Abstract

This article examines the history of South Africa's response to HIV as a human rights issue and the manner in which rights linked to HIV have been or have not been connected to the liberation struggle. It also considers the contradiction that, while civil and political rights have been vigorously supported during the past five years, there has been silence about the meaning of economic and social rights. If South Africa's Bill of Rights is to have any relevance for people living with HIV/AIDS, a genuine national negotiation on priorities about resources is required. Without public debate about the meaning of rights of "access to health care, including reproductive health care," the South African National AIDS Plan will be stymied. The analysis focuses on South Africa, which has a unique history in the struggle for democracy. The majority of its population lives in third world conditions that make the South African experience akin to other African countries, as well as parts of Asia and Latin America. It is these conditions—and tolerance of them—that will determine the patterns, prognosis, and future of the epidemic.

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Cet article examine l'histoire de la réaction de l'Afrique du Sud face au VIH du point de vue des droits de la personne, ainsi que la manière dont les droits liés au VIH ont eu partie liée ou non avec la lutte pour la libération. Il envisage aussi la contradiction entre le fait que durant les cinq dernières années les droits civils et politiques ont été vigoureusement promus tandis que le silence a régné sur la signification des droits économiques et sociaux. Si la Déclaration des Droits de l'Afrique du Sud doit avoir quelque signification pour les personnes affectées par le VIH/SIDA, une véritable négociation nationale sur les priorités en matière de ressources est nécessaire. Sans débat public sur la signification des droits à "l'accès aux soins, y compris les soins en santé reproductive", le Plan National sud-africain sur le SIDA se trouvera dans une impasse. L'analyse est centrée sur l'Afrique du Sud, qui a une expérience unique en matière de lutte pour la démocratie. Une majorité de sa population vit dans des conditions de sous-développement qui rapproche le cas sud-africain d'autres pays d'Afrique ainsi que de certaines régions d'Asie et d'Amérique Latine. Ce sont ces conditions—et leur tolérance—qui détermineront les modes, les pronostics et l'avenir de l'épidémie.

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El artículo examina la historia de la respuesta de Sudáfrica al VIH como un asunto de derechos humanos y a la manera en que los derechos relacionados con el VIH han estado o no conectados con la lucha de la liberación. También considera la contradicción de que, mientras se han apoyado vigorosamente los derechos civiles y políticos durante los últimos cinco años, ha reinado el silencio sobre el significado de los derechos económicos y sociales. Si la Declaración de Derechos de Sudáfrica va a tener alguna repercusión para las personas que viven con VIH/SIDA, se necesita una negociación nacional genuina sobre las prioridades de los recursos. Sin debate público sobre el significado de los derechos de "acceso a la atención en salud, incluyendo atención en salud reproductiva", el Plan Nacional de SIDA sudafricano lo va a tener difícil. El análisis se centra en Sudáfrica, país con una historia única en la lucha por la democracia. La mayoría de su población vive en condiciones tercermundistas que hacen de la experiencia sudafricana similar a la de otros países africanos y a zonas de Asia y de América Latina. Son estas condiciones, así como la tolerancia que generan, las que determinan los patrones, el pronóstico, y el futuro de la epidemia.

HUMAN RIGHTS AND AIDS
IN SOUTH AFRICA:
From Right Margin to Left Margin

Mark Heywood and Morna Cornell

A real danger for AIDS prevention, treatment, and care is that political problems must be sorted out before AIDS can be tackled. This will not work, as there is simply not time.[1]

For instance, the results of the 1996 antenatal survey revealed a 35 percent increase in the number of persons infected in South Africa, meaning that HIV now infects 6 percent of the population or 2.4 million men, women, and children.[2]

South Africa has a history of human rights activism, focusing on issues of race, class, and to a lesser extent, gender. During the waning years of apartheid, the human rights movement was consolidated and radicalized. This movement gathered pace at the same time that an HIV epidemic was beginning. Following the release of Nelson Mandela in February of 1990, the completion of the liberation struggle became all-consuming. This rendered invisible many other human rights issues—prioritizing the solving of the most obvious issues relating to the most visible expressions of racial oppression of black people.

Nonetheless, in the early 1990s there were tentative signs that HIV prevention might be made a national priority. Moreover, on every occasion when AIDS was discussed, the implications of the epidemic for human rights were recognized. In April 1990, the Fourth International Conference on Health

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in Southern Africa took place in Maputo, Mozambique. It brought together organizations from inside and outside South Africa, including the African National Congress (ANC), the United Democratic Front (UDF), and health and welfare workers. The conference produced the *Maputo Statement on HIV and AIDS in Southern Africa* which in addition to acknowledging the urgent need to prioritize HIV prevention, resolved that "[T]he rights of people with HIV disease, as with any other health condition, must be firmly recognized."[3] Thereafter, major South African health organizations committed themselves to establishing a national AIDS program through nongovernmental channels, primarily the National Progressive Primary Health Care Network (NPPHCN). Momentum was gathering; in May 1990 the ANC held a seminar in Lusaka, Zambia, titled "Towards Comprehensive Intervention Strategies for the Prevention and Control of AIDS/HIV Infection." In June 1990, a National AIDS Task Force was established at the instigation of the ANC.[4]

