AIDS Law Project

FINAL REVIEW

JANUARY 2009 TO MARCH 2010

AIDS Law Project

+27 (0)11 356-4100 (t)
+27 (0)11 339-4311 (f)

PO Box 32361
Braamfontein 2017
South Africa

Unit 6/002, 6th Floor
Braamfontein Centre
23 Jorissen St, Braamfontein
Johannesburg
South Africa

info@alp.org.za
www.alp.org.za

Edited by Jonathan Berger, Mark Heywood and Adila Hassim
Typesetting & design: AdlibStudio

Contents

Mission statement

The AIDS Law Project (ALP) is a human rights organisation that seeks to influence, develop and use the law to address the human rights implications of HIV/AIDS in South Africa, regionally and internationally. In particular, it uses legal and policy processes and litigation to protect, promote and advance the rights of people living with HIV/AIDS, as well as to change the socio-economic and other conditions that lead to the spread of infectious diseases and their disproportionate impact on the poor. In addition, it conducts and publishes research in order to assist with policy formulation and the development of appropriate legal and regulatory frameworks needed to respect, protect, promote and fulfil human rights.

Although the ALP maintains a focus on HIV/AIDS, it recognises that the progressive realisation of a set of human rights – and socio-economic rights in particular – is fundamental to sustainable progress in tackling the epidemic. Developing content and a better understanding of the duties of the public and private sectors regarding the right of people to health care is a particular objective of the ALP.

The ALP believes that empowering vulnerable people living with or affected by HIV/AIDS with knowledge of the law and human rights is effective and sustainable in tackling the epidemic. To this end, we work in partnership with other human rights organisations – particularly the Treatment Action Campaign (TAC) – to educate and train people about law, human rights and how they can use the legal framework.

The ALP is committed to the highest level of professionalism, accountability, transparency and respect for people's equality, dignity, privacy and autonomy.

Andrew Richard Warlick

3 August 1982 - 11 April 2010

It is with deep sadness that we remember Andrew. His personal dignity reflected his belief in the right to dignity of all people. We will miss Andrew in the next stage of our struggle.

Dedication

Since the advent of our constitutional democracy, litigation and legal advocacy has done a great deal to protect, advance and clarify the rights of people living with HIV. This would not have been possible without the courage of individuals who placed faith in the Constitution and used the law to advance their rights and those of others. Over the years there have been too many clients to name individually here, but we have tried to recall those people whose cases we have reported publicly upon.

The people listed below forged a new path for equality in relation to unfair discrimination against domestic workers, employment discrimination in other workplaces (including the public service), discrimination by life insurers and medical schemes, and discrimination in access to treatment.

As the years passed, the ALP began litigating increasingly in relation to the positive obligations on the state, state accountability and the constitutional responsibilities of the private sector.

The ALP remembers the courage of all our clients and comrades whose personal struggles made the law, some of whom have died as a result of HIV. This, the ALP's final review, is dedicated to them.

A (*A v Connell Instruments (Pty) Ltd*)
A (*A v SAA*) – died in 2001
Dr Steven Murray Andrews – died in 2009
AKM, TSM, ZSM and XM (individuals challenging the SANDF)
Baby A and her parents, IH and AO
Dr Mark Blaylock
CM (*CM v SANDF*)
DK *(DK v Dept of Home Affairs*)
Gugu Dhlamini – died in 1994
EN, BM, DM, EJM, LM1, MAZ, MSM (died 2006), ND, NS, SEM, TJX, TS, VPM (died 2005), ZPM and LM2 (inmates at Westville Correctional Centre in *EN v Government of the RSA*)
FH (*FH v Compcare Medical Scheme*)
GA (*GA v SAPS*)
Dr Costa Gazi
Sindiswa Godwana
Dr Eric Goemaere
Dr Strinivasan Govender
Fanelwa Angel Gwashu
Sarah Hlahlele – died in 2003
John Ndimande Hlatshwayo
Barbara Kenyon
K (Highveld Mediclinic)
LM (individual challenging Spectramed)
Ronald Louw – died in 2005
Edward Mabunda – died in 2003
Mr and Mrs Maimela
Mandla Majola
Sizeka Maya
Barry McGeary (challenged violation of privacy) – died in 1991
Khanya Mkoko
Thapelo Mlonyeni (Free State ARV treatment moratorium) – died in 2009
Dr William Nkhangweni Mmbara
Sr Nompumelelo Mntangana
Dr Thys von Moellendorf
Christopher Moraka – died in 2000
Sgt Sipho Mtethwa
NS (*NS v Old Mutual*)
Dr Malcolm Naude
Matomela Paul Ngubane – died in 2003
Simon Tseko Nkoli – died in 1998
Neliswa Nkwali
Norute Nobola
Karen Perreira
Dr Colin Pfaff
Sr Susan Roberts
Dr Haroon Salojee
Bulelwa Sekosana
Isaac Skosana
SM, NM and LH (women challenging violation of their privacy in *NM v Smith*)
Lourens Swanepoel – died in 1994
TMS
Hazel Tau
Nomafrica Velem
Dr Willem Daniel Francois Venter
VRM (challenged misconduct by her doctor in *VRM v HPCSA*)
Charlene Wilson – died in 2003
X (*X v ADT Security*)
Nontsikelelo Patricia Zwedala

Finally, we acknowledge Constitutional Court Justice Edwin Cameron who had the foresight and faith in human rights law to start the ALP in 1993. We hope that SECTION27 will remain true to his vision.

People at the ALP

Board of directors

Chairperson

- Vuyiseka Dubula: *General secretary, TAC, and person living openly with HIV*

Deputy chairperson

- Johann Kriegler: *Former justice of the Constitutional Court and chairperson of the Independent Electoral Commission during South Africa's first democratic elections*

Treasurer

- Nhlanhla Ndlovu: *Programme manager, Centre for Economic Governance and AIDS in Africa (CEGAA)*

Other directors

- Quarraisha Abdool Karim: *Epidemiologist, Centre for the AIDS Programme of Research in South Africa (CAPRISA), Nelson Mandela School of Medicine, University of KwaZulu-Natal and Columbia University; and first director of South Africa's HIV/AIDS and STD programme in the Department of Health (1995-1996)*
- Brian Brink: *Senior vice-president (medical), Anglo American Corporation and member of the board of the Global Fund for AIDS, TB and Malaria*
- Sharon Fonn *(ex officio): Head of the School of Public Health, University of the Witwatersrand, Johannesburg*
- Mark Heywood *(ex officio): Executive director, ALP*
- Marius Pieterse *(ex officio): Professor of law, University of the Witwatersrand, Johannesburg*
- Theo Steele: *National organiser, Congress of South African Trade Unions (COSATU)*

Staff

• Muhammad Abdur-Rahim	*Finance manager*
• Jonathan Berger	*Senior researcher and director of policy and research*
• Paul Booth	*Research assistant to executive director (in his capacity as deputy chairperson of the South African National AIDS Council (SANAC)) (until September 2009)*
• Meryl Federl	*Information officer (until December 2009)*
• Nathan Geffen	*Researcher*
• Adila Hassim	*Advocate and director of litigation and legal services*
• Mark Heywood	*Executive director*
• Brian Honermann	*Researcher*
• Nonkosi Khumalo	*Researcher (currently seconded to TAC as full-time chairperson)*
• Linda Lea	*Interim chief operating officer*
• Mpho Maledimo	*Administrator (until February 2010)*
• S'khumbuzo Maphumulo	*Attorney*

• Phindile Mlotshwa	*Office assistant*
• Gerniene Myles	*Receptionist (until April 2009)*
• Shalom Ncala	*Receptionist*
• Sue Niekerk	*Organisational secretary (until February 2010)*
• Dan Pretorius	*Attorney and trainer (until February 2010)*
• Umunyana Rugege	*Attorney*
• Asanda Saule	*Communications officer*
• Ella Scheepers	*Personal assistant to the TAC chairperson*
• Tummy Seboko	*Administrative officer*
• John Shija	*Personal assistant to the executive director*
• Nasser Sujee	*Finance officer*
• Marije Versteeg	*Project manager, Rural Health Advocacy Project (RHAP)*
• Agnieszka Wlodarski	*Attorney*

Interns

• Robyn Griffiths	*Intern from Cardiff University (September – October 2009)*
• Lucky Mkhize	*Intern from Students for Law and Social Justice (SLSJ), University of KwaZulu-Natal (January – February 2010)*
• John Stephens	*Intern from the University of Virginia (May – July 2009)*

ALP staff: Standing – from left: Jonathan Berger, Umunyana Rugege, S'khumbuzo Maphumulo, Ella Scheepers, Phindile Mlotshwa, Brian Honermann, Tummy Seboka, Muhammad Abdur-Rahm, Asanda Saule, Nathan Geffen and Mark Heywood. Seated – from left: Agnieszka Wlodarski, Nasser Sujee, Marije Versteeg and John Shija. Inserts – from left: Adila Hassim, Linda Lea, Shalom Ncala and Nonkosi Khumalo.

Acknowledgements

Clients, deponents, witnesses and expert advisers

GA, Dr. Vivian Black, Community Media Trust (CMT), Dr. Ashraf Coovadia, David Cote, DD, Yoliswa Dwane, Equal Education, Dr Eric Goemaere, Sara Hjalmarson, MK, Evans Kuntonda, PM, Thapelo Mlonyeni, Stella Mothatha, Médecins Sans Frontières (MSF) South Africa, Sgt. Sipho Mthethwa, Dr. Luvuyo Mtongana, Trymore Mushirizindi, Sacred Heart College, Priya Singh, Dr. Vanessa Tanser, Bianca Tolboom, Dr. Francois Venter, BV, Jacob van Garderen, Bishop Paul Verryn, Dr. Doug Wilson, deponents in the challenge to the Johannesburg loitering by-law, and health care providers in the Free State and Edendale Hospital in KwaZulu-Natal.

Donors

The Ford Foundation, the Levi Strauss Foundation, the Royal Netherlands Embassy and the Swedish International Development Agency (administered by the AIDS Foundation of South Africa)

Lawyers and legal advisers

Adv. Daniel Berger SC, Jason Brickhill (Legal Resources Centre (LRC)), Adv. Steven Budlender, Adv. Matthew Chaskalson SC, Adv. Lilla Crouse, Adv. Gcina Malindi, Adv. Gilbert Marcus SC, Tembeka Ngcukaitobi (LRC), Ian Small-Smith, Andrew Smith (Bowman Gilfillan Attorneys), Adv. Lwandile Sisilana, Adv. Wim Trengove SC and Suzette Gerber.

Individual contributors

Zackie Achmat, Adv. Geoff Budlender, Nicholas Crisp, Adv. Andrea Gabriel, Trudie Harrison, Shireen Hassim, Teboho Klaas, Jody Kollapen, Jack Koolen, Anna-Maria Lombard, Danie Louw, Mandla Majola, Kabelo Makhetha, Precious Matsoso, Sello Mokhalipi, Shan Ramburuth, Phumi Mtetwa, Dr. Nono Simelela, Adv. Wim Trengove SC and Anso Thom.

Government officials

Minister Barbara Hogan, Minister Aaron Motsoaledi, Deputy Minister Andries Nel, Dr. Anban Pillay, Dr. Yogan Pillay and Minister Jeff Radebe.

Organisational partners

AIDS and Rights Alliance for Southern Africa (ARASA); AIDS Consortium; Budget Expenditure and Monitoring Forum (BEMF); Centre for Rural Health, University of the Witwatersrand, Johannesburg; CMT; COSATU; Equal Education; Free State AIDS Coalition; Health-e News Service; Joint United Nations Programme on HIV/AIDS (UNAIDS); Lawyers for Human Rights (LHR); Legal Aid South Africa; LRC; MSF South Africa; ProBono.Org; Reproductive Health and HIV Research Unit (RHRU), University of the Witwatersrand, Johannesburg; Rural Doctors Association of South Africa (RuDASA); RHAP; South African Human Rights Commission (SAHRC); SANAC; Southern African HIV Clinicians Society; SANAC Law & Human Rights Sector Working Group; School of Law, University of the Witwatersrand, Johannesburg; SLSJ; TAC; Webber Wentzel Attorneys; and Zimbabwe Lawyers for Human Rights (ZLHR).

Professional services

Designs4development, David Furnival and Kate Soal.

Foreword

Ring in the new!

From the AIDS Law Project to SECTION27 (incorporating the AIDS Law Project)

By Vuyiseka Dubula, Chairperson, Board of Directors

This is the last edition of the AIDS Law Project review and the last publication of the ALP. Within days of its publication, the ALP will take the bold step of incorporating itself into a new organisation, called SECTION27.

This is the end of a long, stressful, rewarding road – and the start of another. Many things have changed since the ALP was founded in 1993 by Edwin Cameron, who is now a justice of the Constitutional Court. In 1993 there was no legislation that sought to protect people with HIV, today there are many important laws. In 1993, there was no jurisprudence on protecting the rights of people with HIV; today such jurisprudence is one of the features of our new constitutional order. In 1993, and indeed as late as 2003, there was not one person receiving antiretroviral treatment through the public health sector in South Africa – today there are nearly one million people!

The evolving landscape on HIV, politics, law and rights is captured diagrammatically on page 66.

The ALP is proud to have worked hard to earn a place as a defender and promoter of human rights alongside other South African organisations such as the Legal Resources Centre that inspired us. We have tried to emulate individual lawyers who blazed the trail of human rights law in South Africa. We are also pleased that this work has been recognised. In March 2010, the ALP, the Treatment Action Campaign (TAC), Nonkosi Khumalo and I were jointly – both organisationally and individually – awarded the 2010 John M. Lloyd AIDS Leadership Award.[1] In presenting the award, Board President Robert Estrin stated:

> TAC's model of advocacy is the gold standard for AIDS advocacy throughout the world. TAC does not work in isolation: it is through the brilliant teaming of TAC's grassroots advocacy

1. For more on the John M. Lloyd Foundation, see *http://www.johnmlloyd.org/*

> and [the] AIDS Law Project's well-targeted litigation that has turned the tide in South Africa from being a country with a government which cruelly allowed its people to suffer without treatment for so many years. ... [The] ALP profits from the extraordinary leadership of both Vuyiseka and Nonkosi, with both participating in leadership roles.[2]

However, whilst individuals have been recognised in this struggle it has overall been the collective efforts of an ever growing and changing team that have proved the value of human rights advocacy. People have died in this struggle and in the dedication to this review we remember some of them.

Nonkosi Khumalo and Vuyiseka Dubula receive the 2010 John M. Lloyd AIDS Leadership Award

In this last edition of the ALP review we comment on and analyse political, policy and legal developments in the major work areas of the ALP during 2009 and early 2010. This period has been one in which there has been a revolution in the state's approach to HIV. It is such dramatic changes in the policy landscape that partly influence our decision to close the ALP and launch SECTION27. But as we do so we remind ourselves that successful outcomes require an efficient, transparent and sustainable organisation. To this end, during the period January 2009 through March 2010:

- The ALP's Board of Directors met on four occasions to review the organisation's work and finances, and to steer the organisational transition that was initiated by the ALP's senior staff;
- An independent review of the ALP's financial systems was undertaken – on a pro bono basis – by Danie Louw, leading to the full implementation of a range of recommendations to improve financial management;
- The ALP came to the end of donor agreements with three of its funders: the Ford Foundation, the Levi Strauss Foundation and SIDA. I am pleased to report that all three agreements have been renewed for a further period.
- The ALP hosted three interns – one from the USA, a second from the UK and a third from South Africa – who had expressed an interest to work in a human rights organisation like the ALP;
- The ALP recruited six new members of staff: Nathan Geffen, Linda Lea, Ella Scheepers,

2. Estrin's speech is available at *http://www.section27.org.za/wp-content/uploads/2010/04/Estrin-speech.pdf*.

Asanda Saule, Tummy Sebeko and Umunyana Rugege to join our team of dedicated staff who are increasingly young, female and black! We were also joined by Marije Versteeg, who is employed by the Rural Health Advocacy Project (RHAP) that is physically based at the ALP.

- As part of the organisational restructuring it was, unfortunately, necessary to retrench several members of staff (and in the case of one person not renew a fixed-term contract): Dan Pretorius, Mpho Maledimo, Meryl Federl and Sue Niekerk. We will continue to work with Dan in her new position as training co-ordinator at the AIDS Consortium.

Old and new partnerships

Success in all struggles for human rights and social justice will be heavily dependent on inspiring a new generation of predominantly young people with the transformative vision of our Constitution and a belief that active citizenship can bring about substantive change. For this reason we have continued our close working relationship with the TAC, South Africa's foremost social movement. Nonkosi Khumalo has continued in her role as TAC's chairperson, and, whenever requested, the ALP has assisted the TAC with leadership training and legal advice.

But in addition, we have started to develop and deepen our relationships with younger new movements, particularly Equal Education (EE) and Students for Law and Social Justice (SLSJ). These membership-based organisations are part of a new generation of activists who are attempting to mobilise learners, parents and teachers with calls for a better and more equal education system, and students with a vision of law as a tool in the struggle for social justice. Our hope is that by combining our skills and campaigns, the social justice movement in South Africa will grow ever stronger.

International collaboration

International work was not a dedicated area of focus for the ALP. However, the ALP is under constant call to attend and address international meetings. In this regard, two developments during the period under review stand out.

For several years the ALP has had an informal partnership with a sister organisation working on HIV/AIDS and law in China: the Korekata AIDS Law Centre, which is a wing of the Dongjen Centre for Human Rights Education and Advocacy. In October 2009, Mark Heywood and Adila Hassim were invited by the Chinese Health Ministry, the Joint United Nations Programme on HIV/AIDS (UNAIDS) and Korekata to assess aspects of China's response to HIV and human rights.[3]

The ALP was also the local partner (and primary organiser) for a conference of senior African judges co-hosted by UNAIDS, the International Commission of Jurists (ICJ), the United Nations Development Fund (UNDP) and the International Association of Women Judges (IAWJ) in Johannesburg in December 2009. The conference drew together more than 25 judges from all parts of sub-Saharan Africa under the theme HIV and the Law in the 21st Century.

The ALP presented its work in three plenary sessions. In addition, the conference was addressed by a number of high level speakers, including Justice Minister Jeff Radebe, UNAIDS Executive

3. The report of their visit is available at *http://www.section27.org.za/wp-content/uploads/2010/03/Hassim-Heywood-final-China-report-21120101.pdf.*

Mark Heywood is welcomed to Chengdu, China

Director Michel Sidibé, former Chief Justices Arthur Chaskalson and Pius Langa, and current Constitutional Court Justice Edwin Cameron.[4]

SECTION27

2009 was a watershed year for us. It was the year in which our directors, members and staff decided, after careful thought and much deliberation, to close the ALP. It was also the year in which we decided to create a new organisation, SECTION27, which will incorporate the ALP.

The decision to launch SECTION27 has been widely welcomed. In the words of Stephen Lewis, a former UN Special Envoy on AIDS in Africa and Canadian Ambassador to the UN:

> I've read the prospectus for "Section 27" top to bottom, every word. The concept is brilliant, absolutely brilliant. It seems to have evolved so organically and so logically from the ALP. I congratulate all of you: it's perfect in timing and content. What an exciting development.

While SECTION27 will work towards its objectives mindful of the new social, political and epidemiological realities of health and HIV in South Africa and beyond, it will grapple with and attempt to shape them with the same determination and method that characterised the ALP for 17 years. More detail on SECTION27 is included in its prospectus, which is published with this review.

