Act has important provisions on the disease.¹⁴⁴ These include rights and duties of both health care providers and users generally;¹⁴⁵ the Minister of Health's obligations regarding the rendering of basic health services;¹⁴⁶ the codification of the law with regard to informed consent for medical treatment, and patient confidentiality;¹⁴⁷ the setting of criteria by which health research priorities are to be determined;¹⁴⁸ obligations with regard to dissemination of information regarding availability and accessing of health services;¹⁴⁹ an obligation to prepare national health plans to realise the objects of the Act;¹⁵⁰ the establishment of crucial health structures (including the national and provincial health authorities, the National Health Advisory Committee, provincial inspectorates for health establishments, the Essential National Health Research Committee and the National Health Research Ethics Council);¹⁵¹ the establishment of a district health system;¹⁵² the recognition that a co-ordinated relationship between private and public health establishment in the delivery of health services is crucial;¹⁵³ the codification of a non-profit blood transfusion service;¹⁵⁴ the setting of criteria by which health research priorities are to be determined;¹⁵⁵ and the national health department's acceptance of responsibility for norms and standards of health care for convicted persons and persons awaiting trial.¹⁵⁶

4.3.5 *Other legislation: Medical Schemes Act 1998*

Other legislation that impacts on HIV and AIDS includes the Medical Schemes Act 131 of 1998. This was enacted to regulate and reform private health care insurers and providers. The legislation aims to equalise access to health insurance irrespective of a person's state of health. The Act is expected to replace operation of health insurance plans on the insurance principles of risk and exclusion or limitation with principles of community rating and social solidarity.¹⁵⁷ An insurer cannot exclude a person who can afford the premium associated with health

insurance, and registered members can not be forced to pay higher premiums merely because of health status.¹⁵⁸ The Act specifically prohibits health insurers from unfairly excluding persons on the basis of past or present state of health.¹⁵⁹ In terms of a recent amendment to the Regulations promulgated under the Act all members of medical schemes are entitled to medical management of HIV infection and medication, including the provision of anti-retroviral therapy, and ongoing monitoring for medicine effectiveness and safety, to the extent provided for in the national guidelines applicable in the public sector.¹⁶⁰

4.3.6 Other legislation: minimum sentencing provisions

Legislation limiting the rights of persons with HIV/AIDS has also been enacted. The Government's clear emphasis on victims' rights, especially in the case of violence against women and children, resulted in Parliament passing two amendments to criminal law and procedure in 1997. First, amendments to the Criminal Procedure Act 51 of 1977 provide for stricter bail measures to be taken *inter alia* in respect of an accused that is charged with or convicted of rape.¹⁶¹ If such an accused knew that he had AIDS or HIV, he is not entitled to bail unless he can satisfy the court that exceptional circumstances exist permitting his release in the interests of justice. The court is in addition obliged to consider the possible sentence that will be imposed if the accused is convicted before granting an extension of bail.¹⁶² Second, the Criminal Law Amendment Act 105 of 1997 provides for compulsory minimum sentences where a person is convicted of certain serious offences. In particular it provides that if a person has been convicted of rape knowing that he has AIDS or HIV, a High Court is obliged – in the absence of substantial and compelling circumstance justifying a lesser sentence – to impose life imprisonment.¹⁶³

4.3.7 Other legislation: sexual offences

The Law Reform Commission's proposed legislation on the compulsory HIV testing of persons arrested in sexual offence cases will affect persons living with HIV/AIDS, though all rape suspects, with HIV or not, fall within its purview. So will the possible

criminalisation of exposure of another person to HIV which Parliament is currently considering.¹⁶⁴

4.4 Case Law on HIV/AIDS

In a relatively small number of cases courts have addressed HIV/AIDS-related legal issues directly. In most of these, they have handed down extremely important decisions and enunciated clear legal principles. This has contributed materially to developing the current legal framework applicable to HIV/AIDS. In addition, the constitutional framework has produced a growing body of jurisprudence in which general principles of equality, unfair discrimination, dignity, freedom and security of the person, privacy and confidentiality, and the limitation of rights have been enunciated. This body of principle is directly applicable to HIV and AIDS. Discussing it or setting it out lies beyond the scope of this paper. In what follows I give a perspective on specific areas where judicial decisions have impacted significantly on HIV/AIDS.¹⁶⁵

4.4.1 HIV Testing and disclosure of HIV-related information

Privacy can be defined as the right of individuals to limit access by others to some aspect of their person. The common law and the Constitution expressly protect the right to privacy.¹⁶⁶ As regards HIV and AIDS the right to privacy finds application in two areas. First, in the freedom to make decisions about what happens in one's own body ("autonomy privacy rights"): this means that a person must consent to all forms of medical treatment, including the drawing of blood for an HIV test.¹⁶⁷ And, second, in the ability of every person to control information about him or herself i.e. to keep it confidential ("informational privacy rights").¹⁶⁸

The primary moral justification for privacy is respect for the individual. Persons living with HIV or AIDS have strong incentives to protect their privacy: not only is HIV traditionally associated with disfavoured populations (including intravenous drug users and gay men), but disclosure of HIV status can lead to various forms of discrimination.¹⁶⁹ More generally, for historical reasons the right to privacy has

particular significance. The Constitutional Court (in a case not directly concerned with HIV/AIDS) observed that the right to privacy -

“is a right which in common with others, was violated often with impunity by the legislature and the executive. Such emphasis is therefore necessary particularly in this period when South African society is still grappling with the process of purging itself of those laws and practices from our past which do not fit in with the values which underpin the Constitution if only to remind both authority and citizen that the rules of the game have changed”.¹⁷⁰

With regard to autonomy privacy, AIDS brought a new dimension to the medical concept of consent to medical treatment.¹⁷¹ Given the immense significance of HIV testing, questions regarding the extent of the information to be supplied before testing were increasingly raised. On the one hand there was the view that blood tests are part of the general method of medical examination and that, as is the case with many other blood tests, the patient’s general consent was sufficient for performing the HIV test. On the other hand it was argued that because of the nature of HIV infection and its grave consequences, consent should be both specific (ie, not general) and express (ie, not implied). It was also argued that HIV testing should be preceded by counselling.¹⁷²

In *C v Minister of Correctional Services*,¹⁷³ the debate was resolved decisively in favour of express specific consent being required for an HIV test, and in favour of the need for pre-test counselling. *C* was one of several cases involving the rights of prisoners in relation to HIV and AIDS. The court laid out parameters under which an HIV test could be performed. It held that, generally, informed consent was a prerequisite for testing a person for HIV. An individual could consent to an HIV test only if he or she understood the object and purpose of the test, understood what a positive result could entail, had time and place to reflect on the information received about the test, and had the freedom to refuse the test. The court held that -

“there can only be consent if the person appreciates and understands what the object and purpose of the test are, what an HIV positive test result entails and what the probability of AIDS occurring thereafter is. Evidence was led in this case on the need for informed consent before the HIV test is performed. Members of the medical profession and others who have studied and worked with people who have tested HIV positive and with AIDS sufferers have

developed a norm or recommended minimum requirement necessary for informed consent in respect of a person who may undergo such a blood test. Because of the devastation which a positive test result entails, the norm so developed contains as a requirement counselling both pre- and post-testing, the latter in the event of a positive test result.”¹⁷⁴

The second area of privacy was at issue in the 1993 Appeal Court decision in what is regarded as the locus classicus on the protection of privacy of AIDS-related information. The then Appellate Division (now the Supreme Court of Appeal) in *Jansen van Vuuren NNO v Kruger*¹⁷⁵ (the case of Barry McGeary, who died during the trial in the Johannesburg High Court) upheld and enforced the common law right to privacy where a medical practitioner unjustifiably disclosed his patient's HIV status.¹⁷⁶ The patient's right to privacy is not absolute and justification for disclosure may be present where the practitioner's duty to society outweighs the doctor/patient duty.¹⁷⁷ McGeary's doctor disclosed his HIV positive diagnosis to two colleagues on the golf course without the consent of the patient. The colleagues had little to do with the care of the patient and the Appeal Court found that the disclosure had been prompted by news-mongering rather than the patient's treatment needs or a desire to protect third parties from possible danger of infection. The Court emphasised that HIV could not be transmitted casually, and that significant public health benefits could be derived from protecting an individual's right to privacy. Endorsing an English decision, it accepted that the need for confidentiality in the case of AIDS was especially compelling:

“There are in the case of HIV and AIDS special circumstances justifying the protection of confidentiality...Disclosure of the condition has serious personal and social consequences for the patient. He is often isolated or rejected by others which may lead to increased anxiety, depression and psychological conditions that tend to hasten the onset of so-called full-blown AIDS.”¹⁷⁸

This second area of privacy was also at issue in the more recent unreported case of *NM, SM and LV v Charlene Smith, Patricia de Lille and New Africa Books*.¹⁷⁹ Three women instituted legal action against the defendants after they had published their full names and HIV status without their consent in the biography of De Lille, written by Smith and published by New Africa Books. The women participated in a clinical drug trial at a public hospital. They disclosed their names and HIV status during an investigation by an internal ethics committee at the University of Pretoria and a

subsequent independent enquiry into whether the drug trial had violated the rules of informed consent. De Lille, a politician who has supported various HIV/AIDS advocacy efforts, assisted the women in raising concerns about informed consent and subsequently received the ethics committee's report. While the report was intended for limited circulation, nowhere did it indicate that its contents were confidential. When de Lille hired Smith, a prominent journalist, to write her biography she provided her with a copy of the report. Smith included some of its contents in the biography, including the names and HIV status of the three women. The High Court found that only the publisher could be held liable for the disclosure as De Lille and Smith have, by their long standing involvement with people living with HIV/AIDS, demonstrated that they are unlikely to intentionally invade the privacy of a person living with HIV. The court also took into account the facts that nobody had yet confronted the three women because of the disclosure and that the readership of political biographies is limited and "unlikely to include people with whom the plaintiffs come into regular contact or may come into contact". The publisher was however ordered to delete the unauthorised references to the names of the plaintiffs in the unsold copies of the book and to pay each plaintiff damages of R15 000.¹⁸⁰ Although Aids organisations welcomed the fact that the violation of the three women's' rights to privacy were recognised by the court, the decision was also criticised because Smith and De Lille were not held liable. It is argued that they should have been liable "precisely because they are acutely aware of the impact of stigma and discrimination on people living with HIV".¹⁸¹ Application for leave to appeal has been made.¹⁸²

4.4.2 Patient rights

The unreported decision of the High Court in *VRM v The Health Professions' Council of South Africa (HPCSA)*¹⁸³ raised important issues on reproductive choice, medical paternalism and the responsibility of the Council to enforce proper behaviour in medical professionals in the context of HIV/AIDS. A pregnant woman consulted a doctor to arrange for antenatal care and delivery. He tested her for HIV without her consent and without pre- and post-test counselling. He also did not disclose her positive test results to her and failed to advise her of the steps she could take to reduce the risk of perinatal HIV transmission. She delivered a stillborn baby and was advised that she had HIV shortly after the birth. The patient filed a complaint with the HPCSA who declined to take the matter further and accepted the doctor's version

that he acted out of compassion in not disclosing the patient's HIV status to her. The High Court found that the committee of the HPCSA who heard the complaint was not entitled to adjudicate on complaints that raise disputes of fact. In particular, the court considered what weight the committee was entitled to place on the version of doctors in responding to complaints and found that the committee must refer the complaint to a disciplinary enquiry where appropriate evidence can be led.

The judgment is regarded as a victory for patients' rights as many complaints about medical practitioners by patients never get beyond the structures of the Health Professions Council responsible for investigating them. The decision led to the AIDS Law Project requesting the HPSCA to reconsider several other complaints by patients against medical practitioners.¹⁸⁴

4.4.3 Criminal justice

4.4.3.1 HIV status as a factor in sentencing and granting parole

In at least three cases the HIV positive status of prisoners has been accepted as a mitigating factor in sentencing. In all, the accused's HIV infection was a factor independent of the offence in question. In all instances it was indicated that a life-threatening condition such as HIV infection could be (or was) a mitigating factor.¹⁸⁵ In a recent case the court expressed itself in favour of granting parole on medical grounds to terminally ill prisoners with HIV/AIDS.¹⁸⁶

Naturally, where HIV is shown to be directly related to the offence committed – for instance in the case of rape – it will always be regarded an aggravating factor in view of the added anguish and heightened risk to life and well-being that the offender's HIV infection necessarily entails. The legislature has already enunciated this principle¹⁸⁷ and the courts have given effect to it.¹⁸⁸

4.4.3.2 Transmission of or exposure to HIV

There is increasing evidence that the courts are using existing common law crimes to deal with harmful HIV-related behaviour.¹⁸⁹ In what is believed to be the first ruling of its kind in the country, the Pretoria Regional Court in November 2003 found a man guilty of attempted murder for raping a young woman, knowing he was HIV-positive.¹⁹⁰ The case was referred to the High Court for sentencing.¹⁹¹ The High Court indicated that it could find nothing wrong with the conviction and supported the Law Reform Commission's view that the common law is sufficiently wide to cover cases of this nature.¹⁹²

4.4.4 **Workplace issues**

In 2000 the Constitutional Court powerfully ruled on the issue of unfair discrimination in the workplace against persons with HIV. The Court in *Hoffmann v South African Airways*¹⁹³ set aside a decision of the High Court¹⁹⁴ that refused a job applicant (an otherwise healthy person with HIV) an order requiring an employer to employ him.¹⁹⁵ The job applicant had applied for a position as flight attendant with South African Airways. He satisfied all requirements but was rejected for the position when he tested HIV positive following a blood test performed during the selection process - despite the fact that he was still in the earlier stages of infection and would be able to carry out all the functions required of him. The High Court's decision was based mainly on submissions by the employer that Hoffmann posed a possible danger to potential passengers as well as to himself, because he could not be vaccinated against certain diseases, including yellow fever.¹⁹⁶ The Constitutional Court found that an asymptomatic person with HIV can perform the work of a flight attendant competently, that any hazards to which such person may be exposed can be managed and that the risks to passengers and other third parties are therefore inconsequential.¹⁹⁷