The attention accorded to HIV prevention by the liberation movement seemed to reflect an awareness of the challenge to human rights from discrimination against people with HIV/AIDS. Thus, the first organizations to talk publicly about the danger of an AIDS epidemic in South Africa were traditionally associated with the struggle for human rights. In 1989, the Congress of South African Trade Unions (COSATU) passed a resolution calling for a trade union campaign concerning AIDS.[5] In 1991, a special COSATU conference convened to discuss AIDS in the workplace, and in 1993 the Chamber of Mines (an umbrella body of white mine owners in South Africa which is reknowned for its conservatism, and which shored up apartheid through its defense of the migrant labor system) and the National Union of Mineworkers (NUM) signed an AIDS Agreement, which included a commitment to nondiscrimination against mineworkers with HIV.[6]

The liberation struggle spawned many organizations. For example, the Congress of South African Students (COSAS), the South African National Civics Organization (SANCO), the ANC Women's League and COSATU were national organizations that had the allegiance of millions of men and women. However, despite a plethora of resolutions, most po-

litical activists did not appreciate how the most fundamental of human rights would be affected by HIV/AIDS. While the political movement was full of sound and fury about AIDS, the most purposeful response to HIV as a rights issue came from the gay community, which was itself a marginalized group in the struggle for liberation.[7] Unfortunately this served to perpetuate the perception that AIDS was a disease which affected mainly wealthy, gay white men.

Although the ANC apparatus began to address AIDS, its constituency did not. In South Africa, AIDS prevention activities became mixed with mistrust and suspicion toward the National Party (NP) (an avowedly racist party that had pioneered apartheid and ruled South Africa since 1948), whose attempts at "AIDS awareness" were frequently tarnished by racism. For example, adoption of a yellow hand as the logo of the government's national AIDS plan created distrust, for it was held by many to suggest that AIDS was primarily an African illness. Furthermore, among Afrikaner people, the NP had tried to inculcate a strong Calvinist morality that led many senior politicians to regard AIDS as divine retribution, sometimes even as a weapon of war.[8] This, including the statements of NP leaders, undermined even the limited prevention and education work which the NP government attempted to carry out. Many other obstacles also existed in the psyche of South Africa's communities that prevented early mobilization of a unified response. For example, there was wide-scale militarization, entrenched sexism, and racism. In these circumstances, a mixture of denial and prejudice characterized the climate in which people with HIV began to experience widespread discrimination and stigma.[9]

In South Africa, discrimination toward people living with HIV has evolved through several phases. The first people to experience overt HIV-related discrimination were from vulnerable groups with little or no immediate recourse to the law, such as migrants and prisoners. For example, in 1987, a sero-prevalence study was carried out among mineworkers that showed a relatively high proportion of Malawian mineworkers to be infected with HIV. The government, supported by the Chamber of Mines, introduced compulsory HIV screening of all migrant workers. HIV and AIDS were declared "diseases the affliction with which will render a person a pro-

hibited person."[10,11] Fortunately, the NUM was at the time the most rapidly growing union in South African history, and mineworkers were highly politicized. It opposed the Chamber's move and the discriminatory policy was quickly withdrawn. The accompanying government regulation was never implemented, although only formally repealed in 1991.

Prisoners were not so fortunate. Very early in the South African epidemic, the Department of Correctional Services (DCS) began mandatory HIV testing of prisoners convicted of certain crimes, "terrorists," and people from outside South Africa. Those found to be HIV-infected were segregated and subjected to assault and insult by prison wardens. This practice continued unchallenged until the early 1990s, when the AIDS Consortium and AIDS Law Project were formed and began to act on behalf of prisoners with HIV. A number of highly publicized legal challenges eventually brought about a reform of DCS policy.[12]

The second phase extended the targets of HIV-related discrimination from vulnerable groups to large segments of the population. Its source also broadened from government to include the private sector and the medical profession. It corresponded with a dawning recognition amongst professionals of the likely scale of AIDS in South Africa and an attempt to "protect" their assets (human and capital) from HIV.[13] Thus, in 1988, the Life Offices Association, an umbrella body covering the insurance industry, introduced "AIDS exclusion clauses" into all private insurance policies. Although an argument is often made that, from the actuarial perspective, this ought to be considered fair discrimination, the immediate result of the policy was to bring about much wider HIV testing, initially with scant regard for obtaining informed consent or maintaining confidentiality. In fact, pre-employment HIV testing and serial breaches of rights to health care and confidentiality by medical professionals became increasingly common.

A series of widely reported legal challenges were required to legally entrench rights, such as privacy in relation to medical practice. The most well-known case in South Africa (the McGeary case) involved a doctor who had communicated information about his patient's HIV status to another doctor and a dentist during a golf game. In September 1993, the Ap-

pellate Division of the Supreme Court unanimously ruled that "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."[14] Legal action helped establish the legally binding character of principles elaborated in the South African Medical and Dental Council's *Guidelines on the Management of Patients with HIV Infection or AIDS.*

And yet, abuses by medical practitioners are still widespread, although more and more relegated to the more vulnerable and powerless in society—those less able to launch legal challenges to discrimination. For example, nearly two million African women in South Africa are employed as domestic workers (cleaners).[15] Recently, many doctors have agreed to test domestic workers for HIV at the request of their employers, flagrantly ignoring the legal requirement for *informed* consent and confidentiality. The consent of domestic workers to such tests is often because their employment depends on it and/or because of ignorance about their rights to privacy and bodily autonomy.[16]