Cape Town
27 April 2010

4. The conference documents are available at *http://www.unaids.org/en/KnowledgeCentre/Resources/FeatureStories/archive/2009/20091211_Safrica_jurists.asp*. Minister Radebe's speech is available at *http://www.justice.gov.za/m_speeches/2009/20091210_min_hiv.html*

Chapter 1

The aftermath of AIDS denialism: confronting HIV in a broken health system

By Mark Heywood

> As we look forward, it is not yet clear whether the next period will be one of opportunity or threat or both. The removal of President Mbeki has brought AIDS denialism to an end. A new Minister of Health – with a track record of personal integrity, passion and commitment to constitutionalism – has been appointed. But on the other side of the scale are burgeoning problems in the health system itself, problems that might accurately be described as the legacy of the Mbeki/Tshabalala Msimang axis of AIDS denial.
>
> *2007/2008 ALP review*

When former Health Minister, Dr Manto Tshabalala-Msimang died on 16 December 2009, there was an outpouring of condolences. Statement after statement celebrated her life. COSATU described her as a "liberation heroine" and lamented that South Africa was losing "a great leader of the ANC".[1] Joel Netshitenzhe, former head of Policy Co-ordination and Advisory Services (PCAS) in the Presidency,[2] claimed that what made her tick was "intellectual debate and a search for the truth".[3]

Delivering the oration at her memorial service, Deputy President Kgalema Motlanthe stated that "[o]n the balance of evidence, dispassionate observers would conclude that her profound efforts and initiatives in the fight against the AIDS pandemic far outstrip whatever foible she had."[4] Amongst her achievements he listed the co-ordination of:

- the establishment of the South African National AIDS Council (SANAC) (2002);
- the review of comprehensive plan of management, care support and treatment of HIV and AIDS and STDs (2007–2011); and
- the operational plan for comprehensive … HIV and AIDS management, treatment care and support adopted 2003 November and implemented 2004 April, ended March 2009.

Aside from inaccuracies in dates and description of these policies, each one of these can be disproved. SANAC was first established in 2000 and was always resisted by Tshabalala-Msimang; the 2007–2011 plan – the national *HIV & AIDS and STI Strategic Plan for South Africa, 2007–2011* ("the NSP") – was drafted whilst she was on sick leave in 2006 and 2007; and she did her utmost to sabotage implementation of the 2003 operational plan, which was only implemented in April 2004 following civil society threats of urgent court action.

In a similar fashion, almost every statement that came from within the ANC alliance brushed aside the consequences of her almost decade-long tenure as Minister of Health. The South African Communist Party (SACP) said nothing at all of her role in the AIDS epidemic. Indeed, there was almost no dissonance in this chorus of praise.

The purpose of challenging this dusk chorus is not a gratuitous desire to injure the late Minister, but because those who cannot be honest about history are doomed to repeat it. As explained elsewhere, Tshabalala-Msimang survived for a decade because of party and governmental failures of accountability and because political protection and patronage carried more sway than measuring politicians against outcomes and their constitutional responsibilities.

Contrary to the claims of Netshitenzhe and others, who by defending the former Minister are ultimately seeking to defend themselves, the reality is that Tshabalala-Msimang bequeathed to South Africa a populace with a much lower life expectancy than needs be, rising infant and maternal mortality, higher rates of communicable and non-communicable disease, and HIV and TB epidemics that remain largely out of control. On top of this, the health system that is supposed to provide care and treatment to the far- from-healthy populace is itself in cardiac arrest.

Tshabalala-Msimang survived for a decade because of party and governmental failures of accountability and because political protection and patronage carried more sway than measuring politicians against outcomes and their constitutional responsibilities.

In the past two ALP reviews, which together cover 2006, 2007 and 2008,[5] we traced political developments linked to health service delivery during the final years of the Minister's tenure in office, as well as the start of the nine-month interregnum following former President Mbeki's recall. These reviews, as well as less partisan publications such as the special country focus of *The Lancet* published in August 2009,[6] document the real legacy bequeathed by the former Minister.

In the 15-month period covered by this review, South Africa has had two Presidents and two Ministers of Health: President Motlanthe appointed Barbara Hogan as his Minister of Health in September 2008; President Zuma replaced her with Dr Aaron Motsolaedi in May 2009. Motsoaledi, who was relatively unknown to many of us at the outset, has tried to rebuild relations with civil society and has quickly established respect for his passion and determination. Further, as this chapter

shows, there is continuity between the Hogan and Motsoaledi administrations and one common theme: trying to work from within the ruins left by the former Minister of Health.

The rest of this chapter looks at how Tshabalala-Msimang's legacy expressed itself in 2009 and critically appraises the steps that are now being taken to overcome it. In particular, the chapter considers the following four sets of issues: the Free State antiretroviral (ARV) treatment moratorium (November 2008–March 2009); SANAC and implementation of the NSP; health reform, with a focus on the fragmentation of health services and widening inequalities; and the state operating outside the law.

Free State ARV treatment moratorium

Soon after taking office, Hogan made it clear that dealing properly with HIV and TB – by promoting clear messages and prioritising interventions such as the prevention of mother-to-child transmission of HIV (PMTCT) programme – would be amongst her priorities. However, her ability to concentrate on HIV was undermined by compound crises of the health system as a whole and a vicious spiral of collapse that was and remains fed by the mounting toll of illness caused by the AIDS epidemic.

At this stage of the epidemic, widespread HIV-related illness is causing many health facilities to become overstretched, and putting unbearable pressure on already weak systems and demoralised health workers. Because of the sheer volume of ill people, HIV is increasing the cost of providing inpatient care, as well as fuelling the cost of managing linked epidemics such as TB. But at the same time, there is the escalating cost of providing ARV treatment in the public sector.

Many of these issues came to the fore in the health crisis that was caused by the institution of a moratorium on initiating new people on ARV treatment in the Free State in November 2008 – allegedly due to a funding shortfall. Whether there was actually a funding crisis is still not clear. The National Treasury claimed that the Free State always had enough money. Off the record, it was even suggested to us that the "funding shortage" was a crisis that was manufactured as part of the power struggle in the ANC: the Member of the Executive Council (MEC) for Finance in the Free State who controlled the purse strings was associated with the Zuma faction and the MEC for Health with former President Mbeki.

Whatever the real reason for the moratorium, the letters that were sent by the ALP on behalf of TAC requesting urgent action and public accountability were effectively ignored.[7] A theme that will be examined later in this chapter, but which is necessary to mention here, is the obliviousness of many health officials to their legal duties, which combines dangerously with a lack of appreciation of the need to even consider the legal framework.

Sello Mokhalipi of the Free State AIDS Coalition

As explained in a report researched and published by the ALP in early 2009, introducing a moratorium on health services is unlawful.[8] In the Free State, the moratorium involved a unilateral decision to stop providing access to

a health care service that the state had previously committed itself to provide.[9] Provincial government officials seemed unaware that to do this was unlawful. Indeed, they do not even appear to have communicated their decision to the national Department of Health (DoH) or the National Treasury. Options to request emergency funding, which are set out clearly in the Public Finance Management Act 1 of 1999 (PFMA), were also not exercised.

To make matters even worse, the decision to institute a moratorium was not even communicated properly to health care workers or their patients. News about it trickled down to clinics and hospitals. As drug supplies dried up in the Free State, the moratorium became a national issue through the growing pleas of activists and people living with HIV for national intervention.

As reported in our last review, the TAC and ALP had first written to Minister Hogan requesting her intervention in November 2008. Initially we were assured that the matter was being addressed. However, a new volley of letters and public calls for action was launched in February 2009 when it became clear that the moratorium was still firmly in force. By this point it was estimated by the Southern African HIV Clinicians Society that the moratorium was costing 30 additional lives per day.[10]

By this point it was estimated by the Southern African HIV Clinicians Society that the moratorium was costing 30 additional lives per day.

Eventually, as a result of pressure from the ALP and TAC, working through the committees of SANAC, and after meeting directly with the Minister of Health and senior officials, the moratorium was lifted. But this was not before much damage had been done to the programme and many people had died, including several of our clients. In a particularly tragic case, Thapelo Mlonyeni – a young boy whom the ALP had tried to help directly – died in October 2009. Further, the resumption of the flow of ARV medicines varied from clinic to clinic and in many places did not take place before the start of the new financial year in April 2009. Neither could it quickly reverse the damage to the programme caused by longer waiting lists and falling staff morale.

However, the outrage over the moratorium had some positive outcomes. It led to the formation of the Free State AIDS Coalition (a loose affiliation of TAC, trade unions and churches), which was launched at a meeting with the ALP in Bloemfontein in April 2009. In addition, the publicity generated by the crisis had the effect of putting a spotlight on problematic budgeting for the ARV treatment programme, leading to measures being instituted by the government to calculate better and plan for the growing numbers of people needing ARV treatment.

The outcry over the Free State also helps explain both the large additional allocation made to ARV treatment in the mid-year adjustment budget (an additional R900 million was allocated in October 2009) as well as the significant budget increase for ARV treatment in the 2010/2011 budget. It remains to be seen whether this injection of additional resources will in fact be used appropriately to save lives.

Getting ahead of HIV/AIDS: SANAC and implementation of the NSP

When Barbara Hogan was appointed Minister of Health in September 2008, HIV prevalence among antenatal clinic attendees was estimated to be 29% and although 600,000 people were recorded by the DoH as having been initiated on ARV treatment, less than 50% of those eligible for treatment – according to the medical criteria as set out in the guidelines at the time – in fact had access.

In our 2006/2007 review, we explained the process that led to the development and adoption of the NSP. In the 2007/2008 issue, we explained the importance of SANAC and expressed hope in its future. In their short tenures, both Hogan and Motsoaledi have validated these hopes by repudiating the former Minister's hostility towards SANAC and making implementation of the NSP a centre-piece of their programmes.

In the new political environment, SANAC has finally begun to emerge:

- Meetings of its various committees took place throughout 2009;
- SANAC was successful with an application to Round 9 of the Global Fund on AIDS, TB and Malaria (GFATM), securing a grant of over $108 million – this was after failing in the three previous rounds, losing the opportunity to access hundreds of millions of rand.
- Dr Nono Simelela was appointed as Chief Executive Officer in October 2009, with other key positions also being filled in the year.

However, in spite of these positive developments, there are also a number of emerging risks that need to be recognised and addressed. In 2009 SANAC became cumbersome and overly bureaucratic. Its intention to be representative of many sectors of civil society was not accompanied by an insistence that those who represent different constituencies must be accountable to them. The need for leadership and decision-making based on knowledge, expertise and science has played second fiddle to democracy of "process".

This has resulted in decisions – especially on important new HIV prevention interventions such as voluntary medical male circumcision – being held up by efforts to try and find an elusive common denominator between culture, ideology and public health. These issues have made the restructuring and streamlining of SANAC vital in 2010. It is also important, as the Inter-Parliamentary Union (IPU) has recommended, that SANAC be made a statutory body and that its duties, responsibilities and accountability be entrenched in law.[11]

Nonetheless there has been unbelievable change! On 1 December 2009, President Zuma addressed South Africans on a live television and radio broadcast, under a SANAC banner proclaiming – ironically – "I am Responsible". Zuma announced government's intention to introduce improved ARV treatment protocols, as well as to expand access by ensuring that all pregnant women, people co-infected with HIV and TB and infants under one year are initiated onto treated much earlier.[12]

World AIDS Day 2009. From left: Michael Sidibé (Executive Director, UNAIDS), Health Minister Aaron Motsoaledi, President Jacob Zuma, Deputy President Kgalema Motlanthe, Mark Heywood and Gwen Ramokgopa (Mayor, Tshwane) (Reproduced with kind permission of Magna Carta)

These were campaign demands that the TAC, ALP and our allies in civil society had made for several years, in line with international scientific consensus. In early 2010, these announcements have been followed by frantic planning within the DoH and SANAC to conceptualise and launch a hugely ambitious health campaign that aims, in one year, to encourage 15 million people to test for HIV, and refer those who are eligible for ARV treatment.

These developments prove that the political landscape has changed irreversibly. However, we are not yet out of the woods. Political will is one thing, but the two greatest objective challenges to South Africa's ability to respond humanely to HIV remain: the capacity of the public health system to provide care and treatment for millions of people with HIV, and government's ability to continue to meet the growing financial demands of the response to AIDS.

Political will is one thing, but the two greatest objective challenges to South Africa's ability to respond humanely to HIV remain: the capacity of the public health system to provide care and treatment for millions of people with HIV, and government's ability to continue to meet the growing financial demands of the response to AIDS.

As we show in this review, the ALP has attempted to respond on both issues. In 2009, for example, legal and human rights analysis was applied to factual investigations into the Free State crisis as well as the ARV moratorium at Edendale Hospital in Pietermaritzburg. The ALP and its partners also initiated a rudimentary drug stock-out monitoring system and, responding to requests for help from health care workers and patients, reported problems that came to our attention directly to senior officials in the DoH. Importantly, their interventions have – in many cases – made a difference.

Health reform: reversing the fragmentation of health services and the widening of inequalities between the public and private health sectors

Two reports were published during 2009 which showed the magnitude of the challenges facing health service delivery in South Africa. In April, the South African Human Rights Commission (SAHRC) issued a report and recommendations arising from its 2007 Public Inquiry into Access to Health Care Services.[14] Several months later, in August, *The Lancet* issued a special report on *Health in South Africa*.[15]

The first report describes how far away from the constitutional vision of access to health care services South Africa remains. The second, basing itself upon scientific evidence, epidemiology and academic analysis, concludes that "[a]lthough South Africa is considered a middle income country in terms of its economy, it has health outcomes that are worse than those in many lower income countries."

In early 2009, Minister Hogan initiated two processes that aimed to enquire into the problems facing the public health system and make recommendations on steps that can resolve the crisis:

- Directly in response to the Free State moratorium, Hogan established multi-disciplinary teams to investigate the management and financial affairs of each provincial health department and the DoH. In March/April 2009, the Integrated Support Teams (ISTs) – as they became known – visited each province and produced ten detailed reports. At the time of writing, requests by TAC to make public these reports have been ignored; two have been leaked to the ALP but the overall recommendations of the ISTs are known only to the Minister.

- In an attempt to reform the overall health system and seek guidance on how to implement the Health Roadmap 10-point plan,[16] Hogan established a Ministerial Advisory Committee on Health (MACH), with six technical task teams (TTTs) of experts focusing on the following aspects of health: service delivery; leadership and governance; medical products (focusing on medicines); health financing; information technology and infrastructure; and human resources.

Jonathan Berger and Vuyiseka Dubula – a staff member of the ALP and General Secretary of TAC respectively – were included as members of two of the MACH TTTs. Apparently this filled our quota. Unfortunately in 2009 there was still a stigma attached to TAC and the ALP within parts of government (another legacy of Tshabalala-Msimang), and we were informed that membership of the TTTs was being vetted by Luthuli House.

Censorship such as this makes it hard to get the ALP's advice heard and have its constitutional lawyers included on the basis of their expertise, regardless of their organisational affiliation. As a result, several of the MACH TTTs, and the IST as a whole, were without persons who could advise on the legal and constitutional framework within which health is supposed to be delivered. Nonetheless, the ALP continued to invest significant time researching recommendations for health policy and programmes that are rooted in law and which set out more clearly the duties that fall on both the state – at all spheres of government – and the private sector progressively to realise the right to have access to health care services.

One important innovation in our work saw the launch of the Rural Health Advocacy Project (RHAP) as a joint project of the ALP, the Rural Doctors Association of Southern Africa (RuDASA) and the University of the Witwatersrand's Centre for Rural Health.[17] RHAP is based at the ALP and the project has begun important advocacy work to draw attention to the needs of rural health services – which still cater for over 40% of the population. Integrating rural health into health reform is essential. It is also important to draw attention to how "traditional" health issues, such as human resource shortages, are more extreme in rural areas.

Integrating rural health into health reform is essential. It is also important to draw attention to how "traditional" health issues, such as human resource shortages, are more extreme in rural areas.

In all of our work, the method employed by the ALP is to attempt to persuade government, the private sector and civil society of the duty to recognise the parameters for the delivery of health care that are created by their constitutional duties. In addition, specific legal arguments about state duties are applied to particular challenges facing the health system, such as the conditions of employment of community health care workers and health budgeting.[18]

One important issue on which the ALP proffered legal advice concerns a growing problem that government describes as "fiscal federalism" – that is, the inability of the national government to control the spending allocations of provincial health departments. In her keynote address at the launch of the ALP's 2007/2008 review, former Health Minister Hogan described the problem in the following way:

> The National Treasury in terms of the Division of Revenue Act allocates a lump sum to each province. That province is then free in terms of the Constitution to divide that money and

> allocate it to the different functions and services that it has to provide (education, health, roads etc). National Treasury allocates on the basis of a formula. However, a provincial treasury can completely subvert that and decide to reduce that amount to certain areas. So we find in some provinces that health receives less than what would have been anticipated. National Treasury makes a decision, it goes to the provincial treasury, they make a decision which is different and then it goes to the health department. In addition, that health department has a right to determine its own set of priorities. The question is how do you get a united vision of what our priorities are? This is leadership that has got to be provided from national and provincial level.

A detailed submission on fiscal federalism was requested from the ALP by the chairperson of the Health Financing TTT of the MACH.[19] Entitled "Constitutional Duties for the Determination, Expenditure, Oversight and Rationing of Available Financial Resources for the Delivery of Health Care Services", the ALP memorandum featured extensively in the TTT's final report to the Minister.

Fortunately in 2010 there seems to be more consciousness at national government of the powers that it holds to ensure that provinces comply with constitutional duties.[20] Finance Minister Pravin Gordhan, for example, commented on this in his 2010 budget speech:

> [T]o achieve the outcomes we have set ourselves in education and health we need better coordination and alignment between national policy imperatives and provincial budget. A breakdown in this regard is a recipe for failure. We have to find a mechanism that balances the constitutional responsibility of provinces to determine their budgets with the constitutional entitlement of citizens to education and health services.

Finally, it is important to reflect on an issue that is usually only whispered about in discussions about the Ministry of Health. Both Ministers Hogan and Motsoaledi had to work in a destructive and dysfunctional managerial environment. Over many years Tshabalala-Msimang created within the DoH a culture of distrust of civil society and health experts. Reports of health system problems were routinely denied, lied about and covered up. Generally, a picture was painted of continual progress with the delivery of health services.

Critics of the DoH were treated as enemies pursuing a hidden agenda. Vital senior posts, such as that of Deputy Director-General responsible for human resources in the health system, were occupied by persons with a growing record of failure but who were shielded from demands for accountability. Party politics, and the connections of senior public servants with ANC power brokers, interfered with delivery and impeded the fulfilment of constitutional responsibilities.

Over many years Tshabalala-Msimang created within the DoH a culture of distrust of civil society and health experts.