In a decision of immense general significance not only to HIV discrimination, but to discrimination jurisprudence generally, the Court went even further. It held that society has responded to the plight of persons with HIV with intense prejudice, subjecting them to systemic disadvantage and discrimination, and specifically that

the impact of this discrimination is even more devastating when occurring in the context of employment as it denies them the right to earn a living.¹⁹⁸ Although legitimate commercial requirements are an important consideration whether to employ an individual, it was held that stereotyping and prejudice must not be allowed to creep in under the guise of commercial interests.¹⁹⁹ Echoing the cautionary remarks of Mr Justice Mahomed in the early 1990s (referred to earlier), the Constitutional Court stated that treatment of persons with HIV “must be based on reasoned and medically sound judgments”.²⁰⁰

The Court held that South African Airways violated the job applicant's right to equality as guaranteed in the Constitution²⁰¹ by refusing him employment because of his HIV status²⁰² and ordered that he be forthwith instated in the position sought.²⁰³ This decision has effectively confirmed the protection conferred upon persons with HIV against unfair discrimination in the workplace.²⁰⁴ It has done so in ringing terms that serve as a powerful denunciation of irrational attitudes to persons with HIV or AIDS.²⁰⁵

4.4.5 The impact of HIV infection

In 1997 the High Court acknowledged the grave consequences of becoming infected with HIV when a plaintiff was granted damages in the amount of R344 399,06 on the ground that the defendant had infected her with HIV during sexual intercourse. The plaintiff in *Venter v Nel*²⁰⁶ was infected with HIV in the course of a consensual sexual relationship. The court noted that becoming infected in this way strikes at the very heart of the plaintiff's life and held that factors to be taken into account in the assessment of damages include the stress and inevitable fear of the unknown, the feelings of helplessness and hopelessness, the adverse effects that the condition had on the plaintiff's general relationship with all others and in the realm of her sex life, and the psychological and social suffering. The court regarded the claim as “extremely serious” and one calling for “extremely high damages”.²⁰⁷

A court in a similar but unreported civil case subsequently awarded the plaintiff (who was unknowingly infected with HIV by her husband during the course of their marriage) just under R1 million in damages for past medical expenses, future medical costs, pain and suffering and the projected progressive loss of amenities of

life. The court in reviewing the impact of the infection on the plaintiff noted the discrimination she has experienced from health-care providers, lawyers, and her family, friends and close-knit community as well as her depression and feeling dirty, segregated, humiliated and embarrassed and her constant fear of death.²⁰⁸

More troubling is the decision of a criminal court that acquitted an accused of murdering his partner. The accused told the court that his partner had informed him after unprotected intercourse that he (the partner) had AIDS. The court did not make an express finding on whether the murder victim in fact had HIV/AIDS. However, it accepted that the accused had experienced an extraordinary stimulus that led to a state of rage reaction and caused extreme provocation. Under these circumstances it could not be proved beyond reasonable doubt that the accused had the requisite criminal capacity at the time of the killing.²⁰⁹

In June 2005 a man who allegedly contracted HIV after being assaulted and sodomised by another prisoner at Westville Prison in 1998 received an amount in settlement of his claim against the Minister of Correctional Services before the case was supposed to begin. The man was in prison because he had not yet paid his R500 bail after being arrested for theft. He based his claim on negligence on the part of warders who breached their duties in failing to ensure his safety. It was reported that the man was suing the Minister for over R4m.²¹⁰

4.4.6 Children's issues

As the HIV epidemic grows, issues relating to children gained prominence. The unreported High Court case of *Karen Perreira v Sr Helga's Nursery School*²¹¹ dealt with the rights of children with HIV to attend nursery school. The private nursery school in question had refused to admit a three-year-old child when her foster mother disclosed the child's HIV positive status to the school, believing that it was in the child's best interest for the school to be aware of her medical condition. The school did not consider itself ready to admit children with HIV, none of its teachers having received any training in this regard. It also expressed fears about the risk of HIV transmission to other children through biting, sharing of sweets and scratching of insect bites. The court found that since the school had not made a final decision to exclude the child (but to defer the application until such time as the school

considered itself ready to admit children with HIV and until the child was “past the biting stage”) its conduct did not amount to unfair discrimination.

The decision was criticised on the ground that it might perpetuate discrimination because it allows a school to effectively exclude a child with HIV as long as it defers the application rather than rejects the child outright. It was said that the judgment also provide no guidance as to the basis on which such a deferral may take place, how long the application may be deferred, and what steps a school should take to accommodate children with HIV. The judgment could also serve as a precedent for other settings where service providers wish to exclude people living with HIV/AIDS.²¹² Leave to appeal was refused.²¹³

4.4.7 Access to health care

A dominant issue in AIDS is access to health care. Although there is no cure for HIV, there are anti-retroviral treatments available that either slow or stop the virus from reproducing. Other treatments deal most effectively with the opportunistic diseases associated with HIV.²¹⁴ People who have access to these treatments can live longer, healthier lives, and with effective anti-retroviral therapy AIDS can now be regarded as a long-term chronically manageable condition.²¹⁵

Where these treatments are affordable, strikingly fewer people are dying of AIDS, and HIV infection has become manageable in ways similar to, for instance, diabetes, epilepsy and heart disease.²¹⁶ The availability of these treatments also changes the social nature of AIDS. Improving access to affordable life-saving medicines changes the perception of HIV as an inevitably deadly disease – thus significantly reducing stigma. Treatment also provides powerful incentives for voluntary HIV testing and openness about HIV infection.²¹⁷

In the developing world, the responsibility of governments and of drug companies that control intellectual property rights to make available and accessible adequate and affordable health care for persons with HIV and AIDS has thus become a burning human rights issue.²¹⁸ In South Africa in particular the issue of access to health care has become critical.²¹⁹ This is because the epidemic has changed from an invisible epidemic of HIV infection to a visible one of AIDS. In addition, South

Africa has the best health infrastructure of any country in Africa. Yet, there is pitifully little access to medicines for people with HIV.²²⁰

The Constitution expressly includes the right to have access to health care services.²²¹ As with other socio-economic rights, this right has budgetary implications and is one of the rights in respect of which the positive obligations imposed on the state are expressly limited. According to the Constitution the state is required to “take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation” of this right.²²² The inclusion of socio-economic rights brings into strong play questions about the separation of powers doctrine.²²³ Some have argued that the judiciary cannot order the state to implement, or itself supervise the implementation of, social justice measures – and that this is an insuperable obstacle to judicial enforcement of socio-economic rights.²²⁴ Should the courts have the power to *dictate* policy choices and budgetary priorities? Or is this an unacceptable intrusion by the judiciary into the legitimate domain of the legislature and executive?²²⁵

During the past decade the courts have defined the parameters of the right to health care. In this process, the state’s obligations and the enforcement of the right as regards treatment for HIV and AIDS have come to the fore dramatically.²²⁶

In 1993, before the constitutional dispensation, the High Court, exercising its powers of judicial review, ordered a provincial health authority to supply a non-paying patient with an expensive drug to treat an eye disease common in AIDS patients (CMV) mainly on the ground that the patient had a legitimate expectation that he would receive the drug.²²⁷ The expectation was based on the facts that a number of other patients (also attending the HIV-clinic at the specific provincial hospital) had been treated with the drug, and that the applicant had been fitted with a special device to facilitate its administration before the decision not to proceed with this treatment.²²⁸ What of budgetary implications? The High Court held that cost was obviously relevant – and though it was proper for the provincial administration to weigh the cost of treating the applicant in relation to budget, drug efficacy and the needs of other patients, it could not be said that the cost of the drug was unacceptable if it was to be administered only to the applicant.²²⁹ The court however stressed that the judgment should not be read as creating a right for all AIDS patients with CMV to receive the

drug: the finding was that on the facts of the specific case, the provincial administration was obliged to continue with the treatment.²³⁰

In 1997 the High Court considered the provision of medical treatment services for prisoners with HIV.²³¹ The question to be determined was whether two prisoners who had reached the symptomatic stage of the disease and whose CD 4 count were below a certain level were entitled to receive, at state expense, anti-retroviral treatment prescribed for them on medical grounds. The prison authorities had declined their request on the grounds that prisoners should have access to treatment equal merely to that provided to persons attending health facilities of provincial hospitals; and that as a result of budgetary constraints such persons in the same condition as the prisoners were not provided with anti-retroviral treatment at state expense.²³²

The applicants however relied on the express constitutional right of prisoners to receive “adequate medical treatment” at state expense.²³³ The court reasoned that section 35(2)(e) of the Constitution guaranteed rights to prisoners not guaranteed to persons outside prison. It accordingly held that the standard of medical care could not be determined by that afforded to persons outside prison.²³⁴ More specifically, the court found that since the state kept prisoners in conditions where they were more vulnerable to opportunistic infections than HIV patients outside, “adequate medical treatment” had to be treatment that was better able to improve their immune systems than that the State provided outside.²³⁵

As regards budgetary constraints the court held that lack of funds cannot be an answer to a prisoner’s constitutional claim to adequate medical treatment. However, what is adequate medical treatment has to be determined in the context of what the state can afford.²³⁶ The Department of Correctional Services could not make out a case that they could not afford anti-viral treatment. It was thus held that the failure to provide the treatment sought, amounts to an infringement of the two prisoners’ constitutional rights and the Department was ordered to provide the treatment.²³⁷ This decision does not serve as a general endorsement of the cause of access to treatment for persons with HIV and AIDS, since the case was decided on the basis of constitutionally preferential treatment for prisoners.²³⁸

The challenge the leading AIDS activist group, TAC, brought against the Minister of Health over her Department's refusal to offer Nevirapine²³⁹ to pregnant women with HIV once again focussed sharp attention on access to treatment. At the end of December 2001 TAC won a lawsuit in the High Court, which found that the government had not reasonably addressed the need to reduce the risk of HIV-positive mothers transmitting the disease to their babies at birth. More specifically the High Court found that the Department has a duty to provide Nevirapine to pregnant women who are HIV-positive, giving birth in state institutions, where it is medically indicated, and where there is capacity to do so. The ruling rejected the Department's then prevailing system of providing the medication only at certain research sites. The High Court ordered the government to present an outline of how it planned to extend provision of the medication to its birthing facilities countrywide.²⁴⁰

This ruling gave rise to intense political and legal debate on the government's responsibility to fulfil socio-economic rights and the power of the courts to enforce such rights, as well as on the reasons for government's resistance to providing treatment in the mother-to-child setting.²⁴¹ The Constitutional Court settled the legal questions in July 2002 when it dismissed the government's appeal against the High Court decision (though it substantially amended the orders granted).²⁴²

The Constitutional Court judgment clarified the expectations that stem from the crucial promises that the Constitution makes about socio-economic rights, in particular the right to access to health care.²⁴³ The court drew extensively on established jurisprudence, especially its *Grootboom* judgment of 2000, which dealt with the right to housing for those in the most vulnerable socio-economic strata.²⁴⁴ In *Grootboom* the Court seemed to have moved away from the suggestion that state decisions on socio-economic distributions were required merely to be rational.²⁴⁵ The *Grootboom* and *TAC* cases appear to require the state to act reasonably to fulfil its constitutional duties regarding socio-economic rights.²⁴⁶ Invoking *Grootboom*, the court in *TAC* emphasised that more is not expected of the state than what is achievable within its available resources.²⁴⁷ Nevertheless, the state must act reasonably to provide access to health care services as provided for in section 27 of the Constitution on a progressive basis.²⁴⁸

The cost of preventing mother to child transmission was not at issue and was admittedly within the resources of the state.²⁴⁹ The government relied on arguments

about safety, efficacy and toxicity of Nevirapine and its capacity to provide the drug for not comprehensively implementing treatment with Nevirapine.²⁵⁰ The Court found these arguments unpersuasive. It expressly rejected the government's policy of waiting for a protracted period before taking a decision on the use of Nevirapine beyond the limited research sites as unreasonable.²⁵¹ It ordered the government to implement without delay a comprehensive nationwide programme for the prevention of mother-to-child transmission of HIV which must include the provision of Nevirapine at public hospitals and clinics when medically indicated.²⁵²

In making this momentous order, the Constitutional Court underscored its function regarding the review of all exercises of public power. It insisted that "where a breach of any right has taken place, including a socioeconomic right, a court is under a duty to ensure that effective relief is granted" and that "when it is appropriate to do so, courts may - and if need be must - use their wide powers to make orders that affect policy as well as legislation".²⁵³

This decision demonstrates the critical role of the courts in maintaining the commitment to the constitutionalism that underpins our vision of a new South Africa.²⁵⁴ It has also been said that the TAC judgment reflects a new depth and maturity in our democracy. It shows that the Constitution creates a powerful tool in the hands of civil society, to ensure that the government gives proper attention to the fundamental needs of the poor, the vulnerable and the marginalised.²⁵⁵ The impact of the Treatment Action Campaign's visionary activism in initiating the legislation cannot be over-stated.