At the end of 1991, in response to a barrage of reports of HIV-related human rights abuse, a group of individuals that was mainly made up of human rights lawyers, gay men, and health professionals formulated a *Charter of Rights on AIDS and HIV*.[17] While the Charter drew on international documents such as the United Kingdom Declaration of the Rights of People with HIV and AIDS, it focused on those rights most commonly under attack in South Africa: informed consent, confidentiality, fair labor practices, information, equal protection of the law, and access to public benefits. It was intended to be the platform for lobbying, advocacy, and policy interventions concerning the human rights of people with HIV. The proposal to form the AIDS Consortium as a forum for discussion and debate by people working in AIDS (mainly health care workers, care givers, lawyers, and gay rights activists) on issues relating to human rights was also made here. This Consortium was also intended to help concentrate the concerns of affected communities. The Consortium was launched in 1992 and has been highly successful in keeping legal and human rights issues in the forefront of public debate.

Human Rights and the Emergence of the National AIDS Plan

During 1992, a renewed effort was made by the Department of National Health and Population Development (DNHPD), with the support of the ANC, to bring together all the players critical for an effective HIV prevention campaign. A Steering Committee was established which included representatives of business, trade unions, churches, and the South African National Civic Organization (SANCO). At an interim consultation in August 1992, participants identified the need to formulate a national AIDS strategy to be implemented when the new government took power. A national conference in October 1992 established task teams to formulate the key principles and components of this strategy. Important principles included: the involvement of people living with HIV/AIDS in all aspects of a national program; recognition of the vulnerable position of women; and an emphasis on human rights and community involvement. The conference led to the formation of the National AIDS Coordinating Committee of South Africa (NACOSA). Within a year, the NACOSA National AIDS Strategy had been finalized.[18]

The Strategy proposed a holistic and multisectoral response, including education and prevention, counseling, health care, welfare, and research. The inclusion of a section on law reform and human rights demonstrated an understanding of the relationship between human rights and public health. Within months of South Africa's first democratic election, the National AIDS Plan was adopted by the new government and implementation was expected to begin immediately.[19]

Thus, in the early 1990s, it seemed that the Liberation Movement was committed to a holistic AIDS prevention strategy. This created optimism among many people that it might be possible to prevent the scale of tragedy that was occurring elsewhere in Africa. The introduction to the National AIDS Plan, written when HIV prevalence was estimated at 4.25 percent of women attending prenatal clinics, stated:[20]

> ...the HIV/AIDS epidemic is still at a relatively early stage and can be slowed down. There is the capacity in the country to understand the potential impact and to act timeously.[21]

In 1994, the NACOSA plan seemed to have an echo in the Reconstruction and Development Programme (RDP), the official election programme of the ANC, which proposed to launch a program that would:

> ...include the active and early treatment of [these] diseases at all health facilities, plus mass education programmes which involve the mass media, schools, and community organisations...[22]

Again reference was made to rights:

> The treatment of AIDS sufferers [sic] and those testing HIV positive must be with utmost respect for their continuing contributions to society. Discrimination will not be tolerated.[23]

But unfortunately, three years later, in 1997, South Africa seem to have repeated rather than learned from the histories of its neighbors. Ironically, resolution of one of the greatest human rights issues of the century, apartheid, obscured early recognition of the emergence of another, AIDS. Although the principles and proposals for an effective response were firmly established on paper by 1994, the pre- and post-election transformation process proved a debilitating distraction. The years preceding the election involved great excitement, social turmoil, and dislocation. State-sponsored violence fuelled local conflicts in the townships around Johannesburg and across KwaZulu Natal. It is no coincidence that these areas, particularly KwaZulu Natal, now have disproportionately high HIV prevalence.[24]

Politics, violence, and national euphoria strengthened the mood of denial about HIV in which prejudice around HIV issues continued, silencing most people with HIV. People living with HIV and AIDS became one of South Africa's newest minorities. The depth of shame associated with HIV infection is evident in the following extract from a recent criminal prosecution of a woman convicted of assault with intent to do grievous bodily harm:[25]

> Q: Did you there hit [her] with an iron rod?
> A: No, with an axe.
> Q: How many times?
> A: Once on her head.

Q: Why did you do that?
A: She cursed me. She insulted me very badly.

Later in the questioning the magistrate asked about the reason for the assault, and the following interchange then appears:

Q: What did the complainant say to you?
A: She said I am HIV-positive.

Post-Election Disappointment

With hindsight, several conclusions can be drawn about South Africa's response to AIDS. A decade of political instability created the conditions for escalation in HIV infections to go unnoticed. After 1990, the constitutional negotiations between the ANC and the National Party eclipsed many other matters that should have been of national concern.

Post-election democratic progress—and the task to make new-found rights meaningful—also included factors that postponed an effective response to AIDS. The Government of National Unity was faced with a huge task of transformation: a new constitution had to be written and virtually every law reconsidered. New institutions had to be established.

Political enfranchisement has been accompanied by a weakening—even paralysis—of many of the popular organizations that had started to consider AIDS as an urgent issue in the early 1990s. Many experienced human rights campaigners have been recruited from mass organizations to public service or elected to provincial and national parliaments. Priorities have changed, and youth organizations, civic movements, trade unions, human rights organizations, and the ANC have been weakened internally.