Many of Hogan's initiatives – which aimed to make the DoH and its performance more transparent and to re-open it to external and independent influences – faced resistance from the Director-General Thami Mseleku, who frequently undermined her authority, clouded her initiatives and slowed down reform. Fortunately, Motsoaledi moved quickly to excise Mseleku and his influence from the DoH, from which he left in October 2009.[21]

Operating outside the law

During a plenary session of South Africa's first national conference on TB in June 2008, Thami Mseleku argued that "human rights are not relevant to considerations of health policy in a developmental state". His comments were condemned across the world. A letter, sent to former President Mbeki and ANC President Zuma and signed by 18 global leaders of the health and human rights movement, asked Mbeki "to reaffirm South Africa's commitment to human rights, not only in health, but across the spectrum of the work of your government and your party." It continued:

> Free and fair elections are one measure of a democratic, progressive state. The promotion and fulfilment of people's civil, political, social and economic rights is the highest goal to which political leaders of all parties should aspire.[22]

Mbeki did not respond to the letter. But in April 2009, former Minister Hogan stated clearly that human rights are important to health, and sought to explain the duty of the DoH to act within the law. At her keynote address at the launch of the ALP's 2007/2008 review, Hogan admitted that in the past "barriers" had been built up between civil society and government over human rights issues relating to health, specifically in respect of HIV/AIDS.

In recognising that "the challenge now was to be able to talk across those barriers", Hogan acknowledged the role of civil society in holding government to account. However, in noting that there would continue to be tensions between government and civil society, she stated that this tension should be a healthy tension: government had to make difficult decisions about the allocation of scarce resources but civil society should be monitoring the appropriateness and rationality of resource allocation decisions.[23]

Unfortunately, however, Mseleku's comment at the TB conference points to a deeper problem.

Contempt for the rule of law, and an attempt to operate outside of the law, was an express characteristic of the conduct of Tshabalala-Msimang and her administration. Unfortunately, however, this was not just the behaviour of a maverick minister but emanated from former President Mbeki. A lack of attention to legal detail and constitutional requirements in the drafting of legislation led frequently to important laws being delayed and/or undermined by litigation. As a result, there are a number of superior court judgments against the former Minister of Health.

In addition, important framework legislation – in particular the National Health Act 61 of 2003 (NHA) – was delayed over many years. Indeed, even after being brought into force in 2005, large parts of the NHA have been inoperative because they have not been proclaimed. Important regulations which are needed to guide health workers on the law, for example on the management of communicable diseases (which the ALP offered to draft on several occasions), have been unfinished for years.

Early in her tenure the ALP provided Hogan with a memorandum setting out a list of regulations, policies and laws which needed to be finalised. To the best of our knowledge most of this has still not been done, although we have recently been notified of plans to implement all outstanding sections of the NHA in 2010.

Looking to the future a shift of mindset is needed in the way politicians and public servants regard and treat the law. This will form part of the mission of SECTION27. Constitutional law should not be regarded as an encumbrance or a hindrance to performance but rather be seen as a vital tool to assist government in thinking through the state's duties and responsibilities in the course of planning. The ALP made this point in a submission to the Presidency and Parliament on the draft Green Paper on National Strategic Planning in October 2009.[24]

The law is also helpful in making it clear both to providers and receivers of governmental health

services what they can expect. It was for this reason that the ALP published its 2008 guide to the NHA.[25] Public servants should be both knowledgeable of law that is directly relevant to their work and seek to operate within it. Our experience suggests that this is ordinarily not the case.

Conclusion

At the start of this chapter we pointed to the fact that the period under review has been one in which there have been two ministers of health charged with leading the revival of the response to HIV / AIDS and the realisation of the right to have access to health care services. Looking back, it is hard to point to distinct achievements under Hogan. What she did do decisively, however, was turn her department's back on AIDS denialism and begin the period of perestroika. It is now up to her successor to deliver on the ANC's 2009 election promises to prioritise and revamp health care in South Africa. It will be up to the ALP's successor, SECTION27, to try to ensure that the challenges identified in this and other chapters of the review are indeed resolved.

Endnotes

1. See *http://www.cosatu.org.za/show.php?include=docs/pr/2009/pr1216.html&ID=2744&cat=COSATU%20Today*
2. The PCAS no longer exists. On 31 March 2010, the Presidency announced that the functions of the PCAS are now being located in the National Planning Commission, the Performance, Monitoring and Evaluation and Administration Department and the Cabinet Office.
3. "'Sis' Manto misunderstood over penchant for debate", *Pretoria News* (18 December 2009)
4. The address is available at *http://www.info.gov.za/speeches/2009/09122209351001.htm*
5. These reviews are available at *http://section27.org.za/wp-content/uploads/2010/04/ALP_2006-2007_Review.pdf* and *http://section27.org.za/wp-content/uploads/2010/04/ALP-Review-2007-20081.pdf* respectively
6. Entitled *Health in South Africa*, the special country focus – which was launched in Johannesburg on 24 August 2009 – is available at *http://www.thelancet.com/series/health-in-south-africa#*
7. The two initial letters are available at *http://section27.org.za/wp-content/uploads/2010/04/Letter-to-FS-MEC-19-12-081.pdf* and *http://section27.org.za/wp-content/uploads/2010/04/Letter-to-FS-MEC-21-01-092.pdf* respectively.
   See also *http://www.tac.org.za/community/node/2491*
8. The ALP's report on the Free State is available at *http://www.section27.org.za/wp-content/uploads/2010/04/ALP-report-on-the-Free-State-final-of-20090211.pdf*
   Also see Adila Hassim and Mark Heywood, "Submission to the Health Financing Technical Task Team", available at *http://www.section27.org.za/wp-content/uploads/2010/04/ALP-report-on-the-Free-State-final-of-20090211.pdf*
9. The NSP is a Cabinet-approved policy. It aims to provide ARV treatment to up to 80% of people in need by 2011. It envisages the progressive roll-out of ARV treatment. Nowhere does it countenance a roll-back of treatment.
10. See, for example, Lara R. Fairall et al, "Effectiveness of Antiretroviral Treatment in a South African Program", (2008) 168:1 *Arch Intern Med. 88*, available at *http://section27.org.za/wp-content/uploads/2010/04/free-state-HAART-study.pdf*
11. In late 2009 the ALP was commissioned to make recommendations on establishing SANAC as a legal entity and, after research, also recommended that it be set up as a statutory body.
12. Further detail on these developments is provided in chapter 4.
13. The ALP's report on the ARV moratorium at Edendale Hospital is available at *http://section27.org.za/wp-content/uploads/2009/01/Death-by-Delay-The-Moratorium-on-ARV-initiation-at-Edendale-Hospital.pdf*. For the Free State report, see above note 8
14. The report is available at *http://www.info.gov.za/view/DownloadFileAction?id=99769*. Unfortunately, in the view of the ALP, the report was a missed opportunity by the SAHRC. It took over two years to publish. Following publication, the SAHRC appears not to have engaged with government to ensure that its recommendations are acted upon. The ALP's views on the report are set out in a letter to the former chairperson of the SAHRC, which is available at *http://section27.org.za/wp-content/uploads/2010/04/Letter-to-Jody-Kollapen-SAHRC.pdf*.
15. See above note 7
16. Our 2007/2008 review provides detail on the Health Roadmap process.
17. For more information on the RHAP, see *http://web.wits.ac.za/Academic/Health/Entities/RuralHealth/Rural+ Health+Advocacy+ Workshop.htm*
18. These issues are discussed in greater detail in chapter 3.
19. See above note 8
20. See chapter 3 for more discussion on fiscal federalism.
21. These issues are explored in more detail in chapter 3.
22. A copy of the letter is available at *http://www.tac.org.za/community/node/2384*
23. The ALP accepts this responsibility. It informed the decision to establish the Budget Expenditure and Monitoring Forum in August 2009, and to begin to try to explain to society the legal processes and duties of government in budgeting for health and how a "principled citizenry" can engage this process.
24. The submission is available at *http://section27.org.za/wp-content/uploads/2010/04/ALP-Submission-on-Green-Paper-National-Strategic-Planning.pdf*
25. T*he National Health Act: a guide* is available at *http://section27.org.za/wp-content/uploads/2010/04/National-Health-Act-A-guide.pdf*

Chapter 2

Recalling the AIDS Law Project's work on law in 2009/2010: Is there a future for social justice litigation?

By Adila Hassim

The evolving debate about law and social justice

In South Africa, the value of using the law to advance social justice was made apparent during apartheid. In an era where the law itself was designed to restrain social justice, astute activists and lawyers were sometimes able to exploit its gaps, contradictions and irrationalities. Litigation was used to stave off the devastating impact of laws that aimed to control where and how black people worked, lived and expressed themselves. Cases challenging the pass laws, such as *Rikhoto*[1] and *Komani*,[2] were beacons of light in the gloom of apartheid bureaucracy.

In addition, the courtroom was occasionally used as the site for making powerful arguments about human rights and freedom, most famously by Nelson Mandela in the Rivonia Treason Trial.[3] But the legal battles alone could not have eliminated apartheid, particularly in a context where Parliament reigned supreme and human rights were not constitutionally entrenched. Then, as now, a necessary condition for advancing social justice was a social movement or coalition of movements that fought for clear objectives.

In 1994, democratic South Africa's interim Constitution finally entrenched a Bill of Rights in the law, but without express provisions to deal with the socio-economic legacy of apartheid.

In 1994, democratic South Africa's interim Constitution finally entrenched a Bill of Rights in the law, but without express provisions to deal with the socio-economic legacy of apartheid. However, the inclusion of socio-economic rights in the final Constitution is significant for the future pursuit of social justice. The right to equality is now linked to explicit rights to have access to health care services, water, food and basic education. These rights are

themselves subject to the constitutional injunction that the state bears positive duties to realise them progressively. This architecture gives legal force to moral and political arguments for state policy to be guided by social justice.

When the ALP was formed as a human rights organisation in 1993, it chose to focus on using law to deepen and protect rights. Since then, the experience has shown that in post-apartheid South Africa there is no area of law – whether statutory, common or customary – that cannot be reshaped by constitutional rights and values. In the experience of the ALP, even areas of law that are seemingly disconnected from human rights – such as competition or intellectual property law – have proved to be critical to advancing the right to have access to health care services. The space for activists and lawyers to work hand-in-hand is vast.

The anger about the squalor in which millions live is evident from the rash of service delivery protests. It can hardly be denied that sufficient water and basic sanitation are integral to living life with dignity.

Yet there are many who doubt this. They cite the fact that in the fifteen years of its existence, the Constitutional Court has heard only a handful of socio-economic rights cases. To date, for example, there has been no case on the inadequacy of basic education, which continues to sustain the pattern of inequality. Almost eight years after it was handed down in 2002, the high water mark of jurisprudence on socio-economic rights remains the *TAC* case.[4]

But this does not mean that the law is without potential for social justice. As we show throughout this review, the ALP – together with its key partners – continued its run of success in combining human rights advocacy with legal action during 2009/2010, mainly in relation to HIV/AIDS and health. But the ALP's work is not self-sufficient. It is influenced by politics and the ebbs and flows of law. In this regard, in the larger theatre of socio-economic rights jurisprudence, 2009 seemed to hold promise as a number of important disputes about socio-economic rights approached the Constitutional Court.

Late in the year, however, when the Court handed down two of its judgments on socio-economic rights, many were deeply disappointed. These cases are *Mazibuko*,[5] dealing with the right to sufficient water, and *Nokotyana*,[6] which concerns access to basic sanitation. Both judgments have been criticised by many social justice activists for not giving due weight to socio-economic rights and favouring the executive over the poor.

Both cases had the potential to evoke enormous public empathy. The anger about the squalor in which millions live is evident from the rash of service delivery protests. It can hardly be denied that sufficient water and basic sanitation are integral to living life with dignity. But from an outside perspective, it seems that in both cases there were factors that may have allowed the Court to avoid making orders against the government and deepening socio-economic rights jurisprudence in favour of the poor. These are questions that must be discussed amongst all who use the law to fight social injustice.

This review is not the place for a full analysis of the strengths and weaknesses of the cases. They are raised here because for some they signal the end of hope in the Constitutional Court as the ultimate guardian of social rights. They are dispiriting for the communities who seek to be the beneficiaries of the courts' protection and for the lawyers who have worked arduously on preparing the litigation. To make matters worse, they came about in a year in which there was a politically driven debate about the role of the judiciary in relation to government, a racial polarisation of the legal profession, and behavior by government that suggested contempt for constitutionalism and the rule of law.

We agree that the outcomes in *Mazibuko* and *Nokotyana* are disappointing. Both cases require a pause for thought, a reconsideration of legal strategy and method, and a further discussion about the

place that law can occupy in society outside of the mostly invisible drama of the courts. Equally, it is important to bear in mind that the Constitutional Court, and its judgments, are not the holy grail of litigation. "Social justice litigation" is about what happens in a process that includes litigation – not just about the litigation itself. Did the litigation teach, reveal, unify, expose and force delivery?

In the ALP's experience,[7] a judgment is just an overnight stop on the road. Its content, good or bad, determines further steps that need to be taken. Indeed, in *Mazibuko*, the pressure of the litigation forced the City of Johannesburg to act in furtherance of the right to sufficient water. In *Nokotyana*, the litigation forced the government to concede that it had failed the residents of the Harry Gwala informal settlement and to "improve" its offer of toilets to one per four families – an offer the Court perversely chose not to accept.

Looking forward, it is also important to bear in mind that while the state is the primary duty-bearer in relation to socio-economic rights, South Africa's powerful and well-resourced private business sector also bears constitutional responsibilities. In the context of growing inequality, monitoring and challenging private power is an essential aspect of social justice advocacy and litigation. We consider this below.

In the remains of this article we report on some of the ALP's legal work in 2009 and early 2010 and what it illustrates about some of the component parts of social justice litigation. Further detail on the ALPs legal work is provided in Appendix A. In this chapter in particular, we look at:

- Challenging the private business sector;
- Working with communities and community-based organisations to defend the rule of law;
- Enforcing court orders; and
- Influencing decisions about budgeting for human rights.

Challenging the private business sector

The ALP, working with the TAC, has a history of challenging the private health sector in order to ensure access to essential medicines, non-discrimination by companies that provide medical "insurance", and access to specific health services in the private sector. It has been the approach of the ALP that the private sector bears legal and constitutional duties in relation to the right to have access to health care services. The scope of the positive obligations that may rest on the private sector remains to be tested.

It has been the approach of the ALP that the private sector bears legal and constitutional duties in relation to the right to have access to health care services.

In 2009, the ALP continued its pressure on the private sector. This included challenges to medical schemes as well as pharmaceutical companies. A notable example concerned the merger of GlaxoSmithKline (GSK) SA, and Aspen Pharmacare (Aspen). Those familiar with the work of the ALP and TAC in competition law matters will recall previous successful challenges to GSK, Boehringer Ingelheim, Bristol-Myers Squibb and MSD regarding the excessive pricing of and sustainable access to HIV-related drugs.[8]

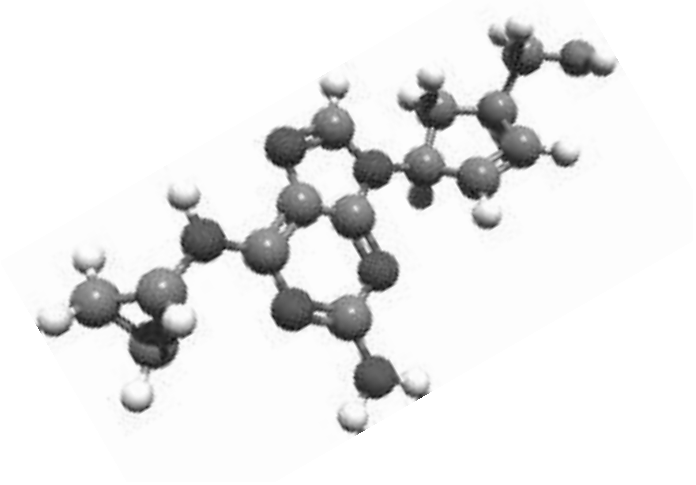
In 2009, the Competition Commission approached interested parties, including the ALP and TAC, to inform them that a merger between GSK and Aspen was being proposed and to request that we make a submission on the proposed merger. As part of the merger, most of GSK's South African operations were to become part of Aspen. GSK was to purchase 16% of Aspen's shares and become the company's single-largest shareholder.

Although the Competition Commission was unable to provide us with the parties' competition analysis, on the information provided a key concern we identified was the potential threat to the affordability and availability of abacavir. Abacavir is an important antiretroviral (ARV) drug, particularly in the treatment of children with HIV in both public and private health care sectors.
Our submission[9] argued that the Competition Commission should only approve the merger on condition that GSK offers no less than three non-exclusive voluntary licences for the importation and/or local manufacture of generic abacavir products in South Africa.[10] In the result, the Competition Commission approved the merger subject to the following condition:

> GSK is required to grant licenses, on a non-exclusive basis, to Adcock Ingram, Cipla Medpro, Ranbaxy, Biotech Laboratories, Feza Pharmaceuticals and any other interested generic manufacturer for the manufacture and/or import of abacavir, on terms and conditions no less favourable than those granted to Aspen.[11]

The intervention is notable because it had the effect of advancing access to an essential medicine. It was also notable because it came about as a result of a history of engagement with the Competition Commission on access to medicines. It is a demonstration of the unanticipated consequences of the first successful use of competition law by the TAC and ALP in 2002 in their complaint against GSK and Boehringer Ingelheim.

In the period ahead, SECTION27 will intensify its focus on the responsibilities of the private sector, paying particular attention to the right to equality, which is pivotal to our Constitution. The right is reinforced by section 8 of the Constitution, which ensures that the Bill of Rights applies to "natural or juristic persons ... taking into account the nature of the right and the nature of any duty imposed by the right."



The chemical structure of abacavir (source: wikipedia)

Ironically, since 1994, inequality in health and education has increased. The feeling of inequality is also exacerbated by the evidence of excessive wealth and opportunity that people see amongst individuals at the top of the corporate sector. This undermines the constitutional vision. Whilst the right to property is respected and protected by the Constitution, it is not absolute. Neither is the conduct of private entities beyond scrutiny.

This will make it more and more important to use the law to demonstrate that powerful private entities that have a public function also bear positive constitutional duties, which may extend to providing resources that contribute to meeting social needs. This is most likely not just in relation to financial resources (which are contributed through taxes, for example). There may also be a duty on powerful private entities to take reasonable measures to make "available resources" accessible to the state.[12] For example, the excessively profitable private hospital sector could offer material assistance to the government in sharing some of its resources to assist with the treatment of HIV infection.

Major corporations should accept that unbridled profiteering from items essential to life and dignity, such as food and medicines, is contrary to the letter and spirit of our law. So far, however, there has been only a tangential engagement by the courts with the rights and responsibilities of private actors (and the state's regulatory obligations in relation to private actors) in cases such as *Kyalami*,[13] *Modderklip*[14] and *New Clicks*.[15] To help entrench constitutionalism, it is important to demonstrate to the government how and where the Constitution can assist it meet its social objectives.

Poor people continue to die on the streets, often within reach of private health care facilities that will not admit them.

One area where the private sector's role is essential is in relation to section 27(3), which provides that "no one may be refused emergency medical treatment". Apart from a tentative definition of "emergency medical treatment" in *Soobramoney*,[16] no one – including the Department of Health (DoH) – has adequately defined this right. This, combined with a lack of engagement of the state with the private sector on its responsibilities, has left this right ineffective. Poor people continue to die on the streets, often within reach of private health care facilities that will not admit them.