Apart from the fundamental legal principles the TAC case addresses, the court also emphasised the need for transparency – and for a concerted, co-ordinated and co-operative national effort in AIDS. This, it said, can be achieved only if there is proper communication, especially by government.²⁵⁶ Significantly, the Court pointed to the government's regrettable response to the TAC challenge that its policy on prevention of mother to child transmission was inadequate - "most if not all, of the disputation is beside the point".²⁵⁷

The judgment's exposition of the facts amply reflects the confusion, procrastination and delays that characterised government's response not only to the epidemic in general but to the challenge posed by the TAC action.²⁵⁸ The court suggested that

the lack of transparency had a bearing on the unreasonableness of the government's response in realising the constitutional right to access to health care.²⁵⁹

Commentators have suggested that this is the greatest gift of the TAC judgment to the country: "It sets a standard for lucid and principled debate which should become the benchmark for all public discourse about this epidemic".²⁶⁰

4.5 Other legal and civil society developments

In addition to the major legal developments concerning HIV and AIDS we have discussed *supra*, there have been several other developments with regard to the rights of specific groups (eg prisoners, children and sex workers) or in relation to specific sectors (eg the insurance industry and health care sector). There are also a vast range of policy documents, reports, manuals, guidelines, ethical codes, and codes of good practice or good conduct, which addresses HIV and AIDS issues. It is beyond the present scope to discuss these.²⁶¹ These materials are however important as they amplify, support, strengthen and in many cases translate into practice the basic legal framework in order to protect the rights of persons with HIV and AIDS.²⁶²

Development of the law with regard to HIV/AIDS has been hugely accelerated by the emergence of a strong public interest movement for the rights of persons with HIV/AIDS. The AIDS Law Project together with allies in Lawyers for Human Rights and other human rights organisations have during the past decade campaigned against stigma, unfair discrimination and human rights violations against people with HIV/AIDS.²⁶³ In the perhaps most significant initiative in this field, the TAC focused national and international attention on access to treatment by challenging the government's refusal to provide Nevirapine to all pregnant women with HIV in state health facilities.²⁶⁴ The Constitutional Court's decision forcing the government to provide such treatment is a momentous development in post-1994 South Africa - not only from the HIV/AIDS perspective, but also as regards South Africa's socio-economic rights jurisprudence.²⁶⁵

5 Conclusion

For most people with HIV – those in Africa and elsewhere in the developing world, including South Africa, who do not have access to treatment – AIDS is still a virulent and a deadly disease. It is also a contagion of metaphors, which has evoked images of taint, deviance and defilement.²⁶⁶ As expected a decade ago, the expansion of the epidemic subjected South Africa's legal system to immense challenge, and tested its legal values.²⁶⁷ Yet the voice of rights-abridging AIDS hysteria has not prevailed in the tension that has at times appeared to exist between public health and human rights.²⁶⁸ In the legal response to the epidemic we have not yielded to public fear and panic nor to the notion that the law must use extreme anti-libertarian measures.²⁶⁹

Instead, South Africans have created a legislative framework to secure people's rights and to protect them from unfair discrimination. However, in spite of major developments, those diagnosed with HIV or AIDS in practice still face not only physical debilitation and death but also severe social discrimination.²⁷⁰ This was pointedly illustrated in a mother's bid to end unfair discrimination against her child with HIV by launching civil proceedings against a nursery school in Johannesburg that responded with apparently dilatory tactics to her application to admit her toddler with HIV.²⁷¹ As Ngcobo J said in *Hoffmann v South African Airways*:

“People who are living with HIV constitute a minority. Society has responded to their plight with intense prejudice. They have been subjected to systemic disadvantage and discrimination. They have been stigmatised and marginalised. As the present case demonstrates, they have been denied employment because of their HIV positive status without regard to their ability to perform the duties of the position from which they have been excluded. Society's response to them has forced many of them not to reveal their HIV status for fear of prejudice. This in turn has deprived them of the help they would otherwise have received. People who are living with HIV/AIDS are one of the most vulnerable groups in our society. Notwithstanding the availability of compelling medical evidence as to how this disease is transmitted, the prejudices and stereotypes against HIV positive people still persist. In view of the prevailing prejudice against HIV positive people, any discrimination against them can, to my mind, be interpreted as a fresh instance of stigmatisation and I consider this to be an assault on their dignity. The impact of discrimination on

HIV positive people is devastating. It is even more so when it occurs in the context of employment. It denies them the right to earn a living. For this reason, they enjoy special protection in our law.²⁷²

It has been said that respect for human rights will not alone ensure public health:

“To achieve aspirations for public health and human rights, society must carefully examine its duties to promote public health, to respect human dignity and to empower vulnerable persons to protect themselves”.²⁷³

The true test of our legal values under the Constitution will be the extent to which the legal system reflects a country in which AIDS discrimination is minimised, and which, at the same time, gives realistic effect to the right of access to treatment that the Constitution enshrines.

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- 1 Department of Health Republic of South Africa *National HIV and Syphilis Antenatal Sero-Prevalence Survey in South Africa* (2004) 12. Reliable empirical data on the epidemic in South Africa are hard to come by. The main source of information is the annual antenatal sero-prevalence surveys the Department of Health conducts. According to these there has been a rapid spread of HIV from 1990 (when the prevalence was less than 1%) to 2004 (when a national prevalence amongst those attending antenatal clinics of nearly 29.5% was recorded) (*National HIV and Syphilis Antenatal Sero-Prevalence Survey in South Africa* 6). Statistics released by the government on 18 February 2005 show a 57% increase in the number of deaths between 1997 and 2002. Government statisticians believe that a large proportion of the increase is attributable to AIDS (Statistics South Africa *Mortality and Causes of Death in South Africa, 1997-2003: Findings from Death Notification* Statistical Release P0309.3 (2005) 9; Sidley "Sharp Rise in Deaths in South Africa is Largely Due to AIDS" *BMJ* (2005-02-26) 438; "Calculation of Mortality in South Africa Confirms Massive Increase in AIDS Deaths" *TAC Electronic Newsletter* (2005-01-31) 1 [online] available at http://www.tac.org.newsletter/2005/ns31_01_2005.htm [2005-02-25]) while it was reported that the then Interim President of the Medical Research Council of South Africa told Parliament on 15 March 2005 that the Council believes that close to 26% of these deaths might be HIV/AIDS-related (Parliamentary Monitoring Group "HIV/AIDS Socio-Economic Impact: Medical Research Council Briefing" *Minutes of the Science and Technology Portfolio Committee* (2005-03-15) [online] available at <http://www.pmg.org.za/minutes.php?q=1> [2005-03-22]).
- 2 The Treatment Action Campaign, established in December 1998, is an HIV/AIDS activist group focusing primarily on health care issues affecting people with HIV in South Africa through highlighting disparities and problems in access to treatment and campaigning to have them eliminated. Information on the TAC and its activities are available at <http://www.tac.org.za>.
- 3 *Minister of Health v Treatment Action Campaign No 2* 2002 5 SA 721 (CC) par 1, citing the Department's HIV/AIDS & STD Strategic Plan for South Africa 2000-2005 (see n 49 infra) and an earlier report to which it refers.
- 4 See also discussions of the decision by Van Wyk "The Enforcement of the Right of Access to Health Care in the Context of HIV/AIDS and its Impact on the Separation of Powers" 2003 *THRHR* 389 401 *et seq*; Ngwena "The Historical Development of the Modern South African Health-care System: From Privilege to Egalitarianism" 2004 *De Jure* 290 303 *et seq*; and Heywood "Preventing Mother to Child HIV Transmission in South Africa: Background, Strategies and Outcomes of the Treatment Action Campaign Case Against the Minister of Health" 2003 *SAJHR* 278 *et seq*.
- 5 Constitution of the Republic of South Africa, 1996 s 1(a) to (c).
- 6 Cf Cameron & Swanson "Public Health and Human Rights - The AIDS Crisis in South Africa" 1992 *SAJHR* 200 201; Van Wyk *Aspekte van die Regsproblematiek rakende VIGS* (1991) 81.
- 7 Although – for those to whom they are available and accessible – combinations of anti-retroviral drugs have since 1996 proved to be extremely effective in diminishing mortality and morbidity, in prolonging lives, improving quality of life, revitalising communities and transforming perceptions of HIV/AIDS, there is still no cure for HIV infection or AIDS (South African Government Information *Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa* (2003-11-19) 13 [online] available at <http://www.info.gov.za/others/2003/aidsplan.pdf> [2005-03-15]). A protective vaccine is also not expected to become available in the foreseeable future. Developing a vaccine is not only complicated by the nature of the virus but by the large financial reserves and human and infrastructural components required (Tanne "AIDS Vaccine is a Long Way Off" *BMJ* (2005-05-21) 1170; Tucker & Mazithulela "Development of an AIDS Vaccine: Perspective from the South African AIDS Vaccine Initiative" *BMJ* (2004-08-21) 454-456; see also South African

Government Information *Update on the National HIV and AIDS Programme* (2003-03-19) [online] available at <http://www.info.gov.za/issues/hiv/update03.htm> [2005-03-15].

8 Van Wyk *Regsproblematiek rakende VIGS* 81.

9 See the incidents recorded by Cameron and Swanson as reported in the press during 1988-1991 (Cameron & Swanson 1992 *SAJHR* 201); cf also Ngwena *Legal Responses to AIDS: South Africa* in Franskowski (ed) *Legal Responses to AIDS in Comparative Perspective* (1998) 117 *et seq.* (Isolation is traditionally applied to isolate ill persons in order to treat them, and to prevent them from spreading disease [Van Wyk *Regsproblematiek rakende VIGS* 444-445; Jarvis, Cloosen, Hermann & Leonard *AIDS Law in a Nutshell* (1991) 285-289]. Quarantine is traditionally used to restrict the freedom of movement of healthy persons who have been exposed to a disease, but who do not yet show signs of infection, in order to prevent the spread of disease [Van Wyk *Regsproblematiek rakende VIGS* 444-445; Jarvis et al *AIDS Law* 285-289].)

10 GN R 2438 in GG 11014 of 1987-10-30 promulgated in terms of s 32, 33 and 34 of the Health Act 63 of 1977.

11 South African Law Reform Commission *Aspects of the Law Relating to AIDS* Project 85 First Interim Report (1997) par 5.1-5.16.

12 See Annexure 1 of the 1987 Regulations.

13 For a more detailed discussion of these measures see *Aspects of the Law relating to AIDS* First Interim Report (par 5.1), Third Interim Report (1998) par 3.8-3.10, Fourth Interim Report (2000) par 6.9-6.14 and Fifth Interim Report (2001) par 5.8-5.12.

14 The circumstances required generally referred to situations where the health authorities were reasonably satisfied that the spread of the particular communicable disease constituted or would constitute a danger to public health (see eg reg 2(1), 3(1), and 14 (1)).

15 Reg 2(1)(a) and (b).

16 Reg 2(1)(c).

17 Reg 2(1)(d).

18 Reg 14(1).

19 Reg 14(3)(a).

20 Reg 14(3)(c).

21 Reg 7.

22 Cf Van Wyk *Regsproblematiek rakende VIGS* 259, 448-452; Cameron & Swanson 1992 *SAJHR* 211 *et seq.*; Ngwena *Legal Responses to AIDS* 119. See also the references to the South African Law Reform Commission's Interim Reports in n 13.

23 In the 1993 Draft (GN 703 in GG 15011 of 1993-07-30), AIDS was removed from the Annexure listing specific communicable diseases. The other inappropriate provisions were reenacted to reflect an apparent intention to lessen the then applicable coercive administrative powers in respect of HIV and AIDS (see the discussions in the Interim Reports of the South African Law Reform Commission referred to in n 13).

24 See the discussion of the Commission's recommendation in its First Interim Report *infra*.

25 Proc R 19 in GG 27503 of 2005-04-18. S 93(1) of the National Health Act 61 of 2003 repeals the whole of the Health Act 63 of 1977 except for certain provisions mentioned. The latter

include sec 1 (defining "communicable disease") and s 32 to 34 (under which the 1987 Regulations were promulgated).

26 The purpose of the National Health Act 61 of 2003 is *inter alia* to reflect constitutional principles (sec 2). Regulations to be promulgated in terms of the new Act to deal with "communicable diseases" will have to reflect these principles (*cf* the long title, the definition of "communicable disease" in s 1, and the Minister's power to make Regulations dealing with such diseases in s 90 (j)).

27 S 13(1)(h) of the Act and reg 17 of the Regulations published in terms of s 54(1) of the Act as amended by GN R 2439 in GG 11014 of 1987-10-30.

28 The 1991 Act's regulations did not include AIDS and HIV infection in the list of diseases affliction with which render a person a prohibited person, when new Regulations superceded the old with coming into operation of the 1991 Act (GN R2438 in GG 13521 of 1991-09-13). See also Cameron and Swanson "Restrictions on Migrant Workers, Immigrants and Travelers with HIV or AIDS: South Africa's Step Forward" 1992 *ILJ* 496-500.

29 Cameron & Swanson 1992 *SAJHR* 232-233; see also Van Wyk *Regsproblematiek rakende VIGS 99 et seq.*

30 *Cf* also Tinker *Introduction* in The Panos Institute *The Third Epidemic: Repercussions of the Fear of AIDS* (1990) i).

31 Sohn *Preface* in Gostin (ed) *International Law and AIDS* (1992) vii.

32 Fluss *National AIDS Legislation: An Overview of Some Global Developments* in Gostin & Porter *International Law and AIDS* (1992) 3-33. This part of the discussion is based on a similar discussion included in *Aspects of the relating to AIDS* Fifth Interim Report par 4.5-4.10.