The holistic response to AIDS envisaged by the National AIDS Plan has been a major casualty of the compelling requirements of transformation. Most of its recommendations, including those on human rights and law reform, have not been acted upon.[26] Among those organizations directly involved with AIDS issues there is a sense that government is not doing enough. Distrust and disappointment have been compounded by a series of errors in the actions of the Department of Health. These include the expensive and ill-considered "AIDS play" *Sarafina II*, commissioned from famous

playwright Mbongeni Ngema. The play was meant to popularize messages about HIV prevention, especially among South African youth. Unfortunately, irregularities in the underwriting process, the R14 million (approximately US $3 million) that was awarded, and the play's confusing content led to a huge public outcry.[27]

Recently, Ministry of Health support for Virodene, a substance that clinical investigators publicly claimed to be a cure for AIDS, had a similar effect. The fact that the Minister of Health endorsed the research despite allegations of serious ethical violations, created renewed conflict with NGOs and professional bodies, such as the Medicines Control Council.[28]

Apart from these scandals and occasional expressions of shock at the latest statistics concerning prevalence, HIV rarely occupies the attention of political leaders or society at large. However, the government is not the only powerful force with the potential to intervene. Culpability is a national responsibility that extends to most of the major institutions. Yet, despite an informed understanding of AIDS and its implications, organized business has done very little, trade unions with millions of members have failed to take the issue beyond their top offices, and church leaders are silent.[29]

Ironically, an AIDS epidemic of the proportion that is facing South Africa could undermine many of the ANC's achievements.[30] This is a concern that was recognized by Nelson Mandela in his speech to the World Economic Forum in Davos, Switzerland, in February 1997. Mandela suggested that "if current trends continue then AIDS will cost South Africa one per cent of our GDP by the year 2005; and...up to three quarters of our health budget will be consumed by direct health costs relating to HIV/AIDS." In the same speech, Mandela also puts forward a call for action by stating that:

> [C]onscious of our own need to put the effort to combat AIDS on a higher plan, South Africa's National AIDS Programme has made a call for "A New Struggle." The vision which fuelled our struggle for freedom; the deployment of energies and resources; the unity and commitment to common goals—all these are needed if we are to bring AIDS under control.[31]

A New Struggle?

Linkages between human rights and public health in the context of AIDS should be obvious.[32] But across Africa there are factors that make a human rights-based response to the AIDS epidemic, and the efficacy of even the best public health response, a very different challenge to that faced in Europe or North America. Across the continent, many fundamental human rights are currently unrealizable.

"Costly" economic and social rights, rather than being "progressively realized," are on permanent hold, ostensibly pending economic regeneration of the continent. The human rights of people living with HIV often disappear in the stigma-supported silence.

In South Africa, advocates of human rights are fortunate that citizens have a unique Bill of Rights and a progressive Constitutional Court responsible for making judgments on the interpretation and definition of these rights. However, among many human rights and legal theoreticians, there remains a lack of insight as to why HIV/AIDS is a human rights issue. For example, at a Pan-African conference on human rights in Africa held in South Africa in 1994, the agenda did not include HIV/AIDS and human rights—despite the fact that by 1996 over 60 percent of the world's total HIV infection was located in sub-Saharan Africa.[33] This attitude has been encountered at even the most respected human rights organizations, including the Centre for Applied Legal Studies (CALS), based at the University of the Witwatersrand in Johannesburg.[34]

The 1991 *Charter of Rights on AIDS and HIV* was drafted in an atmosphere of mounting abuse of the rights of people with HIV. It therefore asserts fundamental human rights. Between 1992-1994 high-level endorsement was secured for the Charter across the spectrum of civil society and government. This helped establish recognition that the response to HIV and AIDS should always be based on principles of non-discrimination.

But principles are not always sufficient. South Africa is simultaneously industrialized and rural, modern and tribal, and—as in other parts of Africa—a rights-based response to AIDS may give rise to tension between local cultures, the law, and individual human rights. For example, just as cer-

tain religions resist the imperatives of safer sex because of opposition to contraception, in South Africa there are aspects of traditional social relations that clearly conflict with human rights and increase people's vulnerability to HIV infection.[35] One example is the inequality of women under customary laws that still support polygamy and wife inheritance, and give women no voice in discussions about reproduction and sex. Also, among many Xhosa people, the passage to adulthood for young men is still marked by circumcision in the "bush" (i.e., away from medical facilities) with an unsterilized knife.

HIV lends urgency to separating out which practice should and should not endure within traditional cultures. But it is not only ancient or traditional practices that increase vulnerability. In both industrialized and developing societies there are many aspects of modern "culture" that contribute to the spread of the HIV/AIDS epidemic, including law. South African common and statute law, although under attack, still criminalizes sex between men, thus supporting and reinforcing prejudices.