The horizontal application of the Constitution is undisputed. In dealing with the right to housing in *Grootboom*,[17] the Constitutional Court stated that "all entities and persons" are bound by a negative obligation not to behave in a way that prevents (intentionally) or impairs (even if unintentionally) the right to adequate housing (and by association other socio-economic rights). In the words of the Court:

> Subsection (1) [of section 26] aims at delineating the scope of the right. It is a right of everyone including children. Although the subsection does not expressly say so, there is, at the very least, a negative obligation placed upon the State and *all other entities and persons* to desist from preventing or impairing the right of access to adequate housing.[18]

Finally, in legal strategy, it is important to be conscious that many of the problems regarding the implementation of socio-economic rights are linked to incapacity or bureaucratic indifference – this is something the law is not particularly well placed to resolve. However, it can be addressed partially by persuading private entities to assist state efforts to meet the public good, and by ensuring that the state acts reasonably in dealing with the private sector.

Working with communities and community-based organisations to defend the rule of law

Refugees, loitering and the Central Methodist Church

As a result of the political crisis in Zimbabwe, there are millions of Zimbabwean migrants and refugees in South Africa. In central Johannesburg, thousands live in and around the Central Methodist Church (CMC), which – thanks to the humanitarianism of Bishop Paul Verryn – became a place of sanctuary for many.

For several years these refugees have been subject to harassment and raids by authorities. Late one night in July 2009, the Johannesburg Metropolitan Police Department (JMPD) and the South African Police Service (SAPS) descended on the streets around the CMC and arrested 350 people. Most were sleeping on the sidewalk around the periphery of the Church – a few were returning from jobs, one was just walking past. All were arrested for "loitering".

In response, the Legal Resources Centre (LRC), Lawyers for Human Rights (LHR) and the ALP banded together with a private criminal law attorney – Ian Small-Smith – to represent those who were arrested. In addition, staff of Médecins Sans Frontières (MSF) South Africa ensured that the detainees received medical attention in the cells, especially since many had been assaulted.

Amongst those they helped was a man with HIV whose ARV medicines had been taken away from him at the time of the arrest, three men who needed care as a result of injuries sustained during beating by the police, an asthmatic man whose inhaler had been destroyed by a police officer, a deaf and mute man who was vomiting uncontrollably, and a pregnant woman in need of antenatal care.[19]

A common complaint recorded in statements taken by the ALP and LRC was that meagre possessions had been stolen by the police, including shoes, blankets, cell-phones and tools upon which people depended for seeking work. People also consistently reported that the police officers directed xenophobic comments at them, like "go back to Zimbabwe" and "you Zimbabweans are a problem". Most of those arrested were kept in cells for the weekend. Then, on Monday 6 July 2009, after negotiations between the legal representatives and the senior prosecutor, the charges of loitering were dropped.

People also consistently reported that the police officers directed xenophobic comments at them, like "go back to Zimbabwe" and "you Zimbabweans are a problem".

To try to prevent such a situation from occurring again, the LRC – assisted by the ALP – decided to bring an application seeking to interdict the police from using the loitering by-law for the ulterior purpose of cleaning homeless people from the streets. The aim was to challenge the constitutionality of the loitering by-law and to request a process of meaningful engagement between the parties so that shelter could be found for those in desperate need. The applicants in the case are the CMC, LHR

Refugees 'beaten, shocked' by metro police

Homeless men have given statements about treatment

LOUISE FLANAGAN

13 July 2009 article carried in The Star

and several individuals, who have brought the application against the JMPD and other relevant authorities.[20] At the time of writing, the case was pending before the South Gauteng High Court, Johannesburg.

However, as often happens with social justice litigation, the main matter often gives rise to new legal issues as well as activities that must be undertaken to help build public support for the issue.

Legal action can take many months. In this case, Bishop Verryn tried to protect refugees from further attacks by allowing more people to seek refuge in the Church at night, so that they need not

sleep on the street. This exacerbated the problem of overcrowding and problems of violence, criminality and sexual abuse that often accompany it.

A particular and justifiable concern about the welfare of unaccompanied minors at the church was raised. In the media some alleged that the CMC was turning a blind eye and even complicit in sexual abuse, and that Verryn was actively preventing the children from seeking appropriate shelter. Surprisingly, evidence of this was not provided to the police.

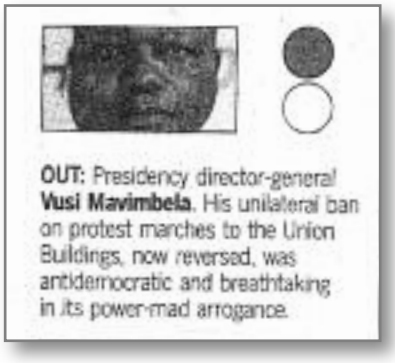
As a result of a media witch-hunt and his unashamed defence of refugee rights to shelter and dignity, Bishop Verryn was roundly attacked in late 2009 by the provincial social development authorities, as well as his superiors in the Church. In the face of this, the ALP began to mobilise other civil society organizations to turn attention back to the real issues.[21] The LRC and ALP also advised Verryn to apply to the High Court for a *curator ad litem* to be appointed to act in the best interests of the children. This he did. However, Verryn's superiors forbade him from engaging in any litigation. In January 2010, the Methodist Church brought disciplinary charges against Verryn and suspended him – a decision that Verryn is contesting.

Ironically, this made it impossible for Verryn to continue with the curator application. Consequently, the ALP applied in late December 2009 to intervene as an applicant seeking the same relief as Verryn. At a hearing on 5 January 2010, the ALP was admitted as a party and, as a result Dr Ann Skelton was appointed as *curatrix ad litem*. As required by the Court order, Dr Skelton submitted a far-reaching written report to the Court within five weeks, making recommendations for the protection of the unaccompanied children. The ALP responded to the report with a submission in which we welcomed most of the recommendations and made suggestions regarding a few.[22]

At the time of writing the refugee crisis at the CMC and more broadly remains unresolved, Bishop Verryn is still suspended and the litigation is ongoing.

The right to demonstrate

Equal Education (EE) is a South African movement of learners, parents, teachers and community members working for quality and equality in basic education through analysis and activism. EE promotes the right to equality and basic education with the belief that the fulfilment of these rights will give the poor and marginalised equal opportunities in life. EE and the ALP are partner organisations.


OUT: Presidency director-general **Vusi Mavimbela**. His unilateral ban on protest marches to the Union Buildings, now reversed, was antidemocratic and breathtaking in its power-mad arrogance.

Business Day gives Vusi Mavimbela the red light

EE aims to grow into a broad social movement that has an impact on education law and policy. Successful and visible public campaigns and gatherings are essential to fulfilling this objective, making the ability to exercise its "right, peacefully and unarmed, to assemble, to demonstrate, to picket and to present petitions" – entrenched in section 17 of the Constitution – fundamental to its work.

As part of its campaign for school libraries, EE started in early 2010 to plan several marches around the country, including one to the Union Buildings, the seat of the Presidency. Despite providing notice of the intended march more than a month in advance (even though the Regulation of Gatherings Act, 1993 only requires seven days' notice), the Tshwane Metropolitan Police Department (TMPD) did not authorise it. Instead the TMPD referred EE to a letter from the Presidency which stated: "Mr Vusi Mavimbela, Director-General in The Presidency, has directed that all marches to the Union Buildings and the Presidency be suspended until further notice."

Equal Education marches peacefully to the Union Buildings on 26 March 2010

Correspondence to the TMPD and the Director-General in the Presidency failed to change this position. As a result, the ALP filed an urgent application on behalf of EE at the North Gauteng High Court, Pretoria on Tuesday, 16 March 2010, to assert EE's right to march to the Union Buildings; and to review and set aside the directive of the Director-General. EE contended that the Director-General has no authority to issue a blanket ban on marches to the Union Buildings, and that his action violated people's constitutional rights.

The urgent application was accompanied by a press release from EE that immediately drew substantial media interest. In a prime time radio debate between the ALP attorney in the matter, S'khumbuzo Maphumulo, and Presidency spokesperson, Vusi Mona, the latter was unable properly to explain the letter containing the instruction to the TMPD.

The next day, the Presidency agreed to the march and issued a press statement denying the ban on marches to the Union Buildings but advising as follows: "The Presidency always encourages march organisers to channel whatever issues they may have to the relevant departments. We would encourage people only to march to the Union Buildings as a last resort." On 26 March 2010, approximately 1000 people peacefully marched to the Union Buildings to demonstrate support for EE's call for school libraries.[23]

In a prime time radio debate between the ALP attorney in the matter, S'khumbuzo Maphumulo, and Presidency spokesperson, Vusi Mona, the latter was unable properly to explain the letter containing the instruction to the TMPD.

EE's advocacy for school libraries, as part of the right to a basic education, would have been significantly weakened without the right to march and demonstrate popular support for its campaign. Ironically, EE had always imagined that their legal case would be in relation to the right to basic education. That matter lies in the future.

Using law to influence decisions about budgeting for human rights

As reported in several chapters in this review, the TAC and ALP blew the whistle on a state-sanctioned moratorium on ARV treatment in the Free State in early 2009. The crisis was a government-made tragedy of immense proportions that cost an untold number of lives, including several people the ALP tried to help.

The efforts of the ALP and TAC to stop the moratorium were multi-dimensional, including working with the media to raise public awareness, attempting to engage directly with the DoH, and initiating correspondence that aimed at uncovering and understanding the causes of the crisis, who was responsible and what could be done to resolve it.

Unfortunately, the Free State crisis demonstrated – as a matter of life and death – the importance of connecting human rights advocacy to the issue of budgeting properly for socio-economic rights, something that the ALP has begun to place greater and greater emphasis upon. Although it did not lead to litigation (it perhaps should have), our work did lead to the establishment of two new networks of organizations: the Budget and Expenditure Monitoring Forum (BEMF) and the Free State AIDS Coalition (FSAC).

Delegates at the first BEMF meeting held on 21 August 2009

It also led to greater focus on research to explain the enforceable duties that the Constitution imposes on government officials who are responsible for the delivery of socio-economic rights. For example, the ALP used the Free State crisis to illustrate its points in a submission made to the Health Financing Technical Task Team of the Ministerial Advisory Committee on Health.[24]

The moratorium revealed the intricate web of law that is meant to provide security for the delivery of essential health services, and what happens when these laws are not heeded. The fact a moratorium arose at all and the manner in which it was imposed evidenced infringements of the Constitution, the Promotion of Administrative Justice Act, 2000 (PAJA), the National Health Act, 2003 (NHA) and the Public Finance Management Act, 1999 (PFMA).

A breakdown of the complex legal implications of budgeting cannot be undertaken here. They are set out fully in a presentation given by Adila Hassim to the first meeting of the BEMF.[25] However, some of the issues that it poses include:

- **The relationship and division of power between national and provincial spheres of government:** The ALP argues that while legitimate provincial autonomy needs to be respected, South Africa has a unitary system of government with a clear duty on the national executive to ensure the protection and fulfilment of fundamental rights.

- **The reasonable allocation of resources:** The ALP argues that health budgets are determined with very little reference to evidence of health needs in a province and that national priorities are not necessarily reflected in provincial allocations to health. This view is now accepted by the National Treasury and the DoH.
- **The mismanagement and spending of resources:** The reports of the Integrated Support Team (IST) have identified extremely weak financial management capacity in the provinces. However, the ALP has also pointed to the lack of knowledge of the law and legal duties amongst senior officials within health departments resulting in the inability to avert financial crises, as required by the PFMA.
- **Administrative justice:** The moratorium was imposed with no regard to the requirement of PAJA, both in respect of procedural and substantive fairness.

In the context of the glasnost that has been introduced into the DoH by Health Minister Aaron Motsoaledi, these issues can now be tabled openly and hopefully without resort to litigation. This, however, does not detract from their urgency.

Enforcing court orders

Securing a favourable judgment is just one step along the road of achieving a goal. Invariably, the ALP and its partners have to spend many months, and even years, post judgment working at ensuring the implementation of court orders. This past year was no different. Below we relate two instances where tremendous energy was spent on securing the enforcement of court orders.

South African Security Forces Union (SASFU) v Surgeon-General

Despite success in *SASFU v Surgeon General* (the South African National Defence Force (SANDF) case, reported on in our 2007/2008 review),[26] the Minister of Defence and the SANDF were dilatory in complying with the court order. This was so in a number of respects. First, the six-month deadline for revising the health classification policy (which was agreed to by the respondents and reflected in the order of court) expired long before the policy was produced. Constant follow-up from the ALP was required before a workshop was eventually held in March 2009 to revise the policy.

After the workshop, and at the ALP's instigation, the SANDF agreed to be advised by HIV/AIDS clinical experts under the auspices of the South African National AIDS Council (SANAC). It was this that eventually – on 4 November 2009, exactly a year after the deadline – led to a revised policy being approved by Cabinet. Even though the new policy has some shortcomings, the ALP recognises that Cabinet's endorsement of a largely fair and reasonable policy dealing with the employment and deployment of people with HIV in the SANDF represented a major victory for our Constitution and the rule of law in South Africa. It marked the end of over ten years of contest between the ALP and the SANDF and is a world first.

HIV-positive soldier joins peace mission

Move comes after legal battle on SANDF policy

GRAEME HOSKEN

28 October 2009 article in the Pretoria News

Secondly, the SANDF continued throughout 2009 to defy other aspects of the court order, particularly regarding the unconstitutionality of the non-recruitment or non-deployment of individuals on the basis of their HIV positive status alone. The ALP and SASFU worked together to gather evidence of unlawful practices from two battalions and presented this evidence to the SANDF in order to expedite the process of finalising a health classification policy. In addition, the ALP represented a person who had been denied a job as a navy technician solely on the basis of his HIV status. Within three months of representing the client, he was employed by the SANDF.

Sergeant Mthethwa of the SANDF's 121 SAI Battalion – which is based in Mtubatuba, KwaZulu-Natal – made history by being the first known soldier with HIV to be deployed externally by the SANDF.

Finally, the process of ensuring that Sergeant Sipho Mthethwa (the second applicant in the case) was able to enjoy his right to foreign deployment was successful only after months of correspondence, calls and eventually warnings of further litigation. On Friday, 23 October 2009, Sergeant Mthethwa of the SANDF's 121 SAI Battalion – which is based in Mtubatuba, KwaZulu-Natal – made history by being the first known soldier with HIV to be deployed externally by the SANDF. Mthethwa has sporadic access to Internet and uses this to report to the ALP on his wellbeing. In an e-mail dated 16 March 2010, Mthethwa says:

> I received my medal last week, they sent someone to give it to me. The diployment will end on 21 May or a week after because of the election. I have managed to get treatment that will last me till june on that I am fine ... here the sun is to hot, I just run so that I cannot feel it .... I go out on patrol infact I work on the front line and in the office I am not going there to sit I just want to expiriance what is like to work on other places.

With regard to "TCM", the third applicant in the case, he is happily employed as a trumpeter in the airforce band and has since married.

Minister of Justice and Constitutional Development v Nyathi ("Nyathi 2")

The *Nyathi 2* matter came to the ALP's attention as a result of our attempt to enforce the court order that the ALP obtained in October 2008 for Dr Malcolm Naude, a doctor persecuted for his ethics by the former MEC for Health in Mpumalanga.[28] Naude was awarded damages of R100 000 and costs. But by mid-2009, the Mpumalanga Health Department had still failed to satisfy the debt. In the course of pressing our claim, the ALP was monitoring legislative developments meant to facilitate the payment of judgment debts by the state.

In that case, the Court had ruled that section 3 of the State Liability Act, 1957, was inconsistent with the Constitution because it did not allow for execution or attachment against the state and it did not provide for an express procedure for the satisfaction of judgment debts.

This legislation was due following a June 2008 order of the Constitutional Court in *Nyathi v MEC for Health, Gauteng and Another* (known as *Nyathi 1*).[29] In that case, the Court had ruled that section 3 of the State Liability Act, 1957, was inconsistent with the Constitution because it did not allow for execution or attachment against the state and it did not provide for an express procedure for the satisfaction of judgment debts. However, as it often does in matters involving legislation found to be unconstitutional, the Court suspended the declaration of invalidity of the law for a period of 12 months to give the legislature time to pass remedial legislation.

Only days before the 12-month deadline was due to expire, the Minister of Justice applied to the Constitutional Court for an extension. In the application, as evidence of the fact that some progress

had been made in developing the remedial legislation, the Minister submitted the draft Constitution Eighteenth Amendment Bill (CAB) and the draft State Liability Bill (SLB). However, the ALP noticed that instead of remedying the defect in the State Liability Act, the SLB expressly retained the objectionable language that *"[n]o execution, attachment or like process may be issued against the defendant or respondent in any action or legal proceedings against the state or against any property of the state."*

Indeed the Bill went even further by extending the prohibition against execution or attachment to local government, despite the fact that this is not addressed by section 3 of the State Liability Act.

The CAB appeared to be even more sinister. It proposed to insulate the SLA from constitutional scrutiny by introducing a new clause into the Constitution – at section 173A – starting with the words "[d]espite any other provision of the Constitution".

This "override" clause is unique and cannot be found anywhere in the Constitution. Its effect would have been to shield the SLB from constitutional review. The SLB (or whatever legislation were eventually to emerge) would not be subject to the Bill of Rights or the founding values of the Constitution. In addition to insulating the SLB from constitutional review, the constitutional amendment would have had the effect of insulating clause 173A itself from interpretation by reference to other provisions of the Constitution. Whether intentional or not, the Bills would have the effect of overruling the *Nyathi 1* order.

On 7 June 2009, the ALP issued a press statement alerting the media to the draft bills and setting off a torrent of opposition. A month later, the LRC and ALP also made a joint written submission on the draft bills, which was endorsed by six other major legal organisations.[30] In addition, we monitored developments at the Constitutional Court, in anticipation of the Court's response to the application for an extension by the Minister of Justice.

On 10 June 2009 the Court issued directions inviting any interested party to oppose the application. The ALP intervened to oppose the application on the grounds that –

- the application failed the test for granting extensions, as set out in the Court's earlier jurisprudence;
- the extension was sought in order to pass legislation that would have had the effect of evading the Court's order in *Nyathi 1* rather than complying with it; and
- were an extension to be granted, there would be an ongoing violation of rights.

We therefore asked the Court to provide interim relief to protect constitutional rights pending the passage of remedial legislation and proposed relief that would allow for the attachment of state assets.[31]

On 12 August 2009, the ALP was amongst four organisations making oral arguments before the Constitutional Court in *Nyathi 2*,[32] with Adila Hassim arguing on its behalf. The hearing turned into an important debate between the justices of the Constitutional Court and the legal representative of the Minister of Justice about the government's duties to respect court orders. In the words of Deputy Chief Justice Moseneke, the issue was "at the essence of our constitutional democracy ... absent which we have nothing left".

On 31 August 2009, the Court issued a provisional order granting an extension to the Minister, but also gave interim relief "to provide for a tailored attachment and execution procedure against state assets". In its final judgment, handed down on 9 October 2009, the Court issued an order that provides for the following:

- It allows a person to give notice of an intention to attach property for non-payment of an order if it has not been paid 30 days after it was made by the Court;
- If the order is still not paid 14 days later, such a person may apply for a writ of execution against the government's property and the sheriff must attach this property; and
- The state is thereafter given a final 30 days to settle the payment, after which the property can be sold to pay the order.

In so doing, the Court made it clear that there is no question that in whatever legislation follows, there must be provision for attachment against state assets. This was a notable victory for the right of access to courts and the rule of law.[33]

As for Dr Naude, on the day of the hearing of the *Nyathi 2* case, the state attorney called the ALP to confirm that the judgment debt was being processed. We have since secured the payment of both damages and costs in this matter, amounting in total to over R350 000.