33 Buchanan *Public Health, Criminal Law and the Rights of the Individual* in United Nations Development Programme (1995) *African Network on Ethics, Law and HIV – Proceedings of the Intercountry Consultation (Dakar, Senegal 27 June – 1 July 1994)* 93-96, 105; Andrias "Urban Criminal Justice: Has the Response to the HIV Epidemic been 'Fair'" 1993 *Fordham Urban Law Journal* (XX) 497 503; Gostin & Lazarinni *Human Rights and Public Health in the AIDS Pandemic* (1997) 43 *et seq.*

34 The core functions and responsibilities of public health measures are threefold: Collection of data on important health problems in a population; developing policies to prevent and control priority health problems; and assuring services capable of realising policy goals. In the past, restrictions on human rights were however often simply justified on the basis that they were necessary to protect public health. This resulted in governments applying coercive measures in the context of disease control (Mann, Lawrence, Gostin, Gruskin, Brennan, Lazzarini & Fineberg "Health and Human Rights" 1994 *Health and Human Rights* vol 1(1) 7 15-17). See also Cameron & Swanson 1992 *SAJHR* 201-202; Van Wyk *Regsproblematiek rakende VIGS* 96-98.

35 Cameron & Swanson 1992 *SAJHR* 201-204, 210 *et seq.*; Buchanan *Public Health, Criminal Law and the Rights of the Individual* 94; Van Wyk *Regsproblematiek rakende VIGS* 167. Direct measures were designed to slow the spread of HIV by targeting the movements or conduct or affecting the civic status of known or presumed HIV "carriers". Indirect measures involved oblique efforts to stop the spread of HIV through criminalising or discouraging conduct that may lead to transmission.

36 Gostin & Lazarinni *Human Rights and Public Health* 75.

37 Jackson "The Criminalization of HIV" in Hunter & Rubenstein (eds) *AIDS Agenda* (1992) 239 240-242; Buchanan *Public Health, Criminal Law and the Rights of the Individual* 94-95.

38 Berge "Setting Limits on Involuntary HIV Antibody Testing under Rule 35 and State Independent Medical Examination Statutes" 1992 *Florida Law Review* 767 805; Gostin & Lazarinni *Human Rights and Public Health* 43 *et seq.*

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- 39 Berge 1992 *Florida Law Review* 805; Gostin & Lazarinni *Human Rights and Public Health* 43 *et seq.* This approach was also endorsed by the Supreme Court of Appeal in *Jansen van Vuuren NNO v Kruger* 1993 4 SA 842 (A) 854B-D.
- 40 Mann et al 1994 *Health and Human Rights* 16-17.
- 41 Mann et al 1994 *Health and Human Rights* 16-17.
- 42 Bayer "AIDS: Human Rights and Responsibilities" *Hospital Practice* (1994-02-15) 155-164. "AIDS exceptionalism" refers to the phenomenon of singling out HIV/AIDS for special treatment as opposed to other infectious diseases (Bayer *Ethics* in Smith (ed) *Encyclopaedia of AIDS: A Social, Political, Cultural and Scientific Record of the Epidemic* (1998) 202-205.
- 43 Bayer *Hospital Practice* (1994-02-15) 155-164; Bayer *Ethics* 202-205.
- 44 Gostin & Lazarinni *Human Rights and Public Health* 102-104. See especially Guideline 3 and Annex I of the United Nations *International Guidelines on HIV/AIDS and Human Rights* (1996) HR/PUB/98/1 (supplying a history of the recognition of the importance of human rights in the context of HIV/AIDS); and World Health Organization "25 Questions & Answers on Health & Human Rights" *Health and Human Rights Publication Series* issue 1 (July 2002) [online] available at <http://www.who.int/hhr/activities/publications/en/index.html> [2005-10-03].
- 45 The Guidelines are the product of the Second International Consultation on HIV/AIDS and Human Rights, 1996. They outline how human rights standards apply in the area of HIV/AIDS and indicate specific legislative and practical measures to be undertaken by governments (*International Guidelines on HIV/AIDS* 1-4, 60-61).
- 46 The Geneva-based Joint United Nations Programme on HIV/AIDS that coordinates the global fight against the disease.
- 47 UNAIDS *International Partnership against AIDS in Africa* 1999 [online] available at <http://www.unaids.org/africapartnership/index.html> [2002-09-20].
- 48 United Nations "Global Crisis – Global Action" *Declaration of Commitment on HIV/AIDS* General Assembly Special Session on HIV/AIDS (2001-06-25) [online] available at <http://www.un.org/ga/aids/coverage/FinalDeclarationHIVAIDS.html> [2002-09-20].
- 49 Department of Health *HIV/AIDS/STD Strategic Plan for South Africa 2000-2005* (2000) 18 [online] available at <http://www.info.gov.za/otherdocs/2000/aidsplan2000.pdf> [2005-03-15].
- 50 Cameron & Swanson 1992 *SAJHR* 232; see also Jürgens *Human Rights for People Living with HIV/AIDS* Unpublished paper read at a conference *Breaking the Barriers – Partnership to Fight HIV/AIDS in Europe and Central Asia* Dublin, 2004-02-24 [online] available at http://www.aidslaw.ca/Maincontent/issues/discrimination/HR_PLWHADublin_/feb2404.pdf [2005-09-16].
- 51 Cameron & Swanson 1992 *SAJHR* 232.
- 52 Cameron & Swanson 1992 *SAJHR* 202.
- 53 Cameron & Swanson 1992 *SAJHR* 202-203. These principles are also reflected in the *International Guidelines on HIV/AIDS* 42-43. The Guidelines provide that although certain rights are nonderogable and cannot be restricted under any circumstances, international human rights law, under narrowly defined circumstances allows states to impose restrictions on some rights if such restrictions are necessary to achieve overriding goods, such as public health, the rights of others, morality, public order, the general welfare in a democratic society and national security. For such restrictions to be legitimate, a state must establish that -

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- (i) the restrictions are provided for and carried out in accordance with the law (i.e. according to specific legislation that is accessible, clear and precise, so that it is reasonably foreseeable that individuals will regulate their conduct accordingly);
 - (ii) they are based on a legitimate interest, as defined in the provisions guaranteeing the rights;
 - (iii) they are proportional to such interest; and
 - (iv) they constitute the least intrusive and least restrictive measures available and actually achieve such legitimate interest in a democratic society (i.e. established in a decision-making process consistent with the rule of law).

⁵⁴ See his opening address to the First National Conference on Legal Rights and AIDS held in Johannesburg on 25-26 June 1992 (published as Mahomed "Legal Rights and AIDS" 1993 *SAJHR* vi-ix. Cf also the discussion of HIV/AIDS as a human rights concern and the need for a human rights approach in dealing with it by Gumedze "HIV/AIDS and Human Rights: The Role of the African Commission on Human and People's Rights" 2004 *AHRLJ* 185 *et seq.*

⁵⁵ The National AIDS Convention of South Africa (NACOSA) *A National AIDS Plan for South Africa 1994-1995* (July 1994) 3-4.

⁵⁶ *National AIDS Plan for South Africa 1994-1995* 3-4. See also Cameron "Human Rights: Consequences for the HIV Epidemic – Beyond Policy Consensus to Effective Activism" 1999 *Canadian HIV/AIDS Policy & Law Newsletter* vol 4(2/3) 105-109.

⁵⁷ The areas of employment, health care, insurance, children's and women's issues, prisons, the criminal law and international travel were identified for this purpose (*National AIDS Plan for South Africa 1994-1995* 45-51).

⁵⁸ Heywood and Cornell "Human Rights and AIDS in South Africa: From Right Margin to Left Margin" 1998 *Health and Human Rights* vol 2(4) 61.

⁵⁹ See in general on the non-implementation of the NACOSA Plan, Schneider & Stein "Implementing AIDS Policy in Post-Apartheid South Africa" 2001 *Social Science and Medicine* 723-731; Cameron 1999 *Canadian HIV/AIDS Policy & Law Newsletter* 105-109; Ngwena *Legal Responses to AIDS* 132-133. Over the years budgetary constraints and alleged mismanagement of funds were indicated as reasons why the comprehensive strategy could not be fully funded (Ngwena *Legal Responses to AIDS* 132-133).

⁶⁰ Ngwena *Legal Responses to AIDS* 118, 135; see also *Aspects of the Law relating to AIDS* Fifth Interim Report par 1.14.

⁶¹ South African Law Reform Commission *Aspects of the Law relating to AIDS* Project 85 Working Paper 58 (1995).

⁶² *Aspects of the Law relating to AIDS* Working Paper 58 par 5.18 *et seq.*

⁶³ See Cameron "Legislating for AIDS" 2002 *Advocate* vol 15(1) 23-24. "Interim" refers to the Commission's approach in dealing with the issues at hand incrementally. All the Interim Reports published contain final recommendations for law reform (*Aspects of the Law relating to AIDS* Fifth Interim Report par 1.3).

⁶⁴ See *Aspects of the Law relating to AIDS* Second Interim Report (par 8.1), Third Interim Report (par 6.1), Fourth Interim Report (par 12.2) and Fifth Interim Report (par 12.6).

⁶⁵ The following persons were members of the Commission's project committee between 1996 and 2001: Mr Justice Edwin Cameron (project leader); Mr Zackie Achmat; Ms Mercy Makhalemele; Dr John Matjila; Prof Thandabantu Nhlapo; Dr Nono Simelela; Ms Ann Strobe; and Prof Christa Van Wyk. Prof Van Wyk had served also on the previous Commission's investigation. Persons who served for part of the investigation 1996-2001 were: Mr Bokkie Botha; Dr PJ Haasbroek; Dr Claudine Mtshali; Mr Justice Pierre Olivier; and Ms Lisa Seftel. Throughout the period 1993-2001, Ms Anna-Marie Havenga of the Commission's professional staff served as the committee's researcher, producing the first drafts of all reports.

⁶⁶ Standard precautionary measures aimed at preventing HIV transmission including instructions concerning basic hygiene and the wearing of protective clothing such as rubber gloves when dealing with blood and body fluids.

⁶⁷ GN 703 in GG 15011 of 1993-07-30.

⁶⁸ The Report was tabled in Parliament by the then Minister of Justice on 30 August 1997. The National Assembly resolved on 18 September 1997 that the government should implement the recommendations urgently. The Department of Health implemented the recommendations related to a universal standard for condoms through administrative action. The Department has taken no action to promulgate the 1993 Draft Regulations relating to Communicable Diseases and the Notification of Notifiable Medical Conditions. The motivation for the Commission's recommendation that the 1993 Draft Regulations be finalised and promulgated was that uncertainty exists in the public mind about the status of the Regulations relating to Communicable Diseases and the Notification of Notifiable Medical Conditions 1987 (GN R 2438 in GG 11014 of 1987-10-30) and whether they may be used in respect of persons with HIV infection or AIDS, particularly as the 1987 Regulations have never been applied to HIV/AIDS and as the 1993 Draft Regulations removed AIDS from the Annexure listing certain *communicable* diseases (*Aspects of the Law relating to AIDS* First Interim Report par 5.1-5.16). Note that the Commission's recommendations did not deal with the *notification* of HIV and/or AIDS. As regards notification, the Department of Health (without input by the Commission) in April 1999 proposed amendments to the 1987 Regulations in order to make AIDS a notifiable medical condition (GN R 485 in GG 19946 of 1999-04-23). Public pressure and lack of support for this step has however induced the government to drop this plan. Press reports quoted a spokesperson saying that the Department had dropped notification because of fear that persons with AIDS may be rejected and violated if their HIV status becomes known - especially in communities where the disease is still stigmatised and has led to violence against persons with HIV/AIDS (*Beeld* (2001-01-12) 14. See also Dagut "Why Aids Should not be Notifiable" 1999 *Focus* vol 15 [online] available at http://www.hsf.org.za/focus_15/f15 [2005-10-03]).

⁶⁹ The Department of Health published a draft policy, based on the Commission's recommendations, for public comment on 10 December 1999 (GN R 1479 in GG 20710 of

1999-12-10). The published draft adopted the Commission's proposed policy in principle but placed more emphasis on the need for pre- and post-test counselling. The policy is expected to be promulgated under the new National Health Act 61 of 2003.

70 The Department of Labour included the Commission's recommendations in its Regulations for Hazardous Biological Agents GN 1390 in GG 22956 of 2001-12-27.

71 Regulations for Hazardous Biological Agents GN 1390 in GG 22956 of 2001-12-27.

72 Then prevailing legal practice regarding medical certificates in respect of HIV/AIDS-related deaths was also identified as a matter to be included in the First Interim Report. In its Discussion Paper 68 (South African Law Reform Commission *Aspects of the Law Relating to AIDS* Project 85 Discussion Paper 68 (1996)), which preceded the First Interim Report, the Commission had previously identified a need to amend the Regulations on the Registration of Births and Deaths 1992 (GN R 2139 in GG 14182 of 1992-09-09) published under the Births and Deaths Registration Act 51 of 1992 to protect privacy in relation to HIV/AIDS while at the same time establishing a reliable mechanism for the collation of essential epidemiological information. Comments on Discussion Paper 68 alerted the Commission to the fact that the Departments of Health and Home Affairs had already started formulating alternatives. The issue was debated at a workshop for all stakeholders that the Commission's HIV/AIDS Project Committee hosted on 7 February 1997. Here consensus was reached that the registration of death process should incorporate two separate aspects. First, a public notification of death containing the deceased's full particulars but otherwise specifying only whether the death was from natural causes or not; and second, a further confidential itemisation fully specifying the direct and underlying cause/s of death that would be available for medical research, health care modelling and (where appropriate) private contractual purposes. The Department of Home Affairs later amended the Regulations in accordance with this consensus (see the Third Amendment of the Regulations on the Registration of Births and Deaths 1992 GN R 879 in GG 19006 of 1998-07-03).

73 *Aspects of the Law relating to AIDS* Second Interim Report par 2.31-2.34.