The South African Constitution entrenches customary and religious law as long as it is not "exercised in any way that is inconsistent with any provision of the Bill of Rights."[36] It also supports the right to nondiscrimination on grounds that include, but are not confined to, race, gender, sexual orientation, and disability.[37] It establishes a Constitutional Court with the power to strike down statute, common or customary law that is in conflict with the Bill of Rights.[38] But cultural practices that deny fundamental human rights cannot be wiped away by a constitution created by lawyers, academics, and politicians. Cultural practices evolve in tandem with social development and progress concerned with a more equitable distribution of resources. Hence, it is essential to consider both the social factors that enhance vulnerability to HIV infection, and the importance of the less commonly heard assertion about the impact that realization of socioeconomic rights could have on HIV prevention.

The Importance of Social and Economic Rights in the AIDS Epidemic

In South Africa, the HIV epidemic developed later than in other parts of Africa.[39] This has at times been attributed to South Africa's previous isolation, including the habit of policing its borders. Of course, labor and refugee migration have been a significant characteristic of the sub-continent and contributes to the AIDS epidemic. But this trickle-down theory of the AIDS epidemic ignores the fact that labor migration was as much a part of the old South Africa as it is of the new.[40] In addition to contributing to xenophobia, this theory can also lead to an underestimation of the internal social factors that have assisted high rates of HIV transmission, and become a convenient excuse for the high HIV prevalence in South Africa's border provinces.

Decades of human rights abuses across the region have contributed to the very high HIV incidence rates. The effect of two decades of destabilization by South Africa's apartheid régime, particularly of Mozambique and Zimbabwe, has been to inextricably intertwine South Africa's future to that of its neighbors. The dislocation caused by civil war in these countries impacts directly on people's vulnerability to infection, regardless of their country of origin. The HIV epidemic is a regional concern requiring regional cooperation.[41] Regional treaty bodies such as the Southern African Development Community (SADC), now with a membership of 15 countries, have occasionally paid lip service to the need for a coordinated regional AIDS strategy and the sharing of resources. However, the last effort to detail this need was made in December 1996 at the joint European Union/SADC Conference on HIV/AIDS. Its resolutions have disappeared into the mid-distance. Manifold social and cultural factors make up the regional equation, but in 1997 the prospects of the HIV epidemic in South Africa being brought under control still seem remote.

In South Africa, according to the Director of the National AIDS Programme in the Department of Health, relatively high awareness about AIDS has not brought about changes in risk behavior.[42] Defining the meaning of awareness is a complex issue, but the failure of knowledge to influence behavior reminds us that "fundamental deprivation makes compliance

with medical advice literally impossible."[43] Rapid rates of HIV infection are a reminder of our society's failure to tackle the root causes of epidemics.[44] In the next decade, as much attention must be given to the fundamental deprivations that accentuate risk behaviors as to the traditional education-based responses to HIV and AIDS.

The biggest obstacle to bringing HIV under control in developing countries like South Africa is the readiness of governments to dispense with, or at best refuse to define, the obligations created by economic and social rights. It is interesting to note that in discussions on the distinction between "negative rights" and human rights as properly defined, which includes health as a human right, the more inclusive approach to rights is so frequently confused or overlooked.[45] The argument seems to be that if you cannot give them health, at least give them civil and political rights. On the contrary—realization of economic and social rights is crucial if the HIV/AIDS epidemic is to be slowed down.

The vagueness of international instruments around rights to health inadvertently help governments in the region to evade their responsibilities to the majority of their populations on matters of health. For example, the International Covenant on Economic, Social and Cultural Rights (ICESCR) proclaims the right of individuals to the "highest attainable standard of physical and mental health" (Article 12.1).[46] The African Charter on Human and People's Rights requires "States...to take the necessary measures to protect the health of their people and ensure that they receive medical attention when they are sick" (Article 16).[47] But who decided what is "the highest attainable standard" and what are "necessary measures"?[48]

While South Africa has not ratified ICESCR, this covenant was influential in the drafting of South Africa's Bill of Rights. At first sight, the South African Constitution appears to support an unqualified right to health by proclaiming that "[e]veryone has a right...[t]o an environment that is not harmful to their health or well-being" (s24).[49] However, subsequent sections of the Constitution entrench only a right for "citizens" to have "access" to adequate housing (s26), "health care services including reproductive health care" (s27,1a) and sufficient food and water (s27,1b). This limitation of extend-

ing economic rights only to citizens, exploits the loophole created by ICESCR Article 2.3, which permits that "[d]eveloping countries, with due regard to human rights and their national economy, may determine to what extent they would guarantee the economic rights recognized in the present Covenant to *non-nationals* [emphasis added]."[50] In South Africa, it is estimated that there are up to 8 million people considered "aliens." Many are permanent residents, illegal immigrants, and undocumented economic and political refugees. It is perhaps understandable that the government believes that it does not have the resources to make access to health care a right for all people in South Africa. But by denying the rights of these groups to access medical treatment, the Constitution discourages health-seeking behavior, including STD treatment and HIV testing and counseling.

Finally, the South African Constitution mimics the ICESCR by linking economic rights to "available resources" and requiring only the "progressive realization" of these rights. Hence the duty of the state, "within its available resources, to achieve the progressive realization of each of these rights" (s27(2)). Similarly, in the context of the manifold social factors that increase the risks of HIV, the meaning of the constitutional right to an "environment that is not harmful to their health or well-being" (s24 a)—and the extent to which it intersects with rights to housing, health care, food, water, and social security—should be explored and established.