Both these cases illustrate the need for constant monitoring and vigilance of implementation of court orders.

Conclusion

It is arguable that during 2009, with the advent of the Zuma Presidency, South Africa entered a new era in both politics and law. If its word is to be trusted, the new government is much more committed to the delivery of socio-economic rights, including the right to health. But even with the best intentions, tackling poverty and inequality will encounter corruption, severe resource constraints, resistance from private power and challenges of capacity. Political will may flag.

The need for social movements to pursue the rights in the Constitution, either in aid of government efforts or to contest government failure, will continue in the period ahead. In this regard the experience of the ALP during the short period under review has taught us that in our struggle for socio-economic justice, we cannot lose sight of the need to continue to defend civil and political rights. The work of the ALP has come to an end, but through SECTION27 we intend to demonstrate that combining constitutional law with social mobilisation remains as relevant to social transformation in South Africa as it ever has in the past.

Endnotes

1. *East Rand Administration Board v Rikhoto* 1983 (3) SA 595 (A)
2. *Komani NO v Bantu Affairs Administration Board, Peninsula Area* 1980 (4) SA 448 (A)
3. The trial lasted from 1963 to 1964.
4. *Minister of Health and Others v Treatment Action Campaign and Others (No 2)* 2002 (5) SA 721 (CC)
5. *Mazibuko and Others v City of Johannesburg and Others (Centre on Housing Rights and Evictions as Amicus Curiae)* [2009] ZACC 28
6. *Nokotyana and Others v Ekurhuleni Metropolitan Municipality and Others* [2009] ZACC 33
7. This is discussed below in relation to the South African National Defence Force (SANDF).
8. For a Competition Commission report on such cases, see *http://www.compcom.co.za/assets/Uploads/AttachedFiles/MyDocuments/March-04-Newsletter.pdf*
9. The submission, which was drafted by the ALP on behalf of the TAC, was endorsed by the Centre for the AIDS Programme of Research (CAPRISA) at the University of KwaZulu-Natal and the Southern African HIV Clinicians Society.
10. Prior to the merger, GSK had granted Aspen such a voluntary licence. The three licences to which our submission referred were in addition to the one already granted to Aspen (which would no longer be necessary in the light of the merger).

11. See *http://www.compcom.co.za/assets/Uploads/AttachedFiles/MyDocuments/02-Sept-09-Competition-Commission-approves-pharma-merger-on-condition-that-Abacavir-is.pdf*
12. In addition, such private bodies must not conduct their businesses in a way that negatively infringes upon constitutionally entrenched rights.
13. *Minister of Public Works and Others v Kyalami Ridge Environmental Association and Others (Mukhwevho Intervening)* 2001 (3) SA 1151 (CC)
14. *President of the RSA and Another v Modderklip Boerdery (Pty) Ltd* 2005 (5) SA 3 (CC)
15. *Minister of Health and Another NO v New Clicks South Africa (Pty) Ltd and Others* (*Treatment Action Campaign and Another as Amici Curiae*) 2006 (2) SA 311 (CC)
16. *Soobramoney v Minister of Health, KwaZulu-Natal* 1998 (1) SA 765 (CC)
17. *Grootboom and Others v Government of the Republic of South Africa and Others* 2001 (1) SA 46 (CC)
18. Ibid at paragraph 34 (emphasis added)
19. These accounts are reflected in statements taken by ALP and LRC staff.
20. The legal papers in this case are available at *http://www.section27.org/2009/10/28/central-methodist-church-vs-city-of-johannesburg-loitering-case/*
21. On 8 December 2009, the ALP issued a statement that was endorsed by more than 40 organisations, including COSATU. The statement is available at *http://section27.org.za/wp-content/uploads/2010/04/Civil-Society-Statement-with-signatories-2009 1208.pdf.* After Verryn's suspension a facebook page was set up by his supporters which quickly gained over 1000 members.
22. The ALP's submission is available at *http://section27.org.za/wp-content/uploads/2010/04/ALP-Submission-on-Report-of-curatrix-Ann-Skelton.pdf.*
23. The application challenging the Director-General's directive continues.
24. This submission is available at *http://section27.org.za/wp-content/uploads/2010/04/legal-perspective-on-health-budgeting-final.pdf*
25. A transcript of Hassim's presentation is available at *http://www.tac.org.za/community/files/bemf/Hassim LegalIssuesForFailuresIn HealthBudgeting-20090821.pdf.*
26. *South African Security Forces Union and Others v Surgeon-General and Others* (North Gauteng High Court case no. 18683/07) (unreported). The legal papers is this case are available at *http://www.section27.org/2008/05/16/south-african-security-forces-union-and-others-v-surgeon-general-and-others-2/*
28. *Minister for Justice and Constitutional Development v Nyathi In re: Nyathi v Member of the Executive Council for Health Gauteng and Another (Law Society of South Africa Intervening; Legal Resources Centre, Freedom Under Law and AIDS Law Project as Amici Curiae)* [2009] ZACC 29. See also *Naude v Member of the Executive Council, Department of Health, Mpumalanga* [2008] ZALC 158 (21 October 2008).
29. 2008 (5) SA 94 (CC)
30. The submission is available at *http://section27.org.za/wp-content/uploads/2010/04/LRC-ALP-Submission-on-SLA-and-CAB.pdf.*
31. The ALP's legal papers are available at *http://www.section27.org.za*
32. The LRC, the Law Society of South Africa and Freedom Under Law also joined the matter in opposition to the state's application.
33. A fact sheet issued by the ALP explaining the judgment is available at *http://section27.org.za/wp-content/uploads/2010/04/ALP-Factsheet-on-Nyathi-Decision-20091015.pdf.*

Chapter 3

South Africa's ailing health system: how should it be treated?

By Jonathan Berger

Introduction

Ours is not a healthy nation. Home to more people living with HIV than any other nation on earth and the epicentre of the global tuberculosis (TB) pandemic, South Africa also fares badly on a wide range of health indicators such as infant mortality, maternal mortality and adult life expectancy. Yet our Constitution recognises that everyone – regardless of race, gender, age, sexual orientation, socio-economic status, nationality or any other related ground – has the right to have access to health care services. In so doing, it expressly imposes obligations – primarily on the state – progressively to realise this fundamental right.

So what has gone so horribly wrong? Why, 16 years after the birth of our democracy, does the gap between the constitutional vision and people's lived realities remain so stark?

So what has gone so horribly wrong? Why, 16 years after the birth of our democracy, does the gap between the constitutional vision and people's lived realities remain so stark?

Despite over R150 billion being spent every year in the public and private sectors, health outcomes in South Africa are often worse than in other African countries with far fewer resources, both human and financial. As Mark Heywood describes in chapter one, many of the problems can and should be attributed to the mismanagement of and abuse of power within the national Department of Health (DoH) from 1999 to 2008. Central to the thesis, however, is an understanding that we should guard against being lulled into a sense of security now that the AIDS denialism that characterised the Mbeki administration has ended.

Put differently, undoing the damage will require far more than a reversal of those policies and practices that undermined the constitutional vision. In addition to locating the development of

policy and law and the provision of health care services within a rights-based framework, the DoH must ensure openness and accountability in all of its programmes and processes. And now that AIDS denialism is officially over, we once more have to square up to the same challenges that we faced in 1994 – except that they have become more extreme, in large part as a result of the conduct of the Mbeki administration.

Structure of the chapter

With this context in mind, this chapter begins by providing a brief update on key legal and policy developments in health considered in our previous review.

The chapter goes on to argue that the Constitution places an express duty on the state to address the following three key challenges: clarifying ambiguities in the legal framework and the obligations imposed by the Constitution; the largely unmitigated human resources for health (HRH) crisis; and the need to strengthen health governance institutions. Addressing these issues, we believe, will improve all aspects of health care delivery.

In conclusion, the chapter considers the official government process underway to establish a system of national health insurance (NHI) for South Africa, the context within which the NHI debate is unfolding, and its implications for SECTION27, the new organisation into which the ALP will be incorporated.

Update on previous review

The previous ALP review focused on a number of developments in health policy and law reform. In particular, the chapter entitled "Rethinking health reform: constitutionalism, law and policy" looked at the work of the ANC's NHI committee, the outcomes of the health roadmap process held under the auspices of the Development Bank of Southern Africa (DBSA), and the tabling in Parliament of three important bills: the Medicines and Related Substances Amendment Bill [B 44—2008], the Medical Schemes Amendment Bill [B 58—2008] and the National Health Amendment Bill [B 65—2008].

The chapter noted that –

- The ANC committee's policy on NHI was finalised and adopted by the ANC's National Executive Committee in late 2008;
- The findings and recommendations of the roadmap process formed the basis of the development of a 10-point plan that was agreed to by most stakeholders in health care provision and thereafter adopted by former Health Minister Barbara Hogan as official DoH policy;
- Parliament passed the Medicines and Related Substances Amendment Bill [B 44D—2008], which – although still deeply flawed – was significantly better than the Bill tabled in June 2008 by Manto Tshabalala-Msimang, Minister of Health throughout the Mbeki administration; and
- Bills B 58—2008 and B 65—2008, both dealing with important aspects of health reform, effectively remained on ice.

As already indicated, the new Minister of Health – Aaron Motsoaledi – has now initiated an official process to establish an NHI system. This is discussed towards the end of the chapter. So too is the relationship between the NHI process and the 10-point plan that underpins current DoH strategic planning. What remains to be discussed now are the proposed amendments to national health statutes.

Although it was passed by Parliament in late 2008, the Medicines and Related Substances Amendment Act 72 of 2008 was only assented to by former President Kgalema Motlanthe on 19 April 2009.[1] But to date, it has yet to be brought into force. This is in line with the recommendations of the Medical Products Technical Task Team (MPTTT) of the Ministerial Advisory Committee on Health (MACH), which was appointed by former Health Minister Barbara Hogan in March 2009.

Amongst other things, the MPTTT – whose membership included the ALP's Jonathan Berger – focused on the issue of drug regulation. In so doing, it considered the appropriateness and constitutionality of Act 72 of 2008, pointing out that concerns had been raised about three aspects of the new law:

- The lack of independence of the proposed South African Health Products Regulatory Authority (SAHPRA);
- SAHPRA's ability to operate transparently and accountably; and
- The manner in which subordinate regulatory authority and discretionary powers are addressed.

With this in mind, the MPTTT recommended that the Act only be brought into effect "if and when the constitutional defects are cured by way of a further amendment that is tabled in and processed by Parliament whilst the DoH prepares new regulations to give effect to the full package of law reform." It further noted that this approach would "leave untouched those provisions of the Medicines [and Related Substances] Amendment Act that are sorely needed".[2] The ALP understands that the concerns raised by the MPTTT are being addressed in draft legislation that is to be published in 2010 for public comment.

While the ALP's interventions – in Parliament and by way of participation in the work of the MPTTT – in respect of medicines regulation appear to have borne fruit, its submissions in respect of the other two health bills tabled in 2008 appear to have fallen on deaf ears. Despite the urgent need for Parliament to consider and process the Medical Schemes Amendment Bill [B 58—2008], the bill has been allowed to lapse. All indications suggest that it is unlikely to be revived.

Despite the urgent need for Parliament to consider and process the Medical Schemes Amendment Bill [B 58—2008], the bill has been allowed to lapse. All indications suggest that it is unlikely to be revived.

While the National Health Amendment Bill [B 65—2008] has also lapsed, the future of the substantive issues it sought to address is somewhat brighter. This is because Parliament's legislative programme for 2010 lists a Health Pricing Commission Bill that is to be submitted for Cabinet approval in June 2010 and introduced to Parliament in October 2010. Given the Minister of Health's refreshing approach to consensus building and his avoidance of unnecessary confrontation, we believe that the Health Pricing Commission Bill will be a significant improvement on Bill B 65—2008.

Clarifying legal ambiguities and constitutional obligations

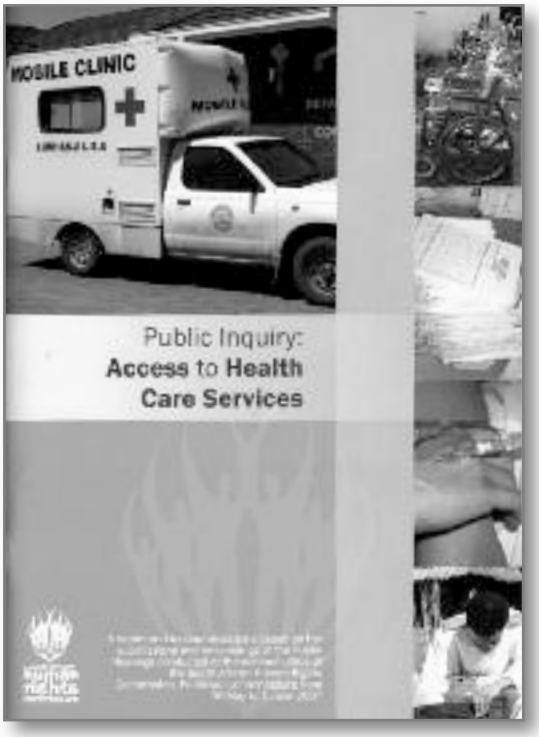
Much has been said about the right to have access to health care services and the obligations it imposes on the state regarding its progressive realisation within available resources. Ordinarily, however, such discussions and debates have focused quite narrowly on the provision of public health services. Seldom have seemingly technical issues – such as health budgeting and expenditure monitoring, fiscal federalism and public procurement – been considered by many in government as integral to the realisation of rights.

In contrast, the work of the ALP is underpinned by respect for the rule of law and the supremacy of the Constitution. In combining research and legal work with social movement strengthening and coalition building, the ALP places the Constitution at the heart of its work, focusing on using and developing the law to defend and advance fundamental human rights – at both a jurisprudential and a practical level. Absent either of these pillars of our constitutional democracy, the ALP's use of the law as a tool of progressive social change – its raison d'être – would fall away.

In large part, this explains the ALP's growing focus on fundamental rule of law questions. While some of this work has looked beyond the fields of HIV/AIDS and health, much of it has considered the topic in relation to the "technical" issues identified above. The focus of this section of the chapter is therefore threefold: first, to frame these issues as human rights concerns; second, to clarify any ambiguities that may exist in respect of the relevant legislative frameworks; and third, to consider these frameworks within the context and overarching structure provided by the Constitution.

Health budgeting and expenditure monitoring

Outside of the context of NHI and health sector reform, the amount of money budgeted for health ordinarily dominates any discussion on public health sector funding. While the quantum of financial resources allocated is always going to be an important part of the broader discussion, so too are the following three related issues: the basis upon which the specific amounts have been allocated in any particular budget; the process in terms of which the budget is developed; and expenditure monitoring. In our view, the Constitution imposes obligations on the state in respect of all three of these issues.



SAHRC report on access to health care services

Forecasting and costing need

The ALP's 2006/2007 review referred to submissions made in April/May 2007 to the South African Human Rights Commission (SAHRC) regarding its public hearings into the right to have access to health care services. In considering the concept of "needs-based budgeting", which our submissions firmly advanced, former Health Minister Manto Tshabalala-Msimang stated that she did "not agree … that … the Commission must hold the government bound to certain methodologies of … budgeting for the realization of the right to health care services", insisting that "budget processes must be left to government".

In its report, which was only published in April 2009, the SAHRC considered the issue of needs-based budgeting in a particularly cautious manner:

> The case for a needs-based approach to budgeting was explored and supported in a number of submissions to the SAHRC. The process followed in the development of the National Strategic Plan for HIV and AIDS was held up as an example of best practice, in which broad consultation laid the foundation for the plan which was budgeted for according to need. The budgeting exercise resulted in a figure much higher than the funds provided for in the allocated budget, and a commitment was therefore made to seek additional funding to meet the shortfall. The debate as to whether to adopt a needs-based funding approach has been discussed in Cabinet, and there appears to be concern as to whether the costly process of determining resource requirements would be worthwhile in light of overarching funding constraints.[3]

Having said that, however, the SAHRC expressly called for "a recognition and realignment of the location of health in national priorities … [that] should be reflected in resource allocation and the design and implementation of an effective and functional needs-based system."[4] It explained further:

> [T]he integrity of a needs-based system relies on ... accurate measurement. ... Health information systems and population data must be improved continuously, because it is essential to be able to monitor progress and inequities. Institutional capacity to collect, analyse and utilise health data at national, provincial and local levels need[s] to be strengthened, so that programme[s] and policies can be responsive to the changing burden of disease profile.[5]

Today, South Africa appears to be no closer either to developing or implementing a budgeting process that is well aligned to the country's health needs and identified priorities. In large part, this appears to be the result of a weak health information system, an inability and/or unwillingness on the part of provinces to forecast appropriately, poor national oversight and a generalised failure to monitor and evaluate programme implementation and budget expenditure. As the ALP argued in a March 2010 submission to the Select Committee on Appropriations in the National Council of Provinces (NCOP):

> [B]oth the Free State and Limpopo [Integrated Support Team (IST)] reports identify unexpected increases in the number of patients on [antiretroviral (ARV)] therapy in each province as a third cause [of provincial over-spending]. The fact that provinces have seemingly "over-performed" their targets has, unfortunately, far less to do with over-performance than with inadequate monitoring and evaluation (M&E) programmes able to forecast patient need in the province. ...
>
> Inadequate M&E systems will inevitably lead to failures to budget according to actual needs in each province and ultimately to further over-expenditures. This is in accordance with the findings of both the Free State and Limpopo IST reports. In this regard, there is great public interest in having all the IST reports published and we call on the Committee to inquire on their status and to hold further public hearings on the reports or to allow the ALP and other civil society organisations to brief the Committee on the issues raised in the reports – including M&E – that fall within its mandate.[6]

The ALP's work on budgeting and expenditure monitoring has not been limited to policy submissions. In August 2009, we helped to establish the Budget Expenditure and Monitoring Forum (BEMF).[7] In addition, as is explained in greater detail elsewhere in this review, the ALP's intervention to address the ARV treatment moratorium in the Free State – which lasted from November 2008 through March 2009 – included engagement with the National Treasury and its provincial counterpart in Bloemfontein. Central to this engagement was the ALP's insistence that the two treasuries account for their failure to provide oversight as contemplated by the Constitution and the Public Finance Management Act 1 of 1999.

Developing budgets and monitoring expenditure

Despite the intended representative and participatory nature of South Africa's democracy, two of the most important pieces of legislation passed by Parliament each year – the Division of Revenue Act and the Appropriations Act – are routinely passed without meaningful parliamentary and public participation. In short, what the Minister of Finance proposes Parliament simply rubber-stamps. This will change significantly if and when the Money Bills Amendment Procedure and Related Matters Act, 2009 ("the Money Bills Act") is fully and appropriately implemented.