74 In its Report, the Commission enunciated the principles it accepted for legislative intervention; offered comment on the Employment Equity Bill 1997 (GenN 1840 in GG 18481 of 1997-12-01) (which had not been enacted at the time and which in principle accommodated many of the Commission's preliminary recommendations); and also, should the HIV testing provisions of the Employment Equity Bill not be enacted, proposed an alternative separate Bill dealing explicitly with pre-employment HIV testing.

75 *Aspects of the Law relating to AIDS* Second Interim Report par 6.1-6.4 and 8.22.

76 *Aspects of the Law relating to AIDS* Second Interim Report par 8.25-8.26 for these principles.

77 See s 7 and 50 (*cf* also s 6) of the Act.

78 See eg Cameron "AIDS – Some Problems in Employment Law" 1991 *ILJ* 193 226-227; Arendse "Employment, HIV and AIDS: Proposals for Law Reform:" 1993 *SAJHR* 89 *et seq*; and Albertyn & Rosengarten "HIV and AIDS: Some Critical Issues in Employment Law" 1993 *SAJHR* 77 *et seq*.

79 *Aspects of the Law relating to AIDS* Third Interim Report par 2.13 *et seq*.

80 *Aspects of the Law relating to AIDS* Third Interim Report par 6.69-6.73.

81 *Aspects of the Law relating to AIDS* Third Interim Report Annexure B.

82 These guidelines include the following (*Aspects of the Law relating to AIDS* Third Interim Report par 6.72):

- (i) Compulsory testing of learners as a prerequisite for admission to any school, or any unfair discriminatory treatment, is not justified.

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- (ii) However, it is recognised that special measures in respect of learners with HIV may be necessary. These must be fair and justifiable in the light of medical facts, school conditions and the best interests of learners with and without HIV.
 - (iii) Learners' rights to privacy are confirmed.
 - (iv) The needs of learners with HIV should, as far as is reasonably practicable, be accommodated with in the school environment.
 - (v) All schools should implement universal precautions to exclude effectively the risk of transmitting HIV in the school environment.
 - (vi) All learners have a right to be educated on HIV/AIDS, sexuality and healthy lifestyles, in order to protect themselves against HIV infection.
 - (vii) All learners should respect the rights of other learners.

⁸³ GenN 1926 in GG 20372 of 1999-08-10. The Department adopted the Commission's proposed policy almost exactly. The main difference between the two policies is the further reach of the officially promulgated policy, which will be applicable also to *educators* in public schools, and to *students and educators in further education and training institutions*. For reasons set out in the Third Interim Report the Commission's proposed policy was intended primarily for *learners* in public schools (see *Aspects of the Law Relating to AIDS* Third Interim Report n 210, par 6.25 and 6.70).

⁸⁴ *Aspects of the Law Relating to AIDS* Fourth Interim Report par 2.1 *et seq.* Although women are mostly at risk, men can also be targeted by criminal sexual acts capable of transmitting HIV, eg non-consensual sodomy (unlawful intentional sexual intercourse by a man with a man i e forced male penetration of the anus by the penis (Snyman Criminal Law 4 ed (2002) 438-439). Physiologically, anal intercourse indeed carries a higher risk of HIV transmission than vaginal intercourse. Since the advent of the Constitution of the Republic of south Africa, 1996 the common law crime of sodomy has been declared unconstitutional. The Constitutional Court found that the sole reason for the existence of the crime was the perceived need to criminalise a particular form of gay sexual expression. Although non-consensual anal penetration between men can be prosecuted under the common law as indecent assault, the Constitutional Court indicated that an offence should be created to criminalise sexual relations per anum, even when they occur in private, where such acts occur without consent or where one partner is under the age of consent (*National Coalition for Gay and Lesbian Equality v Minister of Justice* 1999 1 SA 6 (CC) par 65-66).

⁸⁵ *Aspects of the Law Relating to AIDS* Fourth Interim Report par 10.3-10.5 and 12.11 *et seq.*

⁸⁶ In April 2002, after this recommendation, the government took a policy decision to provide post-exposure prophylaxis (anti-retrovirals) for survivors of sexual assault in public sector health facilities (Department of Health *HIV/AIDS and TB Newsletter* (2002-06-03) 1; see also *Update on the National HIV and AIDS Programme*).

⁸⁷ The following principles are included in the draft legislation (*Aspects of the Law Relating to AIDS* Fourth Interim Report par 10.3-10.5 and 12.11 *et seq.*):

- (i) The process should be victim-initiated to ensure that only a person with a material interest in the arrested person's HIV status may apply for a compulsory testing order.
- (ii) A specified standard of proof should be required on which to base an order for compulsory HIV testing.
- (iii) Compulsory HIV testing of an arrested person should take place only with court authorisation.
- (iv) To ensure an uncomplicated and speedy process and to protect the victim from a potentially further traumatising confrontation with the alleged attacker, the arrested person (or his or her legal representative) should not be allowed to be present or to give evidence in an application for compulsory HIV testing. The arrested person should retain his or her right to apply to the High Court for review in the event that an order for compulsory testing is not properly granted.
- (v) The procedure should provide for the confidentiality of the arrested person's HIV test result.
- (vi) A limited period of time should be allowed for bringing an application and executing it. This period should coincide with the period during which a victim's own HIV test would not clearly

indicate whether he or she had been infected with HIV (the "window period"). A time limit of 60 days was considered maximally appropriate.

- (vii) The information regarding the HIV status of an arrested person so obtained should not be admissible as evidence in subsequent criminal or civil proceedings. This insulates the procedure as much as possible from consequential constitutional infractions.
- (viii) Malicious activation of the proposed procedure or the malicious disclosure of the test results should be criminally punishable.
- (ix) The state should be responsible for all costs related to the proposed procedure.

88 South African Government Information *Statement on Cabinet Meeting* (2002-10-23) [online] available at <http://www.info.gov.za/speeches/2002/02102411461003.htm> [2005-10-03].

89 According to minutes of its meetings the Justice and Constitutional Development Portfolio Committee discussed the proposed draft on 4 March 2003. On that occasion it directed the Department of Justice to do further research regarding certain aspects of the proposed legislation (Parliamentary Monitoring Group "Compulsory HIV Testing of Alleged Sexual Offenders Bill" *Minutes of the Justice and Constitutional Development Portfolio Committee* (2003-03-04) [online] available at <http://www.pmg.org.za/viewminute.php?id=2476>). The latest official version of the proposed draft Bill (Compulsory HIV Testing of Sex Offenders Bill [B10-2003]) is available [online] at <http://www.info.gov.za/gazette/bills/2003/b10-03.pdf>.

90 *Aspects of the Law Relating to AIDS* Fifth Interim Report par 11.13 and 12.5. See also the discussion of this issue by experts reflected in par 11.4 *et seq.*

91 *Aspects of the Law Relating to AIDS* Fifth Interim Report par 6.11 *et seq.*

92 *Aspects of the Law Relating to AIDS* Fifth Interim Report par 12.7 *et seq.*

93 These mechanisms may include (*Aspects of the Law Relating to AIDS* Fifth Interim Report par 12.18):

- (i) Making the public aware of applicable common law crimes coupled with the assurance that our existing law will indeed be used in respect of harmful HIV-related behaviour.
- (ii) Introducing practical measures to establish a standard of policing, investigation and prosecution that would ensure successful prosecutions of harmful HIV-related behaviour under the existing law.
- (iii) Maintaining and improving public health measures relating to awareness about HIV and its prevention, and public access to HIV testing and counselling. Such activities should be aimed at encouraging a culture of responsibility (Ibid par 12.18).

94 Cf UNAIDS *Criminal Law, Public Health and HIV Transmission: A Policy Options Paper* (2002) [online] available at www.unaids.org/html/pub/publications/irc-pub02/jc733-criminallaw_en_pdf.pdf [2005-10-06].

95 See *Aspects of the Law Relating to AIDS* Fifth Interim Report ch 4.

96 South African Law Reform Commission *Sexual Offences* Project 107 Report (2002) Annexure A 6.

97 According to minutes of its meetings, the Justice and Constitutional Development Portfolio Committee discussed the proposals on 11 February 2004. On that occasion it considered for inclusion in the Bill two possible provisions dealing with "criminal exposure of another to HIV" and "criminal exposure of another to sexually transmissible infection other than HIV"

respectively (Parliamentary Monitoring Group “Criminal Law (Sexual Offences) Amendment Bill: Deliberations” *Minutes of the Justice and Constitutional Development Portfolio Committee* (2004-02-11) [online] available at <http://www.pmg.org.za/viewminute.php?id=3874> [2005-03-22]). The proposed sections (which were not included in the Law Commission’s recommendations and are not included in the currently available official version of the Bill) are however included in a working document [online] available at <http://www.pmg.org.za/docs/2004/appendices/040204sexbill.htm> [2004-3-22]. The latest official version of the Bill (Criminal Law (Sexual Offences) Amendment Bill [B50-2003]) is available [online] at <http://www.info.gov.za/gazette/bills/2003/b50-03.pdf>.

⁹⁸ “Legislation: Women Oppose Law Making Deliberate Transmission of AIDS a Crime” *Legalbrief Today* (2004-08-10) [online] available at <http://legalbrief.wnd.co.za> [2004-08-10].

⁹⁹ The Central African Republic’s Penal Code was reviewed in 2003 *inter alia* to provide for the punishment of people found guilty of “deliberately spreading HIV/AIDS”. The call for action was sparked by increasing incidents of women being infected with HIV through rape (“Minister Calls for Tough Law on HIV/AIDS” *UN Integrated Regional Information Networks* (2003-07-08) [online] available at <http://allafrica.com/stories/200307080091.html> [2003-07-11]). Swaziland has recently also moved forward with legislation that will make it a crime “not to disclose one’s HIV status to a partner” (“Legislation: Failure to Disclose HIV to be a Crime in Swaziland” *Legalbrief Today* (2005-09-16) [online] available at <http://legalbrief.wnd.co.za> [2005-09-16]).

¹⁰⁰ The Namibian High Court heard its first trial of an accused with HIV charged under the Combating of Rape Act 8 of 2000 (in terms of which one, aware of his HIV infection when he rapes another, faces a higher prescribed sentence) on 17 March 2003 (Werner Menges “Court Hears First HIV-rape Case” *The Namibian* (2003-03-18) [online] available at www.namibian.com.na/ [2003-03-19]).

A person with HIV was convicted for the first time in France of engaging in sexual intercourse leading to HIV infection and not disclosing his HIV. A Strasbourg court sentenced the man to six years in prison for “voluntary transmission of a harmful substance leading to bodily harm or permanent illness” (Mysko “HIV/AIDS in the Courts – International” 2004 *Canadian HIV/AIDS Law & Policy Review* vol 9(3) 63 64).

¹⁰¹ In New Zealand a court sentenced a man to six years’ imprisonment for having sex with four women without disclosing his HIV. He was charged with criminal nuisance and assault. The judge said that the anguish of the victims in waiting for their HIV test results were aggravating factors (Mysko 2004 *Canadian HIV/AIDS Policy and Law Review* 63). In another case a man was charged in April 2005 with committing criminal nuisance by failing to tell a partner that he had HIV, knowing it would endanger her health (*New Zealand Herald* (2005-04-29) [online] available at http://www.nzherald.co.nz/index.cfm?c_id=1&ObjectID=10122868 [2005-05-05]).

In Australia a man who failed to disclose his HIV to three women whom he infected was sentenced to ten years' imprisonment in May 2004. He was charged with causing grievous bodily harm (Mysko 2004 *Canadian HIV/AIDS Law & Policy Review* 64).

There have been four successful prosecutions in England and Wales in the past two years for the transmission of HIV. All those prosecuted have been convicted under the Offences to the Person Act 1861, which requires that the prosecution prove that the defendant caused serious bodily harm to another and was aware of the risk of causing such harm. It should be noted that the UK Government in 1998 rejected the recommendation off the Law Commission for England and Wales that there should be criminal liability for the reckless transmission of disease – *inter alia* because of its concern for the negative public health implications (Weait & Azad "The Criminalization of HIV Transmission in England and Wales: Questions of Law and Policy" 2005 *Canadian HIV/AIDS Policy & Law Review* vol 10(2) 5-12; Dyer "Man Convicted of Grievous Bodily Harm for Infecting Two Women with HIV" *BMJ* (2003-10-25) 950).

In Canada the British Columbia Court of Appeal in 2004 affirmed the sentence of a man convicted of aggravated assault for having unprotected sex with a woman without disclosing his HIV (Mysko "HIV/AIDS in the Courts – Canada" 2005 *Canadian HIV/AIDS Policy & Law Review* vol 10(1) 53 54).

102 *Aspects of the Law Relating to AIDS* Working Paper 58 par 5.18-5.22 and Annexure A.

103 Constitution of the Republic of South Africa, 1996.

104 55 of 1998.

105 4 of 2000.

106 The interim Constitution (enacted as the Constitution of the Republic of South Africa Act 200 of 1993, which came into operation on 27 April 1994) was replaced by the final Constitution (the Constitution of the Republic of South Africa, 1996), which was adopted on 8 May 1996 and came into operation on 4 February 1997.

107 See also Ngwena *Legal Responses to AIDS* 134 -135.

108 S 9(1): everyone is equal before the law and has the right to equal protection and benefit of the law. S 9(3): the state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including amongst others race, gender, sex, sexual orientation and disability.