Possible conflicts created in the Constitution by the close juxtaposition between rights and resources reminds us of the dilemmas confronted in debates concerning conflicting rights, restricted resources, and bottom-line duties. In the course of one such debate, Albie Sachs, now a Judge of the South African Constitutional Court, declared that "the most compelling health needs...are a matter of a right and do not depend upon some remote notion of efficacy."[51] This approach to rights is rarely pursued—a preferred approach, particularly in the context of HIV and AIDS, being one that often puts the supposed public health benefit before the right itself. But, as has recently been argued:

> Premising the extension of rights to people with HIV on the public health benefit diminishes the inherent value

of those rights. Rights are not extended on the basis of the utilitarian value to society of that extension; they are not given out by a small group of rule makers, only at the point when some benefit is derived; rights were there first.[52]

One might ask, therefore, which are the most compelling health needs and why is this "right" not more explicitly stated (or interpreted) in the Constitution? Perhaps this is a matter that the Constitutional Court will eventually decide.

The exact duties that the Bill of Rights places on the government on matters relating to socioeconomic rights therefore remain to be seen. But with intelligent litigation, the possibilities are enormous.

South Africa has the most powerful economy on the African continent. It has a first-world communications system and a relatively developed infrastructure. Economists argue that for South Africa to overcome the legacy of poverty left by apartheid it must become an African "tiger."[53] There may be truth in this, but this imperative quickly blurs other needs.[54] It is left to governments and their economic advisers (usually from the World Bank or the International Money Fund) to set the benchmarks for what is the "highest attainable standard of physical and mental health" within the constraints of resources.[55] Even if it is accepted that realization of rights compel trade-offs, it follows that trade-offs require negotiations, and negotiations require informed discussion and decision on priorities. The problem in South Africa, and in most of the world, is that the rights advocates are not invited to the talks where the decisions are made.

Is Access to Health Care Becoming a Minority Right?

Fifteen years into the AIDS epidemic, South Africa has a reasonable record of asserting and defending the civil rights of people living with HIV. Human rights principles are entrenched in the National AIDS Plan. Up until mid-1997, the Minister of Health defended rights to privacy and confidentiality, even when the Director-General of the Department of Health was questioning them.[56]

The government recently reinforced its commitment to these rights when it prohibited pre-employment HIV testing throughout the public service, including in the military.[57] Nonetheless, many people with HIV will be forgiven for ask-

ing about the lasting value of civil rights when rights issues related to risks of infection, treatment, and care are not resolved.

It is estimated that 90,000 South Africans will develop AIDS in 1997.[58] The imminence of a mature AIDS epidemic means that these questions will become more urgent, particularly as news spreads of more effective treatments. In South Africa the majority of people living with HIV do not disclose their HIV status. But on matters concerning access to treatment, there is an unparalleled speaking out of people living with HIV/AIDS, on the radio, on television, and in the print media.

Thus far, the struggle for human rights in relation to HIV has mainly been to assert civil rights. A growing awareness of these rights and the limited achievements that have been won is evident from the publication of *HIV/AIDS and the Law: Resource Manual.*[59] But it is the question mark that hangs over the progressive realization (or lack thereof) of economic and social rights that must now be of most concern. Rights, such as that of "access to...reproductive health care" (s27,1a) require definition and enforcement.[60] How society responds to these matters, and the degree of sensitivity with which government addresses the issue, will have an impact on rates of transmission. Early treatment and access to managed health care might be an incentive for people with HIV to "come out," and seek HIV testing and counseling. This might help to break down enduring stigmas.

South Africa suffers from a plethora of health problems, including epidemics of STDs, malaria, and TB.[61] These interact and feed on each other. A suitable response to one has the potential to dramatically impact another. But public health has not entered the national parlance, and none of them receive sufficient attention.

A recent editorial in the *Economist* focused on the much-heralded breakthroughs in therapy for HIV infection and AIDS, but warned: "...such a victory would not, in itself, mark the conquest of AIDS. Indeed, for most of the 21 million or so people carrying HIV, the hope the treatment brings is likely to be the hope of Tantalus: ever present, but out of reach."[62] A senior businessman from the Anglo American Corporation, South Africa's largest economic monopoly, puts it more

bluntly: "We accept that a richer person can have a better car or a better life, but there's something less acceptable about the rich being able to purchase more years of life."[63]

It is this dilemma, touching upon the most fundamental of human rights, that the South African government must urgently confront. There appears to be an awareness of these challenges. In May 1997 at the opening of the first conference of the South African Human Rights Commission, the Minister of Justice warned:

> "I have one fear concerning the Bill [of Rights]—which is a wonderful document entrenching important civil liberties, socioeconomic rights, women's rights and children's rights. Because of the imbalances we have inherited, only a few people have the capacity to enjoy their rights and the danger we face is that the Bill will be the sole preserve of the rich and powerful."[64]

However, the special relevance of this comment to the rights and needs of people living with HIV does not appear to be appreciated by politicians. Additional resources to slow down new HIV infections are overdue. The National AIDS Plan is still funded mainly through overseas donors with the result that a sense of ownership is not felt by South Africans, not even by the government.[65] The response to AIDS is not felt as the result of a movement of affected populations or a broad consensus on the priorities of public health.