Despite coming into force on 16 April 2009, the Money Bills Act had little impact on the 2010/11 budget. To try to rectify this in future, the ALP's submission to Parliament on the Division of Revenue Bill, 2010, called for the urgent establishment of the Parliamentary Budget Office (PBO) – a key structure set up by the Money Bills Act – and for it to be provided with the necessary financial and human resources it requires to begin its work on the 2011/12 financial year budget. The submission contextualised the new statute and substantiated its call for the PBO to be set up and appropriately resourced urgently:

> The Constitution vests Parliament with the responsibility for establishing budgeting procedures and passing the annual national budget. More fundamentally, Parliament has the responsibility to ensure that the manner in which resources are raised, appropriated and ultimately spent advances the constitutional project, the cornerstone of which is the Bill of Rights and the obligation it imposes on the state to respect, protect, promote and fulfil those rights, including the progressive realisation of the right to have access to health care services.
>
> ...
>
> The Money Bills Act, as required by section 77(3) of the Constitution, provides Parliament for the first time with the statutory powers necessary to fulfil its constitutional mandate in respect of the budget. However, implementation of the Money Bills Act must be prioritised urgently by Parliament. Given the limited timeframes in the Money Bills Act and the complexity of the budget, there is insufficient time to engage substantively with the [Division of Revenue Bill] as tabled. However, for Parliament to implement fully this constitutional mandate for the 2011/12 financial year, it is essential that the PBO be established urgently.

Our submission also expanded on an appropriate role for the PBO. Recognising that Parliament – on its own – "is ill equipped for the mammoth task of tackling the entire budget within the very tight timeframes required", the Money Bills Act nevertheless "provides little guidance on how the PBO is to conduct its research and provides little direction to National Treasury on how to include the PBO in the budgeting process." With this in mind, we recommended that the PBO be granted –

- Sufficient financial resources;
- A sufficient number of members of staff with appropriate skills and experience to engage with the budget and related processes; and
- An observational role in the National Executive's development of the annual budget.

Once the Money Bills Act is appropriately implemented, it will provide Parliament and civil society with the requisite space to participate fully in the national budget process. However, as important as this is, it will not – in and of itself – ensure that public health programmes, for example, are fully funded. For this to happen, Parliament must play the oversight role entrusted to it by the Constitution. So too must institutions of civil society – such as the BEMF – continue to monitor and evaluate expenditure for and the implementation of such programmes.

Addressing concerns about "fiscal federalism"

The Constitution makes health a functional area of concurrent national and provincial legislative competence. By doing so it introduces the possibility of fiscal federalism, that is provinces making decisions about expenditure on health services independently of national priorities and thereby subverting and/or departing from national priorities.

Even if the Money Bills Act were to be fully and appropriately implemented, this would not adequately address concerns relating to provincial budgeting processes and outcomes. In particular, both national government and civil society are considering how best to ensure that nationally agreed priorities in health are appropriately funded.[8]

The problem of fiscal federalism may arise because of one or more of a number of factors, including – but not limited to – the following:

- Although provincial equitable shares are allocated with particular national priorities in mind, there is nothing in law that requires provincial budgets to reflect these priorities;
- Conditional grants are often allocated in a manner that provides for too much flexibility in the way national money is spent at a provincial level; and
- Provinces have yet to enact legislation similar to the Money Bill Act, despite the requirement in section 120(3) of the Constitution that a "provincial Act must provide for a procedure by which the province's legislature may amend a money Bill"

The issue of fiscal federalism was dealt with extensively in a memorandum prepared by the ALP for the Health Financing Technical Task Team of Hogan's MACH.[9] We argued "that while there are constraints on the national government, there are circumstances where it is appropriate and constitutional (indeed, at times necessary) for national government intervention at the provincial level." The ALP's submission further argued that "there is space for reform of the fiscal system in order to ensure efficiency of budgeting and expenditure within the constitutional framework."

Central to this submission was the argument rebutting the claim that the "lack of alignment between provincial spending and national priorities … is an unforeseen result of the federalist nature

of the fiscal system and … short of a constitutional amendment, the national government is unable to intervene in the provinces to ensure service delivery that is compatible with national priorities." In particular, it focused attention on how the Constitution deals with national override powers, co-operative government, and unity of purpose in relation to duties. This input featured strongly in the task team's report to the Minister.

In our later submission on the Money Bills Act, recognising that the Constitution places certain restrictions on national government's reach into the provincial sphere, the ALP recommended that one way to counter fiscal federalism is to adopt a more aggressive approach to conditional grant allocations so as to achieve appropriate funding levels for priority public health programmes. In particular, the submission argued the following in respect of the HIV Conditional Grant:

> If we look at the conditions in the HIV Conditional Grant, they provide few actual conditions other than where such funds must be spent. Of concern is that they do not recognise the importance of adequately funding those aspects of provincial health systems necessary for proper implementation of the HIV sub-programme in each province. … In our opinion, these conditions [in the business plans that the DoH and National Treasury must still approve] do little to ensure a functional environment in which the HIV sub-programme is to operate. It does little good to fund HIV sub-programmes adequately or substantially through a conditional grant allocation if the remainder of the provincial health care system is chronically underfunded. … We believe that the [Division of Revenue Bill] should impose an additional condition on certain conditional grants through a matching funds requirement.

Public procurement

Legitimate concerns about "tenderpreneurs", corruption in the award of state tenders and collusive practices amongst bidders ordinarily dominate debate on public procurement. Less popular topics for debate include legislative frameworks and departmental practices that undermine access to health care services in a somewhat subtler manner. Unsurprisingly, there is some degree of overlap between the two categories of issues, as weak frameworks and opaque and unaccountable practices either facilitate or provide some cover to the headline-grabbing tender-related practices.

In all aspects of its work on public procurement, the ALP has sought to flesh out the guidance provided by the Constitution, to clarify ambiguities in the legislative framework, and to recommend how best to amend various statutes and regulations that do not give full and proper effect to the Constitution.

The ALP has worked on three aspects of procurement. First, it provided legal advice to a task team appointed to advise the Minister of Health on procurement and supply chain management reform in relation to medical products.[10] Second, it made a detailed submission in late 2009 on draft Preferential Procurement Regulations published by National Treasury.[11] Finally, in conjunction with the BEMF (which organised a special meeting to focus on the ARV tender), it has been providing legal support to the DoH in relation to the upcoming 2010 ARV tender. Work in this area is ongoing, aimed at ensuring that the state is able to procure medicines of proven quality, safety and efficacy at the lowest possible price.

In all aspects of its work on public procurement, the ALP has sought to flesh out the guidance provided by the Constitution, to clarify ambiguities in the legislative framework, and to recommend

how best to amend various statutes and regulations that do not give full and proper effect to the Constitution. The ALP's work on public procurement is based on respect for the Constitution and the overarching framework it provides, understanding that amendments to the Constitution should only ever be contemplated as a matter of last resort.

Addressing the HRH crisis

Concerns regarding HRH have been on the ALP's agenda for many years. In this review, we focus on three issues that – if properly addressed – could make a significant dent in the HRH vacancy rate as well as ensure that we make use of our limited human resources more efficiently and effectively:

- Implementation of the Occupation-specific Dispensation (OSD) – effectively a salary supplement – for nurses and doctors;
- Scope of practice and task shifting; and
- Employment of foreign-trained health care professionals.

As important as these issues are, they are – unfortunately – not the only HRH matters of concern. More broadly, the DoH has yet to develop a reasonable plan that commits the state to "taking all reasonable steps to ensure that sufficient numbers of appropriately trained HCWs – including health care providers and other non-health personnel – are trained, attracted to and retained in the public and private health sectors health system to provide and manage the provision of health care services." This, the ALP argued first in 2005, is necessary for the state to "discharge its constitutional obligations regarding health care services".[12] Fortunately, Minister Motsoaledi, in his health budget vote for 2010/2011, promised a reworking of the HRH plan.

OSD for nurses and doctors

In 2008, the DoH negotiated and agreed to the OSD for nurses. The OSD has been widely cited in the media and in other reports as one of the largest factors in provincial overspending over the 2008/2009 and 2009/2010 financial years. As stated in both the Free State and Limpopo IST reports, the flaws in the implementation of the OSD stem from a lack of communication, costing of national policy decisions and insufficient allocation of resources to implement. In respect of the latter, the Eastern Cape Provincial Health Department has acknowledged that it ran out of funds to pay the OSD for nurses.[13]

Dr Zola Ntshona, an obstetrician at Polokwane Hospital, gets ready for surgery (reproduced with kind permission of Health-e News Service)

In our submission to Parliament on the Division of Revenue Bill, 2010, we noted National Treasury's attempt to cushion the impact of the OSD by allocating additional resources through the Adjustment Appropriation Act, 2008. However, we also noted that this allocation was according to the standard equitable share distribution formula, not on the basis of a costing exercise designed to cover the actual expenses being faced in each province. Put differently, government adopted and implemented a temporary band-aid solution that is unlikely to resolve the problem in any sustainable way.

This review is not the place to discuss various alternatives open to national government to ensure that it allocates sufficient financial resources to the provinces to ensure the reasonable implementation of the OSD, as well as the mechanism by which it is able to ensure that provinces use the allocated resources appropriately. Suffice it to say that while the DoH has negotiated an OSD for each of an additional number of categories of health workers, in particular doctors and pharmacists, the Division of Revenue Bill, 2010 has not put in place measures to ensure that the OSD is properly implemented.

Scope of practice and task shifting

For almost 30 years, the HIV pandemic has turned various aspects of public health policy upside down. Consistently challenging conventional wisdom in respect of a wide range of sacred cows, many AIDS activists across the world have been unwilling to accept an ordinary, unexceptional response to what is generally understood as an extraordinary threat. The HIV epidemic has revealed flaws in traditional wisdoms about the delivery of health care services and has forced innovation. This "out-of-the box" thinking has also characterised responses to the global HRH crisis and its impact on HIV prevention and treatment programmes. Put simply, traditional scopes of practice have been reconsidered so as to maximise the use of available skills.

Over the last few years, the ALP, TAC and our allies have worked through the South African National AIDS Council (SANAC) to focus discussion on three aspects of this broad topic: nurse-initiation of ARV treatment; counsellors drawing blood by way of finger pricks for rapid HIV tests; and the work conditions of community care workers (CCWs) such as HIV test counsellors, treatment supporters and home-based care workers. In terms of policy, the DoH has made significant strides in relation to the first two issues. In principle, it has agreed that nurse-initiation of ARV treatment will become the norm, as will finger pricking by counsellors for HIV rapid tests.

In contrast, progress to resolve policy about the role and conditions of employment of CCWs has been slow. Of concern to the ALP is the DoH's apparent unwillingness to recognise that CCWs provide a range of health services that are central to its core function, and that they should therefore be properly employed and integrated into the health system. The list of complaints raised

Adila Hassim considers the impact of HIV/AIDS on the health system in Health Management Review Africa

by CCWs is long, including the quantum of the "stipend" paid (which is lower than the Expanded Public Works Programme wage), delays – sometimes running to months – in payment, and a general lack of DoH oversight. However, instead of employing CCWs directly, which would regularise their work conditions and safeguard their constitutionally guaranteed workplace rights, the DoH has been developing a new policy that retains the status quo, effectively seeking to continue employing CCWs indirectly through non-profit organisations that are often better characterised as labour brokers.

To date, however, government and civil society have yet to reach consensus on a set of core principles, let alone the details of a policy on CCWs.

The ALP has worked with a range of organisations to try to halt this process. In June 2009, for example, we co-authored a letter to the Ministers of Health, Labour, Social Development and Economic Development that aimed to draw their attention to the issue.[14] This led to an informal civil society alliance on the issue, as well as to concessions by the DoH to halt finalisation of the contested policy. To date, however, government and civil society have yet to reach consensus on a set of core principles, let alone the details of a policy on CCWs. Unless resolved, many public health programmes, particularly those on HIV and TB, will remain at risk.

Foreign-trained workforce

The final HRH issue considered in this review relates to the difficulties faced by foreign-trained health care professionals to register and work in South Africa. While the ALP recognises that South Africa should not be poaching health professionals from other developing countries, it does not support the DoH's current inflexible approach to the matter – one which results in pushing such doctors and nurses, for example, to seek jobs in developed countries such as Canada and the United Kingdom (UK). Put differently, closing doors in South Africa does not result in foreign nationals returning to their countries of origin.

The inflexibility appears to result from a misunderstanding of South Africa's international obligations relating to the recruitment of health workers from developing countries. In the ALP's view, there should be a clear distinction between recruiting health workers from developing countries and allowing those who seek work in South Africa to practice. While the former is clearly prohibited, the latter is indeed permitted. The impact on South Africa of the DoH's inflexible approach is great, particularly given that foreign-trained health care professionals would ordinarily be expected to take up positions in (largely rural) underserved areas.

The impact on South Africa of the DoH's inflexible approach is great, particularly given that foreign-trained health care professionals would ordinarily be expected to take up positions in (largely rural) underserved areas.

The ALP has already started to provide legal advice and litigation services to foreign nationals who have encountered bureaucratic and legal obstacles in the way of them practising in the country. One case, involving a UK-trained doctor with over six years' experience in the provision of ARV treatment in the South African public sector, was successfully resolved – the doctor received a work permit shortly after consulting the ALP and acting on its advice. Another case, involving a permanent resident who has not been able to register as a specialist, is ongoing.

In considering how best to take up the issue in a sustainable and systematic manner, the ALP is working closely with Africa Health Placements (AHP) and the Rural Health Advocacy Project (RHAP). AHP, a joint venture between the Foundation for Professional Development and the Rural Health Initiative, seeks to place foreign-trained health care professionals in public sector posts in

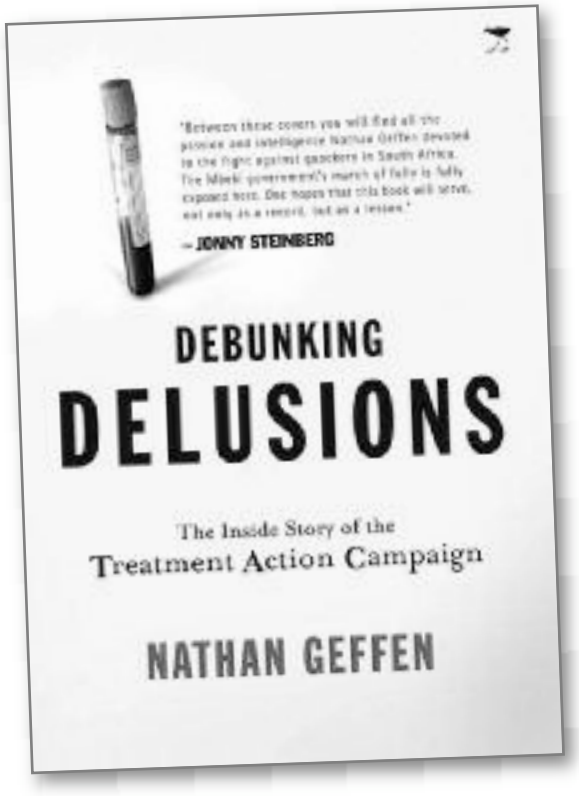
South Africa. RHAP, a partnership between the Wits University Centre for Rural Health, the Rural Doctors Association of South Africa (RuDASA) and the ALP, focuses much attention on addressing the even greater rural HRH crisis.

Strengthening health governance institutions

As a result of denialism and neglect the public health sector is characterised by a systemic lack of capacity at the DoH, most of its provincial counterparts,[15] as well as a collection of weakened regulatory and oversight institutions. When talking about lack of capacity, we are not only referring to the capacity of hospitals, health centres and clinics to deliver public health services, but also to the lack of strategic, technical, managerial and administrative capacity.

In addition to concerns about the quality and performance of many deputy directors-general and chief directors, a quick scan of the DoH's organogram indicates a number of vacancies at this crucial level. This has resulted in burdening those who are already responsible for other directorates with additional responsibilities in the form of acting chief directorships. This has been a hallmark of the DoH for many years. For example, one person (at a time) was assigned responsibility for both the Medicines Regulatory Affairs (MRA) and Pharmaceutical Policy and Planning (PPP) directorates from 2005 to 2009.[16]

Medicines regulation provides a disturbing picture of the type of damage caused by a combination of neglect, mismanagement and political interference in the work of a health governance institution.



Nathan Geffen takes on quacks, charlatans and their supporters in government

Medicines regulation provides a disturbing picture of the type of damage caused by a combination of neglect, mismanagement and political interference in the work of a health governance institution. Established in terms of the Medicines and Related Substances Act 101 of 1965, the Medicines Control Council (MCC) has a mandate focused on ensuring the quality, safety and efficacy of medicines used in South Africa. The MCC was established in the wake of the thalidomide tragedy, which drew attention to the dangers of untested medicines.

In a recently published book entitled *Debunking Delusions*, the ALP's Nathan Geffen shows how state-sponsored AIDS denialism was a primary driver of attacks on the independence and integrity of the MCC.[17] These attacks began under former President Mandela's administration in response to the MCC's principled opposition to Virodene, a toxic industrial solvent that was being punted as a cure for AIDS.[18] Once purged of its "problematic" chairperson, the MCC became more compliant. After that, as Geffen notes,

"[m]easures to control quackery went unimplemented and a large backlog developed of medicines waiting to be registered." He adds: "The authority that the MCC had had over the regulation of medicine eroded and the market began to flood with quack remedies."[19]

Concerns regarding the structure and capacity of the MCC were central to the work of the MPTTT.

Amongst other things, it recommended that work start urgently to address the massive backlog of applications for registration. In addition, as already discussed in this chapter, the MPTTT made a series of recommendations in relation to the structure and mandate of the proposed successor to the MCC. Further, a number of other concerns relating to its role in the post-Virodene era were placed on the MCC's agenda, including the vexed question of the regulation of so-called complementary and alternative medicines.

However, the problems that beset the MCC were not confined to it alone. Institutions such as the Health Professions Council of South Africa, the South African Nursing Council and the Medical Research Council have also been victims of denialism, undue Ministerial interference, parliamentary attacks on their independence, and DoH mismanagement.[20] In addition, there is no overarching framework within which regulatory and oversight institutions in health are located. In short, much work remains to ensure that these bodies are indeed able to operate in a constitutional manner.[21]

The only health governance institution that has emerged relatively unscathed from the Mbeki years is the Council for Medical Schemes (CMS). Established in terms of the Medical Schemes Act 131 of 1998, the CMS plays a central role in enabling the state to discharge its constitutional duty to deal appropriately with medical schemes operating in the private health sector. While it is important to strengthen the public sector and ensure the delivery of quality health care services, it remains equally important to regulate the private health industry, particularly given that its conduct has the potential to undermine the Constitution's guarantee of access for all.

The CMS has, however, been undermined by Parliament allowing the Medical Schemes Amendment Bill [B 58—2008] to lapse. In our previous review we had warned that "a failure to process the bill in 2008 would leave open a legal loophole for 'financial service providers to begin introducing health insurance products designed to lure young and healthy persons away from the medical schemes environment.'" We further argued that this, in turn, would "leave older and sicker persons behind, effectively undermining the ability of schemes to keep contributions and benefits at current levels."

However, the problems that beset the MCC were not confined to it alone. Institutions such as the Health Professions Council of South Africa, the South African Nursing Council and the Medical Research Council have also been victims of denialism, undue Ministerial interference, parliamentary attacks on their independence, and DoH mismanagement.

In addition to these concerns, the failure to process and adopt legislation that would also have introduced a mechanism for risk sharing between medical schemes – the Risk Equalisation Fund (REF) – is in part responsible for increasing pressure on scheme contributions. Put simply, the inability to share risks with others translates directly into higher premiums for some schemes. To protect themselves, they simply pass the risks onto their members.

Having said this, it is important to remember that high premiums are inevitable in a context of largely unregulated health provider costs and the prescribed minimum benefit (PMB) requirements appropriately imposed on schemes by the Medical Schemes Act. This is because schemes are required to cover the full costs of certain benefits for all members and beneficiaries,[22] and yet have little power to address spiralling provider costs. The ALP has thus identified the need for appropriate regulation of provider costs as an integral part of its ongoing work.