109 S 10: everyone has inherent dignity and the right to have their dignity respected and protected.

110 S 11: everyone has the right to life.

111 S 14: everyone has the right to privacy.

112 S 22: every citizen has the right to choose their trade, occupation or profession freely.

113 S 23(1): everyone has the right to fair labour practices.

114 S 24(a): everyone has the right to an environment that is not harmful to their health or well-being.

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- 115 S 27(1): everyone has the right to access to health care services, including reproductive health care.
- 116 S 29: everyone has the right to a basic education.
- 117 S 32(1): everyone has the right of access to information.
- 118 S 28(2): a child's best interests are of paramount importance in every matter concerning the child.
- 119 S 36: the rights in the Bill of Rights may be limited to the extent that the limitation is reasonable, and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including the nature of the right; the importance of the purpose of the limitation; the nature and extent of the limitation; the relation between the limitation and its purpose; and less restrictive means to achieve the purpose. Thus in *Jordan v S* 2002 6 SA 642 (CC), 2002 2 BCLR 1117, the State argued that the suppression of commercial sex was justified because prostitution carries a greater risk of HIV transmission. The minority judgment (par 86-89) acknowledged the complex relation between cause and effect in this area.
- 120 *S v Manamela (Director-General of Justice Intervening)* 2000 3 SA 1 (CC) par 69, articulating the Constitutional Court's approach regarding proportionality as stated in *S v Makwanyane* 1995 3 SA 391 (CC) and *National Coalition for Gay and Lesbian Equality v Minister of Justice supra*. Note that s 36 limitation analysis is a two-stage procedure: first, establishing that the activity for which constitutional protection is sought falls within the sphere of activity protected by a particular constitutional right; and second, determining whether the infringement is nevertheless justified (*S v Zuma* 1995 2 SA 642 (CC)). See also the discussion on the limitation of rights in the HIV/AIDS context in *Aspects of the Law Relating to AIDS* Fifth Interim Report par 7.9-7.11.
- 121 S 7(2): the state must respect, protect, promote and fulfill the rights in the Bill of Rights. Section 8(1): the Bill of Rights binds all organs of state. S 8(2): a provision of the Bill of Rights binds a natural person if, and to the extent that, it is applicable, taking into account the nature of the right and the nature of any duty imposed by the right. See also De Waal, Currie & Erasmus *The Bill of Rights Handbook* 4 ed (2001) 45-46.
- 122 S 6 provides that no person may unfairly discriminate, directly or indirectly against an employee, in any employment policy or practice on one or more grounds, which expressly include HIV status. The 1998 statute's list expands the constitutionally enumerated grounds on which unfair discrimination is prohibited (s 9(3) of the Constitution) and those enumerated in the Labour Relations Act 66 of 1995 (s 187(3)). It has been submitted that discrimination on the ground of "perceived" HIV status is also prohibited by section 6 - this perception can be created where employees for instance refuse to undergo routine HIV testing or where they fall into a "risk group" associated with HIV infection (Heywood & Hassan "The Employment Equity Act and HIV/AIDS a Step in the Right Direction" 1999 *ILJ* 845 849-850). See also Ngwena

“HIV in the Workplace: Protecting Rights to Equality and Privacy” 1999 *SAJHR* 513 *et seq* and “HIV/AIDS and Equal Opportunities in the Workplace: The Implications of the Employment Equity Act” 2000 *CILSA* 96 *et seq* on constitutional protection of persons with HIV in the workplace.

123 For a discussion see Cohen “Justifiable Discrimination – Time to Set the Parameters” 2000 *SA MER LJ* 255 265 *et seq*; and Ngwena 1999 *SAJHR* 531 *et seq*.

124 Ngwena 2000 *CILSA* 104.

125 S 7(2) prohibits testing of an employee to determine that employee’s HIV status unless such testing is determined justifiable by the Labour Court in terms of s 50(4) of the Act. In contrast, the Act in section 7(1)(b) allows “medical testing” (i e non-HIV medical testing) when it is justifiable in the light of medical facts, employment conditions, social policy, the fair distribution of employee benefits or the inherent requirements of a job. Significantly, the Labour Court in addition to other factors, also took into consideration the criteria required for non-HIV medical testing as set out in s 7(1)(b) in considering whether HIV testing is justifiable (see *Joy Mining Machinery Division of Harnischfeger (South Africa) (Pty) Ltd v National Union of Metal Workers of South Africa (NUMSA)* (2002) 23 ILJ 391 (LC), [2002] 4 BLLR 372 (Landman J)).

126 S 50(4) of the Act.

127 S 9 provides that applicants for employment are included in the protection provided for by s 6 and 7 of the Act.

128 See *Ex Parte Ndebele Mining Company (Pty) Ltd* LC 2001-07-10 Case no J1466/2001; for a discussion of the case see Krautkramer “HIV Tests for Employees Approved” *De Rebus* (November 2001) 56); and *Joy Mining Machinery Division of Harnischfeger (South Africa) (Pty) Ltd v National Union of Metal Workers of South Africa (NUMSA) supra*. In both cases the employers approached the court for authorisation to test employees for HIV with their consent in order to determine workforce prevalence so as to better support employees. The Labour Court granted the applications subject to the following conditions (amongst others): that the tests be done on an anonymous basis and with the consent of the employees concerned; that the intention of the testing shall be to establish what percentage of employees is HIV infected in order to assist the employers to plan effective HIV/AIDS prevention strategies; that the testing will not be a job requirement; that prejudicial inference will not be drawn from a refusal to submit to testing; that the employers at no time intend to discriminate against HIV positive employees should they become aware of their status; and that employees be fully informed of the conditions of the testing to be undertaken.

129 Heywood “HIV Testing in the Workplace: Clarifying the Meaning of South Africa’s Employment Equity Act” 2000 *AIDS Analysis Africa* vol 10(6) 13-14 contends that the prohibition extends solely to employer-instigated *compulsory* workplace testing. See also

Heywood & Joni “Judgment on Section 7(2) of the Employment Equity Act Creates Uncertainty regarding HIV Testing in the Workplace” 2002 *ILJ* 670-677.

130 See *Irvin & Johnson Ltd v Trawler & Line Fishing Union* (2003) 24 *ILJ* 565 (LC) (Rogers AJ) and *PFG Building Glass (Pty) Ltd v Chemical Engineering Pulp Paper Wood & Allied Workers Union* (2003) 24 *ILJ* 974 (LC) (Pillay J). Both decisions confirmed that anonymous and voluntary testing of employees for HIV does not fall within the ambit of s 7(2) of the Employment Equity Act 55 of 1998 and therefore does not require prior court authorisation. See also Leonard “To Test or not to Test Employees fir HIV” 2003 *JBL* 140 *et seq*; Joni “*Irvin & Johnson Ltd v Trawler & Line Fishing Union & Others*” 2003 *ILJ* 771-773.

131 Code of Good Practice on Key Aspects of HIV/AIDS and Employment GN R 1298 in GG 21815 of 2000-12-01.

132 Cf Heywood & Hassan 1999 *ILJ* 854.

133 Heywood & Hassan 1999 *ILJ* 854; Ngwena 2000 *CILSA* 108-109.

134 Cf Ngwena 1999 *SAJHR* 532 and 2000 *CILSA* 102.

135 S 9(4) of the Constitution provides that national legislation must be enacted to prevent or prohibit unfair discrimination.

136 S 6. The following grounds are expressly listed: race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language an birth (s 1 (xxii)).

137 Definition of “prohibited grounds” in s 1 (xxii).

138 S 34(1). In terms of this section the Equality Review Committee must within one year investigate and make the necessary recommendations to the Minister (this provision came into operation on 1 September 2000). Apparently the Committee some time after May 2003 recommended to the Minister that HIV/AIDS status should be included in the list of prohibited grounds. At time of writing, it is unclear whether this recommendation has been implemented (correspondence between Ms M Richter [Research Officer at the AIDS Law Project, University of the Witwatersrand] and Mr R Skosana of the Department of Justice and Constitutional Development dated 31 August 2005 made available to me).

139 S 29 and item 5 of the Schedule to the Act.

140 Definition of “HIV/AIDS status” in s 1(xiv).

141 *Harksen v Lane NO* 1998 1 300 (CC) par 47 (referring to *Prinsloo v van der Linde* 1997 3 SA 1012 (CC) which held that –

“where discrimination results in treating persons differently in a way that impairs their fundamental dignity as human beings, it will clearly be a breach” of the equality provision of the Constitution; other forms of differentiation, “which in some other way affect persons adversely in a comparably serious manner, may well constitute a breach ... as well” (par 33).

142 See n 135 for the listed grounds. See also the discussion on HIV/AIDS as a disability by
Ngwenya *Legal Responses to AIDS* 138-139.

143 S 2(c)(i).

144 Cf also Law & Treatment Access Unit, AIDS Law Project “Joint Submission of the AIDS Law
Project and the Treatment Action Campaign to the Portfolio Committee on Health: Public
Hearings on the National Health Bill, B32-2003 (31 July 2003)” [online] available at <http://www.w.aidslaw.org.za> (health rights) [2005-09-16].

145 Ch 2.

146 S 4.

147 S 7-9 and 14.

148 S 75.

149 S 12.

150 S 25.

151 See eg s 21, 23, 28, 30, 33, 74, 77 and 82.

152 Ch 5.

153 S 50.

154 Ch 8.

155 S 75.

156 S 83.

157 Hassan *AIDS and the Law in South Africa* in Weber (ed) *AIDS and the Law* (1999)153-160.

158 Hassan *AIDS and the Law in South Africa* in Weber (ed) *AIDS and the Law* (1999)153-160.

159 See s 30(h)(1).

160 Reg 2 of the Amendment to the General Regulations made in terms of the Medical Schemes
Act 131 of 1998 GN R 1410 in GG 27055 of 2004-12-03. The national guidelines referred to
are, according to the amendment, set out in the Operational Plan for Comprehensive HIV and
AIDS Care, Management and Treatment for South Africa; and the National Anti-retroviral
Treatment Guidelines – both of which are available at the office of the Director-General:
National Department of Health.

161 The amendments are contained in the Criminal Procedure Second Amendment Act 85 of
1997.

162 S 50(6)(c), 58 and 60(11)(a) of the Criminal Procedure Act 51 of 1977 as introduced by s 1(b),
2, 4(f) and 10 of the Criminal Procedure Second Amendment Act 85 of 1997.

163 S 51(1) and Part 1 of Schedule 2 of the Act read with s 51(3).

164 See the discussions *supra* with regard to these two issues.

165 *Jansen van Vuuren NNO v Kruger supra*; *C v Minister of Correctional Services* 1996 4 SA 292 (T);
Venter v Nel 1997 4 SA 1014 (D); *Hoffmann v South African Airways* 2001 1 SA 1 (CC); *Minister of
Health and Others v Treatment Action Campaign No 2 supra*.

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- 166 In terms of the common law every person has personality rights such as the right to dignity, autonomy and bodily integrity (*Stoffberg v Elliot* 1923 CPD 148). See s 14 of the Constitution of the Republic of South Africa, 1996 which provides that “everyone has the right to privacy”.
- 167 *Burriss Testing, Disclosure and the Right to Privacy* in Burriss, Dalton & Yale AIDS Law Project (eds) *AIDS Law Today: A New Guide for the Public* 115. Cf also *S v A* 1971 2 SA 294 (T); *Jansen van Vuuren NNO v Kruger supra* 849; Strauss “Privaatheidskending en die Toestemmingsvereiste by Bloedtoetsing vir VIGS” 1996 *THRHR* 492; Van Wyk *Regsproblematiek rakende VIGS* 131 *et seq*; Cameron “Confidentiality in HIV/AIDS – Some Reflections on South Africa and India” 2001 *OUCLJ* 35-57.
- 168 *S v A supra*. See also Neethling, Potgieter & Visser *Neethling’s Law of Personality* (1996) 248.
- 169 Cf *Aspects of the Law Relating to AIDS* Fourth Interim Report par 5.6.
- 170 *Case v Minister of Safety and Security* 1996 3 SA 617 (CC) par 100, per Langa J, on behalf of the majority of the Court.
- 171 Strauss 1996 *THRHR* 492 *et seq*.
- 172 Strauss 1996 *THRHR* 492 *et seq*. See also *Aspects of the Law Relating to AIDS* Working Paper 58 par 3.30-3.32.
- 173 *C v Minister of Correctional Services supra*.
- 174 *C v Minister of Correctional Services supra* 301.
- 175 *Jansen van Vuuren NNO v Kruger supra*.
- 176 The case was heard in 1993 before the enactment of the Interim Constitution (see n 105) and thus relied on the common law principles of confidentiality.
- 177 Cf Van Wyk “Vigs, Vertroulikheid en ‘n Plig om in te Lig” 1994 *THRHR* 141 142 *et seq*.
- 178 *Jansen van Vuuren and Another NNO v Kruger supra* 854J, discussed and analysed by Cameron 2001 *OUCLJ* 35-57.
- 179 *NM, SM and LV v Charlene Smith, Patricia de Lille and New Africa Books* WLD 2005-05-13 Case no 02/24948/2005.
- 180 See discussions of the case by Gibson “South Africa: Book Publisher Ordered to Pay Damages for Disclosing Women’s HIV Status” 2005 *Canadian HIV/AIDS Policy & Law Review* vol 10(2) 53; and the AIDS Law Project “Privacy, Confidentiality and Stigma: the Case of NM, SM and LH v Patricia De Lille, Charlene Smith and New Africa Book Publishers” [online] available at <http://www.alp.org.za> (Judgements & Court Papers) [2005-09-21].
- 181 AIDS Law Project “Privacy, Confidentiality and Stigma: the Case of NM, SM and LV v Patricia De Lille, Charlene Smith and New Africa Book Publishers” [online] available at <http://www.alp.org.za> (Judgements & Court Papers) [2005-09-21]. See the discussion of the case by the ALP on their website at <http://www.alp.org.za>.
- 182 AIDS Law Project “Privacy, Confidentiality and Stigma: the Case of NM, SM and LV v Patricia De Lille, Charlene Smith and New Africa Book Publishers” [online].