Therefore, as the industrialized world moves towards treating AIDS as a chronic but manageable illness, causing death mainly among groups of people marginalized by society and without the resources to help themselves, it seems that AIDS will remain at the center of populations in Africa and Asia leading to millions of deaths, similar to the "traditional" third world epidemics of malaria, TB, and dysentery.

AIDS compounds threats to human rights throughout Africa. One hundred years of colonialism set the scene for African people's vulnerability. Decolonization, while necessary and progressive, left behind fractured and fragile societies, often at war with themselves or each other and powerless in global decision-making. Populations were malnourished, their economies imbalanced and undeveloped and a variety of epidemics had fatal consequences for large parts of the population. As a result, most countries were unequipped

to tackle a new epidemic in the 1980s. In fact, other epidemics were so rife that an appreciation of the extent of the AIDS epidemic only emerged with the advent of sero-prevalence studies.

With the apparent "stabilization" of these societies in the 1990s, a national and even a regional response to the AIDS pandemic could be developed.[66] The will certainly exists. Countries like South Africa and Namibia, where the response to AIDS has lagged behind countries like Uganda, are beginning a process of serious soul-searching to review their failings up to this point. But there is a danger that the "priorities" of the "emerging markets" may do even more to nudge AIDS and public health off the agenda, than prejudice did in the last decade. The civil, political, and socioeconomic rights of people with HIV/AIDS and people vulnerable to HIV infection cannot be resolved without a resolution of major causes of inequality that bedevil Africa. The new South Africa might feel proud of its Bill of Rights, but without an attempt to give solid consideration to socioeconomic rights, including access to health care in the context of AIDS as one of its central aims, the human rights of all people will remain unfulfilled.

Acknowledgment

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4. A. Fleming, "South Africa and AIDS: Seven Years Wasted," *AIDS Analysis Africa*, Southern Africa Edition 3(7) (1993):7-8.
5. See *COSATU Congress Resolution on AIDS*, 1989; "Aids," *Industrial Relations Digest Quarterly Review* (September 1991):14-15; "Cosatu Sets Out Aids Programme," *South African Labour News* 4(12) (1993):11-12; "Workplace Programmes The Trade Unions Intervene," *Critical Health* 44 (1993):29-34.
6. M. Hermanus, "HIV/AIDS Policy in the Mining Industry," *South African Journal on Human Rights* 9(1) (1993):113-122.

7. The ANC has always had an ambiguous position on the question of gay rights, adopting a politically correct position in its resolutions, but doing nothing to counter homophobia that has been encouraged by leaders like Winnie Madikizela-Mandela who have argued that homosexuality is "unAfrican."

8. Evidence given at an inquest in September 1997 included a revelation that *Askaris* (members of the African National Congress who had been captured and "turned' by the Security Police) were given missions to deliberately infect prostitutes with HIV.

9. Even in 1995, when one of the authors addressed a meeting of leaders of the Congress of South African Trade Unions (COSATU) in KwaZulu Natal, there was still a strongly held opinion that AIDS was an "imperialist" plot to make African people afraid to have sex and thereby reduce population growth, and that people with HIV could be cured by *sangomas* (traditional healers).

10. The 1988 AIDS policy of the Chamber of Mines stated: "[n]o person from a high-incidence area defined by the Chamber, whether foreign or South African, will be employed by a mine unless he has been tested and the employer is satisfied that he is free from HIV infection." *South African Journal on Human Rights* 9(1) (1993):118.

11. In terms of s13(1)(h) of the Admission of Persons to the Republic Regulation Act 59 of 1972.

12. Z. Achmat and M. Heywood, "The Weakest Amongst Us: Managing HIV in South African Prisons," *Imbizo – Research in Progress Series,* 2/ 1996.

13. P. Doyle, "The Impact of AIDS on the South African Population," *Metropolitan Life,* July 1991.

14. *Jansen van Vuuren NNO vs Kruger* ([1993] 4 SA 842).

15. Readers may find it surprising that in South Africa, labels inherited from apartheid are still used to describe the racial character of the main population groups: "African" referring to black people (regardless of tribal/ ethnic origin), "coloured" to people of mixed race, "Indian" to people originally from Asia and "White" to whites (also regardless of origin).

16. In July 1997, the AIDS Law Project forced the South African Medical and Dental Council to issue a warning to doctors about this practice. In August 1997, the first matters concerning unfair discrimination of domestic workers related to their HIV status were brought before the Commission for Conciliation, Mediation and Arbitration (CCMA), a statutory body that deals with labour disputes.

17. The AIDS Consortium Charter of Rights on AIDS and HIV, *South African Journal on Human Rights,* 9(1) (1993):161-164.

18. National AIDS Coordinating Committee of South Africa, *A National AIDS Plan for South Africa,* 1994-1995, July 1994.

19. Debates of the Senate (Hansard), V. 6, 1994.

20. Department of Health, *Summary of the Results of the Fifth HIV Survey of Women Attending Antenatal Clinics of the Public Health Services of South Africa,* October/ November 1994, 1995.

21. NACOSA, *A National AIDS Plan for South Africa,* 1994-1995, 1994: p. 7.

22. African National Congress, *Reconstruction and Development*

Programme, 1994.