NHI: a magic bullet or a red flag?

Up to this point this chapter has focused on how to address the most pressing and obvious challenges facing the health system. In a sense it has focused on key aspects of the government's 10-point plan. However, throughout the period under review, another health process has been ongoing: NHI.

In our previous review we reported on the genesis of this policy within the ANC and the process that led to a commitment to a system of NHI becoming part of government policy. In line with these developments and the ANC's election mandate, Health Minister Aaron Motsoaledi established the National Health Insurance Advisory Committee ("the NHI Advisory Committee") on 11 September 2009. The ALP's Mark Heywood is one of the committee's 25 members.[23]

Set up in terms of section 91(1) of the National Health Act 61 of 2003 (NHA), the NHI Advisory Committee's mandate is "to advise the Minister on policy and legislation development and the implementation plan for the [NHI] system." Its terms of reference include the following expected outcomes and deliverables:

- Making progress reports to the Minister on a regular basis;
- Finalising a public consultation process on a draft NHI policy within three months of the draft policy's publication for general comment;
- Submitting draft proposals on NHI legislation to the Minister within three months of Cabinet approval of the final NHI policy;
- Finalisation of the NHI system implementation plan proposal, including transitional arrangements, by June 2010; and
- Providing regular reports to the Minister on the progress of the implementation of NHI over a five-year period.

The NHI Advisory Committee began its work in December 2009. At the time of going to press, some four months later, a draft NHI policy had not yet been published for public comment.

The ALP has paid close attention to the debate about NHI since its inception, and been part of various policy processes. During this period "NHI" has caused much sound and fury in the media, ironically even before a draft policy is on the table. On the political left, the Congress of South African Trade Unions (COSATU) and the South African Communist Party (SACP) have been vocal in demanding the "implementation of NHI". On the other hand, parts of the private health industry seem determined to leave their financial interests untouched, and therefore claim that the solution lies solely in repairing and building the public health system.

It is important, in this debate, to be crystal clear on the rationale for NHI, what must be done to make it feasible, and what it aims to achieve.

It is important, in this debate, to be crystal clear on the rationale for NHI, what must be done to make it feasible, and what it aims to achieve. In theory and in law, all people in South Africa have access to health care services. However, there is gross inequity in the quality and resources available to these services, skewed in favour of the rich and urban. In effect this means that many people do not actually have access to the services they need. There is both under-expenditure and over-expenditure on health, and

the disjuncture between public and private health systems undermines health outcomes. As evidence of this is the gross mismatch between what is spent on public health and what is spent on private health.

In our view, NHI envisages a funding mechanism that levels the playing field by pooling all financial resources for health and targeting them much more rationally and efficiently at actual health needs. One aim is to use the funding mechanism better to integrate public and private health delivery systems and ensure the provision of quality health care services. But the ALP understands that NHI, as a funding mechanism, does not in and of itself provide any guarantee of access. Put differently, the challenges facing the public and private health sectors and their eventual integration into a single national health system include but extend way beyond the allocation and management of rands and cents.

Put differently, the challenges facing the public and private health sectors and their eventual integration into a single national health system include but extend way beyond the allocation and management of rands and cents.

In the light of this, the big question is what model of NHI will meet these objectives and what needs to be done *first* to implement such a model?

Answering such questions has understandably slowed the process down. In his 2010 State of the Nation Address, President Zuma noted that government would "continue preparations for the establishment of a[n] NHI system." In the Parliamentary debate that followed, Health Minister Motsoaledi stated:

> Many opponents of the NHI opportunistically cite ... problems of poor quality of our health care services as a reason why the NHI will not work, and why it should not see the light of the day. I have reassured them time and again that NHI is never going to be implemented in isolation away from the other items of our 10-point Plan. The quality of provision of health-care services is definitely going to be one of the criteri[a] used before a health institution is accredited for purposes of NHI.

And in his 2010 budget speech the Minister of Finance noted that "[a]longside longer-term reforms to the financing of health care, a closer partnership between the public and private health care systems is a prerequisite for the introduction of a[n] NHI system."

It is likely that the debate on NHI will intensify in the period ahead. Through Heywood's membership of the NHI Advisory Committee and independently, SECTION27 – the ALP's successor – will do all that it can to make sure that the right choices are made.

Endnotes

1. *Government Gazette* No. 32148 (21 April 2009)
2. Jonathan Berger, "Legislative Review for the Medical Products Technical Task Team (MPTTT)", May 2009. The MPTTT's recommendations have yet to be made public.
3. At page 31
4. At page 57
5. Ibid
6. The submission – on the Division of Revenue Bill, 2010 – is available at *http://section27.org.za/wp-content/uploads/2010/04/ALP-Submission-on-the-Division-of-Revenue-Bill-2010.pdf*. As explained in Chapter 1, former Health Minister Barbara Hogan established the ISTs in February 2009 to investigate and review the underlying causes of budget overspend by provincial health departments.
7. BEMF's composition, mandate and work are addressed more fully in chapter 4. Reports of and correspondence from BEMF are available at *http://www.tac.org.za/community/BEMF*.
8. The same concern applies to education, which is similarly a functional area of concurrent national and provincial legislative competence.

9. The ALP memorandum is available at *http://section27.org.za/wp-content/uploads/2010/04/legal-perspective-on-health-budgeting-final.pdf*.
10. This work grew out of the recommendations of the MPTTT.
11. The submission is available at *http://www.section27.org.za/wp-content/uploads/2010/04/ALPSubmission- DraftPreferential-Procurement Regulations2009.pdf*
12. See joint ALP/TAC submission entitled "A Strategic Framework for the Human Resources for Health Plan: Draft for Discussion", available at *http://section27.org.za/wp-content/uploads/2010/04/Strategic-Framework-for-the-Human-Resources-for-Health-Plan- 2005-TAC-ALP.pdf*.
13. See "Joint Statement by the Treatment Action Campaign (TAC) and Public Service Accountability Monitor (PSAM) on OSD", available at *http://www.tac.org.za/community/node/2829*
14. The ALP's letter is available at *http://www.section27.org.za/wp-content/uploads/2010/04/LetterToMinistersOnCCGs.pdf*
15. The provincial sphere of government is primarily responsible for health service delivery.
16. On the recommendation of the MPTTT, Mandisa Hela was relieved of her responsibilities in respect of the PPP directorate to concentrate on the MRA (now known as the Pharmaceutical and Related Product Regulation and Management (PRPRM) directorate) and her duties as Registrar of Medicines. Unfortunately, another chief director, Anban Pillay, has now been assigned responsibilities in respect of the PPP directorate in addition to his responsibilities as chief director of health economics.
17. See also Jonathan Berger, "Exorcising the ghosts of Dr. No's war on science: exploring what the Constitution means for the institutions that regulate medicines", available at *http://papers.ssrn/abstract=1353944*
18. See also Nathan Geffen and Edwin Cameron, "The deadly hand of denial: governance and politically-instigated AIDS denialism in South Africa", Centre for Social Science Research Working Paper 257 (July 2009), available at *http://www.cssr.uct.ac.za/publications/working -paper/2009/257*
19. Nathan Geffen, *Debunking delusions: the inside story of the Treatment Action Campaign* (Jacana: Cape Town, 2010) at page 182
20. See the 2006/2007 and 2007/2008 ALP reviews for further information.
21. For example, section 50 of the National Health Act 61 of 2003, which establishes the Forum of Statutory Health Professional Councils, has yet to be brought into force.
22. A CMS investigation of systemic violations of the PMB requirements by schemes and administrators determined that medical schemes and administrators were creating bureaucratic barriers and implementing unlawful payment practices in order to avoid their obligations to make full payments for PMB claims. It resulted in the CMS issuing a directive in December 2009 ordering all medical schemes and administrators to end these practices. The ALP's press release welcoming the CMS action is available at *http://section27.org.za/wp-content/uploads/2010/04/CMS-press-statement-15-Dec.pdf*.
23. The committee's membership is set out at *http://www.doh.gov.za/docs/pr-f.html*

Chapter 4

Government in the cockpit (at last): the new challenges facing HIV prevention and treatment

By Ella Scheepers

Introduction

On 29 October 2009, President Jacob Zuma brought a decade of AIDS denialism to an end. In a landmark speech to the National Council of Provinces (NCOP), Zuma recognised "the devastating impact that HIV and AIDS is having on our nation."[1] This was in stark contrast to the speech given by former President Mbeki to the same chamber a decade earlier. On 28 October 1999, arguably the start of state-sponsored denialism, Mbeki questioned the call for the public provision of zidovudine (AZT) – a key antiretroviral (ARV) drug used to prevent and treat HIV infection – by noting "a large volume of scientific literature alleging that, among other things, the toxicity of this drug is such that it is in fact a danger to health."[2]

For the first time, Zuma's address indicated an appreciation by the President of the scale and human impact of the HIV/AIDS epidemic, as well as what still needs to be done to address it. He told the NCOP:

> [S]tatistics do not, however, fully reveal the human toll of the disease. It is necessary to go into the hospitals, clinics and hospices of our country to see the effect of HIV and AIDS on those who should be in the prime of their lives. It is necessary to go into people's homes to see how families struggle with the triple burden of poverty, disease and stigma. Wherever you go across the country, you hear people lament the apparent frequency with which they have to bury family members and friends. ... We must accept that we need to work harder, and with renewed focus, to implement the strategy that we have developed together. We need to do more, and we need to do better, together. We need to move with urgency and purpose to confront this enormous challenge.[3]

Importantly, Zuma's address went beyond rhetoric. In outlining steps in the government's invigourated response, he focused much attention on the need for "all South Africans … to know their HIV status". Recognising the importance of people being "armed with information", Zuma noted that this will not only allow those living with HIV to be informed of the treatment options available to them, but would also "help us to confront the denialism and the stigma attached to the epidemic." He then identified World AIDS Day 2009 as "the beginning of a massive mobilisation campaign that reaches all South Africans, and … spurs them into action".

Focus of this chapter

This chapter identifies and addresses the challenges in HIV prevention and treatment in 2010 and beyond. But while focused on the future, it will also – where relevant – reflect on the past: the decade of denialism under Mbeki, the decisive break with the past that characterised Kgalema Motlanthe's eight months as President, and the seismic shifts that have followed Zuma's election.

The chapter begins with a consideration of HIV-specific policy and programme developments that have taken place since Zuma's NCOP speech. In particular, it considers significant changes designed to ensure that the prevention and treatment targets of the national *HIV & AIDS and STI Strategic Plan for South Africa, 2007-2011* ("the NSP") are met. Thereafter, the chapter considers the current state of the epidemic, reflecting on a number of scientific research reports published in the period under review.

The chapter then focuses on three "new" challenges in HIV prevention and treatment – challenges that have been on the agenda for some time but have yet to be addressed in any meaningful way across sectors. These are: budgeting and expenditure monitoring;[4] human rights and access to justice; and new threats to HIV funding. Details on ALP participation in the South African National AIDS Council (SANAC) are contained in Appendix B.

Implementing the President's commitments

In the six months that followed Zuma's address to the NCOP, government – under the leadership of Health Minister Aaron Motsoaledi – has effected a series of policy and programme shifts designed to ensure that the NSP's prevention and treatment targets of the NSP can indeed be met. Key events at which these changes were announced include the following:

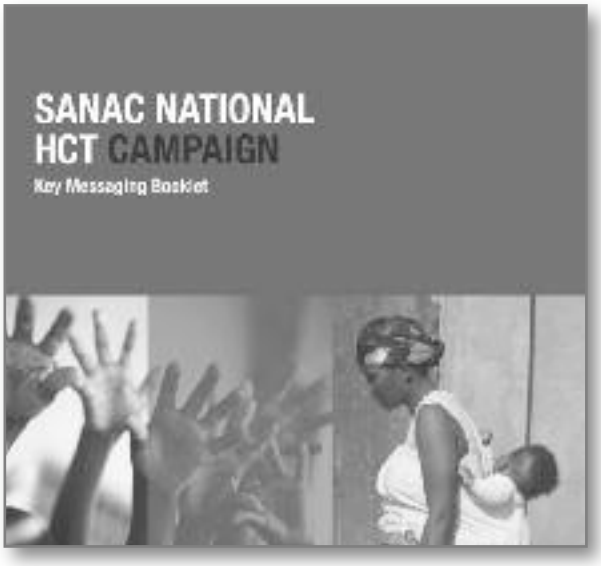
- World AIDS Day 2009, held under the theme of "I am responsible, we are responsible, South Africa is taking responsibility", where Zuma announced improved ARV treatment protocols;
- Finance Minister Pravin Gordhan's budget speech on 17 February 2010, which announced a significantly increased budget for ARV treatment;[5] and
- Cabinet's statement of 11 March 2010 announcing the HIV Counselling and Testing (HCT) campaign and the commitment of all ministers to test publicly for HIV.[6]

Explicitly linked to these shifts is a commitment to a significant scaling up of health interventions expressly recognised in the NSP: a massive public drive to increase access to and utilisation of HCT services; offering comprehensive HIV services – including ARV treatment – at all health facilities; and

full implementation of an improved prevention of mother-to-child transmission of HIV (PMTCT) programme. These new policies will require a significant injection of both human and financial resources.

Increasing access to HCT services

One of the most significant – although little commented upon – changes in policy is the shift from Voluntary Counselling and Testing (VCT) to HCT. The new policy will, in effect, see the routine offer of HIV testing at all points in the health system. While testing will remain voluntary, health care workers will now be expected to play an active role in encouraging people to test and ensuring that access to HCT services is guaranteed. Central to the campaign is the recognition that testing should be the gateway to a comprehensive package of care that includes – but is not limited to – ARV treatment.



SANAC explains the HCT campaign

The ALP has been part of the debate about HIV testing policy, trying to balance the right to testing and its medical benefits with recognition that many human rights violations continue against people living with HIV. HCT is not about mandatory, compulsory or routine testing. People testing for HIV will still be required expressly to provide informed consent, as the legal framework correctly demands. As has been the case with VCT, the right to privacy – in particular the confidentiality of private medical facts – remains in force.

But unlike VCT, which was an approach to testing developed in a very different medical and social environment, HCT is based on the right to have access to appropriate health care services, which includes HIV testing services, and the corresponding duty on the government to facilitate access. It will, however, remain important for civil society to monitor HCT to ensure that it does not become involuntary and that it is indeed a "gateway" and not a prison.

Expanding the pool of people eligible for treatment

Since ARV treatment was first provided in the South African public sector in 2004, access has been limited to adults or adolescents with a CD4 count of 200 or below, or a World Health Organization (WHO) stage 4 AIDS-defining illness (such as pneumocystis pneumonia, oesophageal thrush or extrapulmonary tuberculosis (TB)). For children, the medical criteria have considered the number of recurrent hospitalisations for HIV-related disease in any year, prolonged hospitalisation, WHO staging and CD4 percentage.

The 2010 guidelines, which were implemented on 1 April 2010, expand access to ARV treatment for all people living with HIV. The following categories of people will be eligible: every pregnant woman with a CD4 count of 350 or below; every person co-infected with TB who has a CD4 count of 350 or below; every person with drug-resistant TB, regardless of CD4 count; and all those already eligible under the previous guidelines. For children, the medical criteria have also been eased.[7]

A victory for treatment access: offering comprehensive services at all health facilities

As a result of these changes, the number of medically eligible people seeking ARV treatment is expected to rise dramatically, increasing demand on an already over-stretched public health system with somewhat limited capacity. In addition, the significantly larger numbers of people testing for HIV is likely to put great pressure on the public health sector. So too will the new commitment to the offering of comprehensive HIV services at all health facilities, which will also see the integration of HIV and TB services.

This is in stark contrast to the provision of care in the past. Since 2004, ARV treatment has only been provided at "accredited" public health facilities. Similarly, the provision of post-exposure prophylaxis (PEP) to reduce the risk of HIV transmission following rape was restricted to "designated" facilities. Introduced under the guise of quality assurance, these requirements limited access. Instead of using the accreditation process to strengthen facilities, it simply served to limit the number of facilities providing care.

The Treatment Action Campaign (TAC), the ALP and others campaigned for years against the onerous and often impossible system of "accreditation", warning that it created bottlenecks that denied access to treatment for many. We also linked these demands to the need for task-shifting and health system strengthening at the district level.

In recognition of this and to enable the decentralisation of care, the new approach will be accompanied by significant changes of policy and practice in human resource management: nurse-initiated ARV treatment and the provision of comprehensive HCT services by non-health professionals.

Both policy shifts have required legislative amendments: the amendment of nurses' scope of practice by the South African Nursing Council, the promulgation of certain sections of the National Health Act, 2003, and the urgent drafting and promulgation of new regulations relating to the drawing of blood. In this regard, the ALP assisted the national Department of Health (DoH) by providing it with a legal opinion in early 2010.

A victory for women: full implementation of PMTCT services

In our previous review, we drew attention to previous efforts of the ALP and TAC to ensure that the PMTCT protocol was brought in line with international good practice. We reported that the revised protocol was eventually approved in late January 2008 in accordance with recommendations adopted earlier by SANAC. Two years and two health ministers later, we now – for the first time – have a PMTCT protocol that firmly places the health of pregnant women, not only their children, at its centre.

Henceforward, every pregnant woman with a CD4 count of 350 or below will be initiated on ARV treatment. In addition, the 2010 ARV treatment guidelines require pregnant women to be "fast-tracked" onto treatment – initiation is to take place within two weeks of being identified as medically eligible. For those not yet requiring treatment, prophylaxis – ARV medicines used solely for PMTCT – will now begin at 14 weeks of pregnancy. In contrast, the 2009 revised protocol only saw the provision of prophylaxis from 28 weeks.[8]

Policy shifts still to be finalised: male circumcision

The NSP recognises that "[e]pidemiological analyses have demonstrated correlations between circumcision and HIV prevalence, and protective effects have been shown in a randomized controlled trial in South Africa and elsewhere."[9] Recognising that "male circumcision reduces the risk of HIV infection of males through female-to-male transmission", the NSP correctly observes that "[i]t remains necessary for men to practice consistent condom use, as well as adopting or maintaining other HIV prevention strategies such as limiting numbers of sexual partners, whether or not they are circumcised."

Almost three years later, South Africa is in the final stages of preparing for the introduction of a public voluntary medical male circumcision (VMMC) programme. SANAC is finalising guidelines for the implementation of VMMC and other clinical and auditing protocols necessary for health facilities to assess their readiness to provide the intervention as demand peaks.

In the debates about a policy on VMMC that took place at SANAC, much emphasis was placed on respect for current cultural practices involving male circumcision and the harm that VMMC might cause to these practices. However, the naysayers were contradicted when, in late 2009, King Goodwill Zwelithini announced the revival of the practice of circumcision for young Zulu men, linking it to the need to reduce the rate of new HIV infections.[10]

The King's announcement vindicates the view that cultures may be dynamic and sensitive to changing contexts. Put differently, cultures are capable of adapting, particularly where a nation's life is literally at stake.

The King's announcement vindicates the view that cultures may be dynamic and sensitive to changing contexts. Put differently, cultures are capable of adapting, particularly where a nation's life is literally at stake. The jury is still out on whether this decision will cause a reassessment of other cultural practices that are understood to exacerbate vulnerability to HIV infection, including virginity testing and widow cleansing.[11]

But as President Zuma has unfortunately made clear in his initial responses to the scandal concerning his love child, "culture" can still be used to defend the indefensible and justify the unjust. A national debate about culture, diversity and human rights is indeed needed in South Africa.