183 *VRM v The Health Professions' Council of South Africa (HPCSA)* TPD 2003-10-10 Case no 1679/02.

184 “VRM v The Health Professions' Council of South Africa (HPCSA)” AIDS Law Project *Annual Report for 2003* 12-13; Veriava “Ought the Notion of ‘Informed Consent’ to be Cast in Stone? VRM v The Health Professions' Council of South Africa” 2004 *SAJHR* 309 et seq.

185 See *S v Cloete* 1995 1 SACR 367 (W); *S v C* 1996 2 SACR 503 (T); *S v Sibonyane* Pretoria Regional Court Case no 14/2865/97; see also the Zimbabwe case of *S v Mahachi* 1993 2 SACR 36 (Z). Cf also *S v Belelie* 1997 2 SACR 79 (W) where the court indicated that HIV infection was regarded as mitigation by the Magistrate’s Court.

186 In *Stanfield v Minister of Correctional Services* 2004 4 SA 43 (C) the court stated that -

“[D]espite the huge increase in the prevalence of HIV/AIDS and other terminal diseases in our prisons, only the tiniest percentage of prisoners suffering from such diseases were released on medical grounds...I associate myself fully with the call...that the release of terminally ill prisoners should receive far more attention, if not priority attention...Even the worst of convicted criminals should be entitled to a humane and dignified death” (par 128).

187 See the provisions of the Criminal Law Amendment Act discussed *supra*.

188 The Pietermaritzburg High Court in September 2005 handed down two life sentences to an HIV-positive man who raped and murdered a five-year-old girl. The judge said the fact that the accused had HIV at the time of the rape (before he killed the child) and knew it, was an aggravating feature (*The Mercury* 2005-09-15 5). Another HIV- positive man found guilty of raping a 12-year-old-girl knowing that he had HIV was also sentenced to life imprisonment in the Pietermaritzburg High Court in August 2005. The court emphasised that in addition to the terrible trauma of the rape the girl has to now live with the trauma of fearing that she might be HIV positive and have her lifespan reduced as a result (*The Witness* 2005-09-01 [online] available at http://www.witness.co.za/content/2005_09/36867.htm [2005-09-01]). See also the case of *S v L Nyalungu* TPD 2004-03-15 Case no CC94/04. Also in this case the accused was sentenced to life-imprisonment after the court referred to the fact that the victim (who was raped by the accused knowing that he had HIV) was severely traumatised by the possibility that she could be infected with HIV.

189 A nurse accused of injecting her four-year-old stepson with HIV-contaminated blood was reported to go on trial on charges of attempted murder on 23 June 2005 (“Criminal: Attempted Murder Charge Over HIV Injection” *Legalbrief Today* (2005-06-23) [online] available at <http://legalbrief.wnd.co.za> [2005-08-01]).

190 “South Africa: HIV Rapist is Found Guilty of Attempted Murder” *Legalbrief Africa* (2003-11-24) [online] available at <http://legalbrief.wnd.co.za> [2003-11-25].

191 *S v L Nyalungu supra*.

192 *S v L Nyalungu supra*.

193 *Hoffman v South African Airways* (CC) *supra*.

194 *Hoffman v South African Airways* 2000 2 SA 628 (W). See also the criticism of the High Court decision by Rycroft & Louw "Discrimination on the Basis of HIV: Lessons from the Hoffmann Case" 2000 *ILJ* 856 *et seq*.

195 The Labour Court heard a similar case in 1999 (*A v South African Airways (Pty) Ltd* LC 1999-05-09 Case no J1916/99). This also involved the refusal by the SAA to employ a person with HIV as a flight attendant. The case was settled when SAA paid damages to the claimant.

196 *Hoffmann v South African Airways* (W) *supra* par 12, 21, and 26-28.

197 *Hoffmann v South African Airways* (CC) *supra* par 15.

198 *Hoffmann v South African Airways* (CC) *supra* par 27-28.

199 *Hoffmann v South African Airways* (CC) *supra* par 34.

200 *Hoffmann v South African Airways* (CC) *supra* par 35.

201 S 9(1) provides that everyone is equal before the law and s 9(4) that the state may not unfairly discriminate directly or indirectly against anyone.

202 *Hoffmann v South African Airways* (CC) *supra* par 41.

203 *Hoffmann v South African Airways* (CC) *supra* par 64.

204 Although some criticised the decision -

"for being unduly selective in that it tended to make the right to equality the sole consideration at the exclusion of other relevant and discrete provisions of the Bill of Rights. In particular (it was argued) that the development more of a holistic constitutional framework for regulating employment-related medical inquiries and testing, not least HIV-related testing, could have been augmented had the respondent's policy of requiring HIV testing of job applicants also come under discrete judicial scrutiny. At the very least, the constitutional right to privacy, (in the view of the authors of the criticism) deserved as much focus and attention as the right to equality...In this way, the Court would have been able to lay down the constitutional benchmarks for the Labour Court which has been vested with special legislative competency regulating employment-related HIV testing" (Ngwena & Matela "Hoffmann v South African Airways and HIV/AIDS in the Workplace: Subjecting Corporate Ideology to the Majesty of the Constitution" 2003 *S A Public Law* 306 329).

Cf also the discussion of the decision by Smit "HIV/AIDS, Equity and Labour Law" 2001 *De Jure* 318 325 *et seq*. See Ngwena 1999 *SAJHR* 513 *et seq* and 2000 *CILSA* 96 *et seq* on constitutional protection of persons with HIV in the workplace.

205 See Cameron 2002 *Advocate* 23-24; and Ngwena & Matela 2003 *SA Public Law* 329-330.

206 *Venter v Nel supra*.

207 *Venter v Nel supra* 1016-1017.

208 WLD Case no 0026053/2000.

209 *S v Moses* 1996 1 SACR 701(C), criticised by de Vos “*S v Moses* 1996(1) SACR 701 (C) Criminal Capacity, Provocation and HIV” 1996 SACJ 354-360:

“[T]he court did not directly express any opinion regarding the HIV status of the [murder] victim. It is therefore probable that [this fact] played no role in the acquittal of the accused. This being said, the hope must be expressed that the judgment will not be misinterpreted...The acquittal of the accused could be seen as indicating that any revelation by persons of their HIV status to partners, lovers, husbands or wives which leads to assault or even murder may very possibly be excused ...” (at 360).

The latter would probably not happen after the decision in *S v Eadie* 2002 1 SACR 663 (SCA) indicating that the Supreme Court of Appeal’s approach, that provocation is a mitigating (and not an exculpatory) factor, was not followed in the *Moses* case (at par 50).

210 “Minister Settles with HIV Prisoner” *Legalbrief Today* (2005-06-21) [online] available at <http://legalbrief.wnd.co.za> [2005-06-21].

211 *Karen Perreira v Sr Helga’s Nursery School* WLD 2003-10-21 Case No 4377/02.

212 Gertholtz & Richter “Developments in South African Law on HIV/AIDS” 2004 *Canadian HIV/AIDS Policy & Law Review* vol 9(1) 57 58; “Karen Perreira v Sr Helga’s Nursery School and the Buccleuch Montessori Nursery School” *AIDS Law Project Annual Report for 2003* 13-14.

213 *ALP Annual Report supra* 14.

214 National Institute for Allergy and infectious Diseases “Treatment of HIV Infection” *United States Department of Health and Human Services Factsheet* (January 2002) [online] available at <http://www.niaid.nih.gov/factsheets/treat-hiv.htm> [2002-09-16].

215 Bollyky “Balancing Private Rights and Public Obligations: Constitutionally Mandated Compulsory Licensing of HIV/AIDS related Treatments in South Africa” 2002 *SAJHR* 530 534-535 and the sources quoted. See also *Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa* 13.

216 World Health Organization *Draft Guidelines for Antiretroviral Therapy in Resource Limited Settings* (April 2002) [online] available at http://www.who.int/HIV_AIDS_Care/ARV_Draft_April_2002.pdf [2002-09-16].

217 The AIDS Law Project & The AIDS Legal Network *HIV/AIDS and the Law: A Resource Manual* 3 ed (2003) 2-3; Heywood *Access to HIV/AIDS Treatments in Developing Countries: A South African Perspective* Paper read at Canadian HIV/AIDS Legal Network *Annual General Meeting and Skills Building Workshops* Montréal, 2001-09-21.

218 Ngwenya “AIDS in Africa: Access to Health Care as a Human Right” 2000 *SA Public Law* 1 2 *et seq*; Baimu “The Government’s Obligation to Provide Anti-retrovirals to HIV-positive Pregnant Women in an African Human Rights Context: The South African Nevirapine Case” 2002 *AHRLJ* 160 *et seq*; Heywood *Access to HIV Treatments*; The AIDS Law Project & The

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- AIDS Legal Network *HIV/AIDS and the Law* 2; Heywood 2003 *SAJHR* 278-279; *cf* also the discussion by Van Wyk 2003 *THRHR* 391 *et seq.*
- 219 Heywood *Access to HIV Treatments*; AIDS Law Project & The AIDS Legal Network *HIV/AIDS and the Law* 2-3. See also *Mortality and Causes of Death in South Africa* 9 on the increase of the adult mortality rate.
- 220 Information issued by the Department of Health indicated that the number of people receiving anti-retroviral therapy in accredited government facilities by end of October 2004 was 19 500 (South African Government Information *Number of People on AIDS Treatment Increases* (2004-11-25) [online] available at <http://www.info.gov.za/speeches/2004/04112512451001.htm> [2005-10-03]. In 2003 the WHO estimated that only 100 000 of the nearly four and a half million persons estimated to be in need of ARV's in Africa are on treatment (an estimated cover of 2%) (Kirby "The Never-ending Paradoxes of HIV/AIDS and Human Rights" 2004 *AHRLJ* 163 177).
- 221 S 27(1)(a) provides that everyone has the right to have access to health care services, including reproductive health care.
- 222 S 27(2) of the 1996 Constitution. See the general discussion of this issue by Van Oosten "Financial Resources and the Patient's Rights to Health Care: Myth and Reality" 1999 *De Jure* 1-18; see also Moellendorf "Reasoning about Resources: *Soobramoney* and the Future of Socio-economic Rights Claims" 1998 *SAJHR* 327- 333; and Bollyky "R if C > P = B: A Paradigm for Judicial Remedies of Socio-economic Rights Violations" 2002 *SAJHR* 161 *et seq.*
- 223 This doctrine requires that the functions of government must be classified as either legislative, executive or judicial and that they must be performed by separate branches of government (De Waal *et al* *The Bill of Rights Handbook* 20; Liebenberg *Socio-economic Rights* in Chaskalson, Kentridge, Klaaren, Marcus, Spitz & Woolman (eds) *Constitutional Law of South Africa* (Revised 1999) 41-i 41-5) and is recognised in the Constitution (s 43, 85, 125 and 165). For the interpretation of this doctrine see *Ex parte Chairperson of the Constitutional Assembly: In re Certification of the Constitution of the Republic of South Africa* 1996 4 SA 744 (CC).
- 224 See Liebenberg *Socio-economic Rights* 41-6. See also Bollyky 2002 *SAJHR* 161 *et seq.*
- 225 Liebenberg *Socio-economic Rights* 41-7. See also Van Wyk 2003 *THRHR* 393 *et seq.*
- 226 More generally the Constitutional Court considered the right of access to healthcare in *Soobramoney v The Minister of Health, KwaZulu Natal* 1998 1 SA 765 (CC), where it refused to order the state to provide expensive (and scarce) dialysis treatment to keep a patient critically ill from renal failure alive. On socio-economic rights, the court held that it will refrain from interfering with budgetary decisions where those are made in good faith and are rational. The Court upheld the state's budgetary constraints argument as a bona fide and rational reason for not providing the patient with continued and indefinite kidney dialysis. (For a

discussion of this case see van Oosten 1999 *De Jure* 11 *et seq*; Moellendorf 1998 *SAJHR* 327-333; Ngwena 2000 *SA Public Law* 13-14; De Vos "Grootboom, the Right of Access to Housing and Substantive Equality as Contextual Fairness" 2001 *SAJHR* 258 *et seq*; Mubangizi "Public Health, the South African Bill of Rights and the Socio-Economic Polemic" 2002 *TSAR* 343-351; Van Wyk 2003 *THRHR* 397-398.)