23. Ibid, p. 48.

24. Statistics that convey the extent of the violence can be obtained from the annual *Race Relations Survey* between 1990 and 1994, South African Institute of Race Relations. An excellent summary of the negotiations process can be found in: A. Sparks, *Tomorrow is Another Country: The Inside Story of South Africa's Negotiated Revolution* (Sandton, SA: Struik Book Distributors, 1994).

25. I am grateful to Justice Edwin Cameron for providing a summary of this matter, which he heard on review in June 1997.

26. A. Strode. AIDS Legal Network Review of Implementation of the Law and Human Rights section of the NAP, June 1997.

27. Report to the University of Pretoria and Gauteng Department of Health on the Alleged Discovery of a Drug for the treatment of AIDS, University of Pretoria/Gauteng Department of Health, February 1997.

28. Public Protector, "Investigation of the Play Sarafina II," Report in Terms of Section 8(2) of the Public Protector Act 23 of 1994, 1996.

29. C. Sunter, *The High Road: Where are We Now?* (Capetown: Tafelburg: Human and Rousseau, 1996).

30. R. Loewenson, "The Economic and Employment Implications of AIDS," paper presented at Workshop on Regional Code on AIDS and Employment, January 1996.

31. Speech by President Nelson Mandela to the World Economic Forum, 1997. Reprinted in *AIDS Analysis Africa* 7(6) (1997):1.

32. François-Xavier Bagnoud Center for Health and Human Rights, Harvard School of Public Health, and International Federation of Red Cross and Red Crescent Societies, *AIDS, Health and Human Rights: An Explanatory Manual,* 1995.

33. The Status and Trends of the Global HIV/AIDS Pandemic Symposium Final Report, Vancouver, July 5-6, 1996; AIDSCAP/Family Health International, François-Xavier Bagnoud Center for Health and Human Rights, Harvard School of Public Health, and UNAIDS (1996), p. 12.

34. To generate an awareness of HIV and legal and human rights issues, the AIDS Consortium held four national conferences between 1992 and 1995 examining different aspects of legal rights and AIDS. Centre for Applied Legal Studies, *Annual Reports,* 1992, 1993, 1994, 1995.

35. D. Defert, "AIDS as a Challenge to Religion," in: *AIDS in the World II: Global Dimensions, Social Roots, and Responses,* J.M. Mann and D. Tarantola (eds.) (New York: Oxford University Press, 1996), pp. 447-452.

36. The Constitution of the Republic of South Africa, Act 108 of 1996, Chapter II, Section 15,3 (a) & Section 31 (2).

37. Ibid. Section 9 (3).

38. Ibid. Section 167.

39. HIV prevalence differs greatly between provinces. Among pregnant women in the Western Cape it is 3.09 percent, compared to the North West, where it is estimated to be 25.13 percent. Department of Health, *Seventh National Survey of Women Attending Antenatal Clinics of the Public Health Services of South Africa, October/ November 1996,* 1997. C. Campbell, B. Williams, "Understanding the Epidemic of HIV in South Africa: Analysis of Clinic Survey Data," unpublished paper, May 1997.

40. In 1990, it was estimated that the Chamber of Mines alone employed nearly 500,000 foreign workers. South African Institute of Race Relations, *Race Relations Survey 1989/90*, Johannesburg, p. 29.

41. According to figures provided in the *Background paper for the Joint EU/SADC Conference on HIV & AIDS*, 1996, HIV sero-prevalence in South Africa's neighbors is: Botswana, 18 percent; Lesotho, 11-31 percent; Mozambique, 5-10 percent; Namibia, 6.5 percent; Swaziland, 3.8 percent; Zimbabwe, 16-32 percent.

42. A nationally representative survey on a range of health issues carried out in 1994-1995 found 98 percent of people had heard about AIDS, and 90 percent knew that sex without a condom was a high risk, but only two-thirds would use a condom when having sex with a new partner. Community Agency for Social Enquiry, *A National Household Survey of Health Inequalities in South Africa: Overview Report*, October 1995.

43. J. Osborne, Harvard Law School, *Economic and Social Rights and the Right to Health, An Interdisciplinary Discussion Held at Harvard Law School in September 1993*, Harvard University, 1995:19.

44. See "From Epidemiology to Vulnerability to Human Rights," *AIDS in the World II*, see note 35, pp. 427-473.

45. For example, see L. Gostin, Z. Lazzarini, *Human Rights and Public Health in the AIDS Pandemic* (New York: Oxford University Press, 1997) pp. xiv-xv.

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47. The African Charter on Human and People's Rights, *ibid.* pp. 342-362.

48. Currently no General Comment or Recommendation exists laying out the content of this right.

49. Chapter II, The Bill of Rights, The Constitution of the Republic of South Africa, Act 108 of 1996.

50. ICESCR, see note 46.

51. Harvard Law School and School of Public Health, "Applying Rights Rhetoric to Economic and Social Claims," see note 32, p. 13.

52. B. Cohen, "Some Questions About the Public Health Model and Its Value to Rights Advocates," University of Michigan/AIDS Law Project, unpublished paper, March 1997.

53. Ministry of Finance, "Growth, Employment and Redistribution: A Macroeconomic Strategy (GEAR)," Pretoria, 1996.

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can military is now one of the few armies in the world that does not perform mandatory HIV testing of recruits. A working paper and draft bill is being prepared by a Project Committee of the SA Law Commission that proposes to extend this prohibition to the private sector.

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