In 1998 the pharmaceutical industry challenged the provisions of the Medicines and Related Substances Control Amendment Act 90 of 1997 (enacted to facilitate access to cheaper medication in both the public and private health sectors by enabling, eg, parallel importation of patented medications, price control, and mandatory generic substitution of off-patented medicines) (*Pharmaceuticals Manufacturers' Association of South Africa v The President of the Republic of South Africa, the Hon Mr NR Mandela TPD* (2001-03-05) Case no 4183/98. The statute purported to give the government power to override intellectual property rights in circumstances contemplated by international trade agreements. The pharmaceutical companies, amidst worldwide activist protest, coordinated by the TAC, abandoned the case in April 2001, freeing the government's hands. The legislation came into operation on 2 May 2003. If implemented appropriately, the legislation will save both the government and the private medical sector millions of rands in drug costs (Kleinsmidt "Pharmaceutical Companies Abandon Case against South Africa: Victory for People with HIV/AIDS" 2001 *Canadian HIV/AIDS Policy & Law Review* vol 6(1/2) 75-77; "Plan to Change Medicines Act under Fire" *Business Day* (2002-09-18) [online] available at <http://www.businessday.co.za/Articles/TarkArticle.aspx?ID=611164> [2005-10-03]; see also Heywood "Debunking 'Conglomo-talk': A Case Study of the *Amicus Curiae* as an Instrument for Advocacy, Investigation and Mobilisation" 2001 *LDD* vol 5 133-159). A cabinet statement of 9 October 2002 envisages government becoming actively involved in "addressing the challenges that must be overcome to create the conditions that would make it feasible and effective to use anti-retrovirals in the public health sector" (Government Communications and Information System *Cabinet Statement: Lend a Hand in the Campaign of Hope against HIV/AIDS* (2002-10-09) [online] available at <http://www.gcis.gov.za/media/cabinet/021009.htm> [2005-10-03]). The Government however concedes that the cost of anti-retroviral drugs remains high despite the facts that Multinational companies have granted voluntary licenses for South African companies to manufacture several generic anti-retrovirals. It is envisaged that the latter may lead to lower prices in the medium term (South African Government Information Update on the National HIV/and AIDS Programme (2003-03-29) [online] available at <http://www.info.gov.za/issues/hiv/update03.htm> [2005-09-13]). In more recent developments pricing regulations (including *inter alia* requirements relating to dispensing fees to be charged by pharmacists and dispensing health practitioners and the price of medicines sold by pharmaceutical manufacturers) promulgated under the Medicines and Related Substances Control Amendment Act were challenged in the Supreme Court of Appeal. It was submitted that the proposed regulations posed a threat to the sustainability of many pharmacies (mainly because it imposed a limited medicine dispensing fee) serving under-resourced areas and that if pharmacies closed, especially those serving poor and under-served areas, access to medicines will be further limited. The Court set aside the regulations in December 2004. The court held that access requires both affordability and availability, and that low medicine prices do not necessarily guarantee access - medicines also need to be available (*Pharmaceutical Society of South Africa v Tshabalala-Msimang NNO; New Clicks South Africa (Pty) Ltd v Minister of Health* 2005 3 SA 238 (SCA); see the discussion of this decision by the AIDS Law Project "Ensuring a Sustainable Supply of Affordable Medicines" *Annual Report 2004* 11-12). The Department of Health then took the matter on appeal to the Constitutional Court. The government considered that the regulations would give force to its policy of making medicines more affordable and medicine pricing more transparent. The Constitutional Court set aside the Supreme Court of Appeal judgment declaring the medicine pricing regulations invalid but ordered that the controversial medicine dispensing fee be reviewed by the Department of Health (Minister of Health v New Clicks South Africa (Pty) Ltd CC 2005-09-30 Case no 2004/59) mainly because the regulatory structure in question was put in place without sufficient regard to the constitutional requirements for open and transparent government, procedural fairness and the principle of legality.

227 *Applicant v Administrator Transvaal* 1993 4 SA 733 (W) - especially 741D. See the discussion of this decision by Ngwena 2000 *SA Public Law* 15-16; Chetty "Human Rights, Access to Health Care and AIDS" 1993 *SAJHR* 71-75; and Van Oosten 1999 *De Jure* 6-7.

228 The Provincial Administration's reasons for this decision was that the drug was not a registered drug; it was toxic and a danger to life; it was extremely expensive and the cost of

supplying it to a rapidly increasing number of AIDS patients would drain the available financial resources; and the only benefit that AIDS patients would derive from the drug would be the delay of inevitable blindness (*Applicant v Administrator Transvaal supra* 737-738).

229 *Applicant v Administrator Transvaal supra* 739H.

230 *Applicant v Administrator Transvaal supra* 741D.

231 *Van Biljon v Minister of Correctional Services* 1997 4 SA 441 (C) (also reported as *B v Minister of Correctional Services* 1997 6 BCLR 789 (C)).

232 *Van Biljon v Minister of Correctional Services supra* par 24-28.

233 S 35 of the Constitution of the Republic of South Africa, 1996 deals with the rights of arrested, detained and accused persons. S 35(2)(e) provides that everyone who is detained, has the right to conditions of detention that are consistent with human dignity, including the provision, at state expense, of adequate medical treatment.

234 *Van Biljon v Minister of Correctional Services supra* par 51-55.

235 *Van Biljon v Minister of Correctional Services supra* par 54.

236 *Van Biljon v Minister of Correctional Services supra* par 49.

237 *Van Biljon v Minister of Correctional Services supra* par 57-60.

238 Ngwenya 2000 SA *Public Law* 17. See also the discussion and criticism of this decision by Ngwenya 2000 SA *Public Law* 16-17 and Van Oosten 1999 *De Jure* 8-11.

239 Nevirapine is a fast-acting and potent anti-retroviral drug used worldwide in the treatment of HIV/AIDS and was specifically approved by the WHO for use against transmission of HIV from mother to child at birth (*Minister of Health v Treatment Action Campaign No 2 supra* par 2). See Heywood "Preventing Mother to Child HIV Transmission in South Africa: Background, Strategies and Outcomes of the Treatment Action Campaign Case against the Minister of Health" 2003 *SAJHR* 278 279-281 for information on the scientific background to this case.

240 *Treatment Action Campaign v Minister of Health* 2002 4 BCLR 356 (T).

241 Criticism of the High Court decision in particular questioned the wisdom of the ruling trenching on the power relations between the executive and the judiciary (see the discussion of this issue by Hopkins "Shattering the Divide – When Judges Go too Far" *De Rebus* (March 2002) 22-26; controverted by Berger "Taking Responsibilities Seriously: The Role of the State in Preventing Transmission of HIV from Mother to Child" 2001 *LDD* vol 5 163-177. See more generally the discussion by Budlender "South African Court Rules on the State's Obligation to Prevent Mother-to-Child Transmission of HIV" 2001 *LDD* vol 5 129 *et seq*; Bollyky 2002 *SAJHR* 161 *et seq*; Baimu 2002 *AHRLJ* 168-171; and Van Wyk 2003 *THRHR* 398-403.

242 *Minister of Health v Treatment Action Campaign No 2 supra*.

243 Cf also the remarks of Budlender re the High Court decision in 2001 *LDD* 130; and Van Wyk 2003 *THRHR* 404-405.

244 *Government of the Republic of South Africa v Grootboom* 2001 1 SA 46 (CC).

245 See *Soobramoney v Minister of Health, KwaZulu-Natal supra* (the first case in which the
Constitutional Court was called upon to consider the ambit of socio-economic rights).

246 De Vos 2001 *SAJHR* 259; Ngwena 2002 *TSAR* 351. See also the discussion of *Grootboom*
by Liebenberg “The Right to Social Assistance: The Implications of *Grootboom* for Policy
Reform in South Africa” 2001 *SAJHR* 232 *et seq*; Bollyky 2002 *SAJHR* 167-171; and Bilchitz
“Giving Socio-economic Rights Teeth: The Minimum Core and its Importance” 2002 *SALJ* 484
et seq.

247 Referring to s 26 of the Constitution of the Republic of South Africa, 1996 as regards the
realisation of the right to access to adequate housing (*Minister of Health v Treatment Action
Campaign No 2 supra* par 32).

248 *Minister of Health v Treatment Action Campaign No 2 supra* par 35.

249 *Minister of Health v Treatment Action Campaign No 2 supra* par 71.

250 *Minister of Health v Treatment Action Campaign No 2 supra* par 51-66. The Department of
Health advanced four reasons for confining the administration of Nevirapine to a limited
number of research sites. These included concerns related to first, the efficacy of Nevirapine
where the “comprehensive package” (including the provision of breast milk substitutes to the
mother, comprehensive care for mother and infant, and proper infrastructure for counselling to
mothers and monitoring treatment) was not available; second, the development of resistance
to Nevirapine and related anti-retrovirals in later years; third, the safety of the drug and its
unknown and potential hazards; and fourth, the capacity of the health system to provide the
comprehensive package (*Minister of Health v Treatment Action Campaign No 2 supra* par 51-
54).

251 *Minister of Health v Treatment Action Campaign No 2 supra* par 81.

252 *Minister of Health v Treatment Action Campaign No 2 supra* par 135.

253 *Minister of Health v Treatment Action Campaign No 2 supra* par 106 and 113.

254 Trengove Jones “Judgment Sets Standard for Lucid Debate” *Business Day* (2002-07-10)
[online] available at <http://www.businessday.co.za/Articles/TarkArticle.aspx?ID=563443>
[2002-10-24]; *cf* also Baimu 2002 *AHRLJ* 173-174 in comments on the judgment in the court
a quo and Van Wyk 2003 *THRHR* 405.

255 Budlender “A Paper Dog with Real Teeth: The TAC Case has Proved that the Constitution is
a Powerful People’s Tool” *Mail & Guardian* (2002-07-12) [online] available at
<http://www.aegis.com/news/dmg/2002/MG020705.html> [2005-10-03].

256 *Minister of Health v Treatment Action Campaign No 2 supra* par 123.

257 *Minister of Health v Treatment Action Campaign No 2 supra* par 21.

258 *Minister of Health v Treatment Action Campaign No 2 supra* par 7, 9, 10-17, 20-21 (most
significantly), 40-43, and 82-89.

259 *Minister of Health v Treatment Action Campaign No 2 supra* par 123. For the history of
lobbying, advocacy, and public mobilisation and the government’s response thereto see also

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- Gertholtz "Preventing Mother-to-Child Transmission: Landmark Decision by South African Court" 2002 *Canadian HIV/AIDS Policy & Law Review* vol 6(3) 20-24.
- 260 Trengove Jones *Business Day* (2002-07-10). *Cf* also more generally on the crisis of truth and truth-telling about AIDS in South Africa, Cameron "Editorial" 2001 *LDD* vol 5 vii-ix.
- 261 See The AIDS Law Project & The AIDS Legal Network *HIV/AIDS and the Law: A Resource Manual* 3 ed (2003) containing comprehensive information on the relevant legal framework and related documents.
- 262 See eg the cases of *Jansen van Vuuren NNO v Kruger supra* 849-850 and *C v Minister of Correctional Services supra* 301 where the court acknowledged and took into account the ethical rules of the medical profession pertaining to the management of patients with HIV/AIDS. In the latter case the court also took into account the Department of Correctional Services' official Management Strategy on AIDS in Prisons.
- 263 The AIDS Law Project (ALP) is a human rights organisation based at the Centre for Applied Legal Studies at the University of the Witwatersrand challenging discrimination against persons with HIV/AIDS through litigation, legal advice, research, policy formulation, public education and international collaboration. Information on the ALP and its activities is available at <http://www.alp.org.za>.
- 264 *Cf* the discussion of the legal action taken from a public interest perspective by Heywood 2001 *LDD* 133-159.
- 265 See the discussion of the decision in *Minister of Health v Treatment Action Campaign No 2 supra*.
- 266 *Cf* Visser 1991 "Foundering in the Seas of Human Unconcern: AIDS, its Metaphors and Legal Axiology" *SALJ* 619 624 *et seq* where the author refers to the metaphors of illness, death, war, "the other", and punishment ascribed to AIDS as a disease to identify with evil and to attach blame to its victims (at 625); and Viljoen "Verligting of Verlosting: Regshervorming in 'n Tyd van Vigs" 1993 *SALJ* 100 108.
- 267 *Cf* Cameron & Swanson 1992 *SAJHR* 201.
- 268 Cameron & Swanson 1992 *SAJHR* 202, 232.
- 269 The Law Reform Commission's recommendations regarding the compulsory HIV testing of persons arrested in sexual offence cases that are still under consideration by Parliament were however regarded by some as submitting to such panic (Goyer "Compulsory HIV Testing for Alleged Sex Offenders: Victim Empowerment or Violation of Rights?" *AIDS Analysis Africa* (April/May 2001) 8-9). See the discussion on the Commission's Fourth Interim Report *supra* for information on these recommendations.
- 270 See also Ngwena *Legal Responses to AIDS* 166-167; Heywood *Access to HIV Treatments*; Richter "Aiding Intolerance and Fear: The Nature and Extent of AIDS Discrimination in South Africa" 2001 *LDD* vol 5 195-211 - according to the author legal action against HIV-related discrimination has not decreased from 1993 to 2000 (at 198); and Jones and Zuberi "A Long

Way From There to Here: Human Rights Approaches to HIV/AIDS in a Local Setting” 2005 *Canadian HIV/AIDS Policy & Law Review* vol 10(1) 14-19.

²⁷¹ See the discussion of the unreported case of *Karen Perreira v Sr Helga's Nursery School supra*. This despite the introduction by the government in 1999 of a national policy on HIV/AIDS for Learners and Educators in Public Schools, and Students and Educators in Further Education and Training Institutions (*supra*). This policy expressly guarantees the right of equal access to public schools. Although not directed at pre-schoolers and daycare centres, or at independent institutions, the policy is enunciated under national legislation and as such should signal a clear governmental stand against unfair discrimination on HIV/AIDS, which those involved with the care of very young children could not ignore. Moreover, the constitutional prohibition against unfair discrimination applies also horizontally (i.e. in respect of independent schools as juristic persons) (*cf Aspects of the Law Relating to AIDS* Third Interim Report par 3.12, 3.27 and 6.13).

²⁷² *Hoffmann v South African Airways supra* par 28.

²⁷³ Gostin & Lazarinni *Human Rights and Public Health* 55. *Cf also Aspects of the Law Relating to AIDS* Fifth Interim Report par 1.14; Richter 2001 *LDD* 210-211. See also Jones and Zuberi who submitted more recently that “(A)bove all, if a human rights discourse is to be relevant in a context where local residents face severe poverty and unemployment, a critical dialogue is required between human rights and socio-economic needs. The justiciability of socio-economic rights may be rapidly gaining ground at a national level in South Africa, but it still requires connection to local-level struggles...for it to be regarded as relevant locally” (Jones and Zuberi 2004 *Canadian HIV/AIDS Law & Policy Review* 19).