Is the war over? Assessing readiness for the new policies

Given the dramatic political, policy and programme developments described so far, one might be forgiven for thinking that the battle for an appropriate state-led response to HIV/AIDS is over. But is this actually the case? Just how well are we doing in our collective response and how ready are we for such a dramatic scale-up of services? Two sets of data are indicative of the challenges we still face with HIV prevention.

Decoding the data

The Human Sciences Research Council (HSRC) South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, 2008 ("the 2008 HSRC household survey"),[12] which was published in June 2009, provides some encouragement of positive signs of behaviour change. Important findings include the fact that 25% of people tested for HIV in the 12 months prior to being interviewed, notably reaching the 2011 target in the NSP! In addition, the survey concluded that there has been a steady decline in HIV prevalence among children over the 2002 – 2008 period, with a significant reduction in national HIV prevalence – 3.1 percentage points – among children aged 2–14.

But not all the news is good news. Significant challenges remain, including the fact that women aged 25–29 continue to have a very high HIV prevalence rate. In this group, a prevalence of 33% has been sustained over the period of the three HSRC household surveys conducted thus far – 2002, 2005 and 2008 – without any change. In addition, the 2008 HSRC household survey indicates a troubling increase in intergenerational sex among female teenagers. These problematic social dynamics will be discussed further below.

The DoH's 2008 National Antenatal Sentinel HIV & Syphilis Prevalence Survey ("the 2008 antenatal survey"),[13] published late again in 2009, adds to the picture of the South African epidemic.

Importantly, it continues to show significant variations in HIV prevalence across and between the 52 health districts in the country. For example, HIV prevalence amongst antenatal attendees ranged from 16% in the Western Cape to 38.6% in KwaZulu-Natal. It shows that there are still different determinants and risk factors driving the epidemic in the different parts of the country.

Such data is helpful in that it assists government and civil society in planning appropriately and targeting their interventions according to identified needs. However, the absence of rigorous and reliable monitoring and evaluation systems is another legacy of former Health Minister Tshabalala-Msimang. The need for accurate information and the ability to introduce this quickly into programmes remains a major challenge.

Sadly, these are not the only challenges we face.

Free-fall in the Free State

We have already written much about the Free State moratorium in this review (chapters 1 and 3) as well as our previous one (which was published at the tail-end of the crisis). What remains to be added here is to recognise the work of the ALP and its partners in addressing the crisis and its aftermath. In early 2009 and again in 2010, ALP staff members – including Agnieszka Wlodarski, S'khumbuzo Maphumulo and Brian Honermann – visited clinics and hospitals and met with activists to research the effects of the moratorium. We helped set up the Free State AIDS Coalition. We also provided ongoing legal and training support with the assistance of partners such as the Health-e News Service, which helped to bring reports about the Free State onto the national stage.

Members of the Free State AIDS Coalition

Our experience paints a disturbing picture of poor budgeting and expenditure monitoring, a lack of appropriate DoH oversight, turf wars between health and finance at the provincial sphere of government, and large doses of buck-passing. Unfortunately, the state of the Free State health service – to some degree – is the state of health services in the majority of South Africa's provinces. This was reflected in a candid admission of the (then) head of health in the Free State – Professor Pax Ramela – that what happened in his province was particularly widespread:

> **The problem that we experience in the Free State has just been suddenly highlighted in the media. But it's not just beginning here. It's happening everywhere.**[14]

The Free State moratorium played out under Barbara Hogan's watch as Minister of Health, but its seeds were firmly planted during the decade of denialism. Rebuilding public health in the Free State and elsewhere is now in the hands of the President, the Minister of Finance and the Minister of Health.

Presidential leadership: prevention is personal is political

The President's robust acknowledgement that fear, stigma and shame surrounding the epidemic must be overcome is an important new gain in leadership. However, his personal life risks undermining HIV prevention campaigns. In response to the scandal surrounding his fathering of another child born to a woman outside of his polygamous circle of wives, Vuyiseka Dubula – General Secretary of the TAC and chairperson of the ALP – stated that "the President holds the highest office in South Africa and therefore there are high expectations of him, as a leader, as an elder and as a role model … [H]e must take responsibility for himself and for those around him and for South Africa".[15]

In "The President and HIV prevention", Kerry Cullinan of Health-e News Service shows how Zuma's history of extramarital affairs with multiple young women and his failure to use condoms provide a textbook example of how difficult it is to change behaviour.[16] As Cullinan explains:

> President Zuma's aversion to using condoms during his extramarital relationships, despite having numerous children born out of wedlock, is a good example of just how difficult it is for older people to adapt to less risky sexual behaviour.

The context within which such behaviour plays itself out is not a "normal" one but rather one where a range of factors (including biology, women's (usually) unequal status in relationships with men, intergenerational sex, and the widespread existence of multiple and concurrent partnerships)[17] conspire to place women at increased risk of HIV infection.

The President cannot be held responsible for existing cultures and behaviours regarding sex, but he can play a decisive role in helping to change them. In our view, he has a responsibility to speak openly and honestly to the nation about the difficulties of undoing learned behaviours, and to place sexuality firmly on the HIV prevention agenda. Instead, he resorted to a generic appeal to culture in which conservative – and arguably dangerous – notions of sexuality became further entrenched.

In such a charged and complex political environment as South Africa's, Zuma's conduct cannot be excused as "personal" and irrelevant to HIV prevention: his actions have clearly not matched his calls for condom use, undermining both his authority and the message; he has resorted to the "culture card" to defend practices not integral to Zulu culture; and he appears unwilling to apologise unless and until it becomes politically unacceptable to remain unapologetic. It is on these grounds that his conduct deserves public reproach.

Mounting new responses to emerging challenges facing HIV prevention and treatment

In the concluding section of this chapter we look at three issues that the ALP and its partners – particularly the TAC – consider vital to the future. These are:

- Budgeting and expenditure monitoring;
- Poor implementation of programmes on human rights and access to justice; and
- Overcoming major threats to HIV funding.

In our view, these challenges must be addressed if we are to realise the NSP's vision as well as its targets on prevention and treatment.

Budgeting for and expenditure monitoring in respect of HIV programmes

On 21 August 2009, the ALP, TAC and others launched the Budget Expenditure and Monitoring Forum (BEMF). Drawing together individuals and organisations from civil society, academia, government, organised labour and business, BEMF focuses primarily on trying to ensure that sufficient money is budgeted for, and appropriately spent on, meeting the targets of the NSP.[18]

To date, BEMF has been convened on two occasions: at its launch meeting on 21 August 2009;[19] and on 5 February 2010.[20] As was the case with the Joint Civil Society Monitoring Forum (JCSMF),[21] which BEMF has effectively replaced, the ALP plays a central role in co-ordinating meetings and providing logistical support, as well as in making substantive input and drafting and finalising meeting resolutions and reports.

21 August 2009 meeting[22]

BEMF's initial meeting focused on explaining the legal framework that governs budgeting and expenditure in South Africa, and people's rights within this framework. It also looked at the trends of moratoriums, long waiting lists and stock outs. The meeting resolved to take action aimed at preventing further moratoriums, including making formal submissions to and engaging the Free State provincial health and finance departments, their national counterparts and the Portfolio Committee on Health in the National Assembly.

The meeting also resolved to take steps to obtain and publish the reports of the Integrated Support Team (IST) commissioned by Barbara Hogan during her term of office as health minister. The IST reports, which are discussed in more detail in chapters 1 and 3, highlight the need for independent monitoring of provincial departments of health to identify corruption, bad budgeting practices and processes, inefficient operations and poor lines of communication.

Brian Honermann addresses delegates at BEMF's launch meeting

5 February 2010 meeting[23]

BEMF's second meeting focused on the 2010 ARV drug tender. It discussed what needs to be done to ensure that the tender is structured and run in a manner that enables the state to procure an adequate supply of appropriate medicines at the lowest possible prices. The meeting was briefed by the ALP on the legislative framework for public procurement in South Africa, and how this framework can and should be used in the public interest.

In a positive indication of the new climate of co-operation between government and civil society, officials from the DoH explained their approach to the issue and the steps that have been taken to ensure that the state is able to purchase what it needs for the public sector ARV treatment programme. In this regard, the meeting provided an important space for debate between government and civil society; it drew attention to some of the ways in which civil society organisations may assist the state in discharging its constitutional obligations.

Of concern to the meeting was the DoH's caution that the special conditions of tender – in terms of internal government practice – are ordinarily subject to National Treasury approval. But as the ALP has repeatedly pointed out, the legislative framework does not empower the National Treasury to play such a role.[24]

The meeting also included an update by the Free State AIDS Coalition on ongoing concerns relating to ARV treatment access. While the first BEMF meeting had been informed of shortages of ARV medicines in public health facilities, this second meeting heard that – as a result of civil society advocacy – most facilities now appear to have adequate stocks of ARV medicines but are short-stocked on a range of other essential drugs. This underscores the importance of addressing underlying health systems challenges as an integral part of any comprehensive HIV/AIDS strategy.

BEMF's future

In the post-denialist era, which is characterised by a relatively healthy relationship between the DoH, the ALP and TAC, it is highly unlikely that key questions of policy and science will be contested and eventually taken to courts to decide. Instead, the battle lines will be drawn over broader questions of good governance, openness and accountability. In this context, the work of BEMF – as a forum and as the sum of the work of its members – will increasingly become important.

Poor implementation of programmes on human rights and access to justice

In November 2009, SANAC commissioned a mid-term review of the NSP.[25] In addition to highlighting progress towards achieving the two key NSP goals – to reduce the number of new infections by 50% and to provide comprehensive treatment to 80% of HIV positive people by 2011 – the review identifies "Key Priority Area 4: Human Rights and Access to Justice" (KPA4) as the most neglected priority area of the NSP. Amongst other issues, KPA4 speaks to the needs of most-at-risk groups such as women and children, survivors of gender-based violence, men who have sex with men (MSM) and sex workers.

Important human rights and access to justice work is being done by a wide range of civil society organisations and networks, including the ALP. But it is often isolated, unconnected with each other and not accompanied by mass-based campaigns.

It is important to note that the findings on KPA4 point to a failure across SANAC sectors and between government and civil society to address issues of human rights and access to justice in relation to HIV/AIDS on the scale envisaged in the NSP. Important human rights and access to justice work is being done by a wide range of civil society organisations and networks, including the ALP. But it is often isolated, unconnected with each other and not accompanied by mass- based campaigns. There are also very few joint government and civil society initiatives aimed specifically at realising NSP targets in KPA4.

The ALP, through SANAC, has attempted to address this lack of co-operation and co-ordination. In July 2009, for example, we coordinated a national consultation of the law and human rights sector to evaluate progress made in implementing KPA4 of the NSP. The consultation focused on three crucial areas where there has been a lack of progress. These are:

- Violence against women and girls (NSP Goal 19);
- Access to legal services (NSP Goal 16); and
- Training and information sharing on HIV/AIDS and the law (NSP Goal 17).

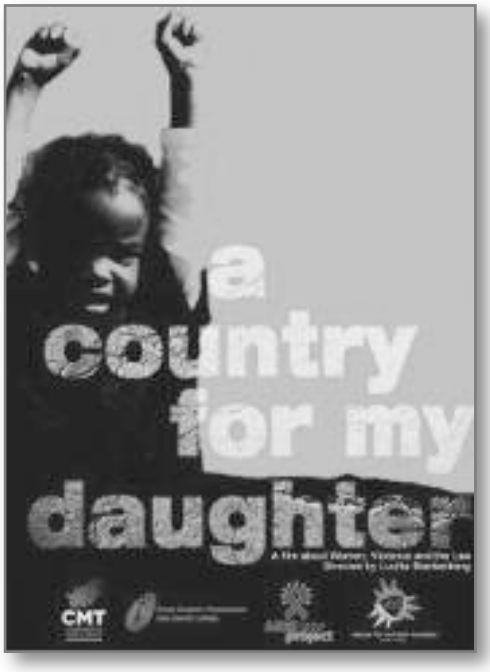
Violence against women

South Africa remains extremely violent towards women and children. Access to PEP services remains patchy. The discussion on violence against women focused on the need to improve access to health and legal services for survivors of gender-based violence. In particular, the consultation recognised the need for social mobilisation and training on this issue to ensure that people providing these services are aware of their obligations and those who seek to access them are aware of their rights.

But in addition, there is a growing concern that the decriminalisation of sex work remains elusive. The NSP recognises "that several higher risk groups, such as sex workers and drug users, face barriers to accessing HIV prevention and treatment services, because their activity is unlawful." With this in mind, the NSP recommends "[t]he decriminalisation of sex work."[26] Yet, although discussed within SANAC, there has been little tangible progress in this regard. Sex workers continue to face violence, discrimination, lack of legal protection and – not surprisingly – high rates of HIV infection.[27]

Access to legal services

The legal services provided directly by organisations such as the ALP, the Legal Resources Centre and other public interest law firms, as well as by ProBono.org,[28] must not hide the fact that access to legal services remains very limited. Yet the Constitution guarantees "the right to have any dispute that can be resolved by the application of law decided in a fair public hearing before a court or, where appropriate, another independent and impartial tribunal or forum",[29] and places positive obligations on the state to promote and fulfil this right.[30]



A Country for My Daughter will premiere at the launch of SECTION27 on 7 May 2010

Legal Aid South Africa (LASA)[31] is the government's primary vehicle for providing state-funded legal support. But it allocates the lion's share of its financial resources to criminal defence matters. In 2008, for example, only 7.5% (or 33 000) of the 435 000 matters it funded were civil in nature. With its extensive network of Justice Centres across the country, LASA has the potential to ensure widespread access to legal services necessary for vindicating and enforcing the rights of people with HIV.[32] In this regard, the national consultation recognised the urgent need for a greater allocation of LASA resources to civil matters.

Training programmes and information sharing

Widespread training on HIV/AIDS and the law is essential if rights are to be protected. But the training that is available is often unfocused, ad hoc and ordinary without any guarantee of quality control. Recognising this, the consultation identified the need for a more cohesive and comprehensive training programme. Promisingly, the AIDS Consortium has agreed to coordinate processes aimed at putting together an appropriate paralegal training proposal. Amongst other things, the proposal will

consider target audiences, areas to be covered, the form and types of training to be offered, materials development and systems for monitoring and evaluation. A former ALP employee, Dan Pretorius, is contributing to the AIDS Consortium's work in this important area.

While the ALP no longer provides training, it remains committed to supporting the development and implementation of appropriate training programmes. As part of this commitment, it worked closely with the Joint United Nations Programme on HIV/AIDS (UNAIDS) and others to conceptualise and host the first meeting of African judges on HIV/AIDS and the law from the 10 to 12 December 2009. Held in Johannesburg, the meeting of senior judges from more than 15 sub-Saharan African countries discussed the role of law and the judiciary in responding to HIV/AIDS.

With the support of civil society, the judges fashioned a consensus statement – the Johannesburg Declaration of Principles – that puts human rights at the centre of all efforts to combat the pandemic across the continent.

Joining more than 25 judges – including the chief justices of Ghana, Lesotho and Senegal and two former chief justices from South Africa – were representatives from the co-hosting organisations and a range of civil society organisations, including the TAC, Zimbabwe Lawyers for Human Rights, the Eastern Africa Treatment Access Movement, the Ugandan Coalition of Women Against AIDS, and the AIDS and Rights Alliance for Southern Africa. With the support of civil society, the judges fashioned a consensus statement – the *Johannesburg Declaration of Principles* – that puts human rights at the centre of all efforts to combat the pandemic across the continent.[33]

Big money matters: overcoming new threats to HIV funding

In 2001 world leaders began committing themselves and their governments to fighting HIV/AIDS, TB and malaria in developing countries. In particular, the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) Declaration of Commitment represented a landmark in global commitment to HIV.[34] This was followed – in 2002 and 2003 respectively – by the establishment of the Global Fund to Fight AIDS, TB and Malaria ("the Global Fund") and the US President's Emergency Plan for AIDS Relief (PEPFAR).

Delegates at the African judges meeting on HIV/AIDS and the law

The TAC recently recognised that these global commitments have kept alive more than five million people who would otherwise have died without access to ARV treatment. It further noted that 4.5 million orphans worldwide have received medical services, education and community care, and that 790 000 pregnant women with HIV have received comprehensive PMTCT services.[35] Yet these tangible gains are now under threat by the apparent change of heart by the most powerful governments of the world who are contemplating reducing direct funding for HIV under the guise of funding "health systems".

As the ALP's Nathan Geffen noted in a briefing paper for the African judges meeting referred to above:

> There has been a backlash against funding for HIV/AIDS from some public health advocates ... that have argued that donor aid for HIV/AIDS is disproportionate to its overall disease burden and that it would be more cost-effective to spend money on bed nets, immunisations and childhood diseases. The argument that increased spending on HIV/AIDS has been disproportionate and consequently taken money away from other medical interventions is wrong for many reasons. Here are just three:
>
> 1. ... [F]or sub-Saharan Africa, the proportion of health spending on AIDS is less than the proportion that AIDS contributes to mortality.
>
> 2. ... [I]ncreased spending on AIDS has resulted in increased spending on health generally.
>
> 3. The Global Fund came about as a consequence of increased advocacy for HIV/AIDS spending. ... Increased spending on HIV/AIDS via the Global Fund has therefore directly led to increased spending on TB and malaria.
>
> The backlash against AIDS spending has potentially profound and damaging consequences for donor funding of health-care in sub-Saharan Africa, and consequently the quality of health and life-expectancy in the region.

In the months and years ahead, it is essential that civil society and governments in developing countries unite to challenge cuts in AIDS funding. It is at this critical time that it is necessary to show the results of successful prevention and treatment strategies. Unfortunately, merely showing the impact of global funding on the pandemic is no longer enough to ensure continued high levels of funding.

Looking forward: HIV/AIDS and SECTION27

On 9 March 2010, the ALP, TAC and two of their leaders – Vuyiseka Dubula and Nonkosi Khumalo – were jointly awarded the annual John M. Lloyd AIDS Leadership Award. The announcement of the joint award provides as follows:

> Under their leadership as General Secretary and Chairperson of TAC respectively, Dubula and Khumalo ensure that TAC continues to organize, educate and develop leadership of fellow

> South Africans to demand affordable and accessibility AIDS treatment, care and prevention. TAC's model of advocacy, including the intensive HIV education which its organizers receive is the gold standard for AIDS advocacy worldwide.
>
> But TAC certainly doesn't work in isolation, it is through the brilliant teaming of TAC's grass-roots advocacy and AIDS Law Project's well-targeted litigation that has turned the tide in South Africa from being a country with a government which cruelly allowed its people to suffer without treatment for so many years, to one which was forced by the courts to begin offering ARV treatment.[36]

The ALP's incorporation into SECTION27 will not bring this relationship to an end. In fact, the model of collaboration pioneered by the ALP and TAC will continue. Effective civil society activism will be as necessary in the years ahead as it was in the years past. Work will continue to ensure implementation of the NSP and strengthening of SANAC.

But to a greater degree than has been the case with the ALP, SECTION27's research, advocacy and legal action will seek to change the socio-economic conditions that undermine human dignity and development, prevent poor people from reaching their full potential and lead to the spread of diseases like HIV that have a disproportionate impact on the vulnerable and marginalised.

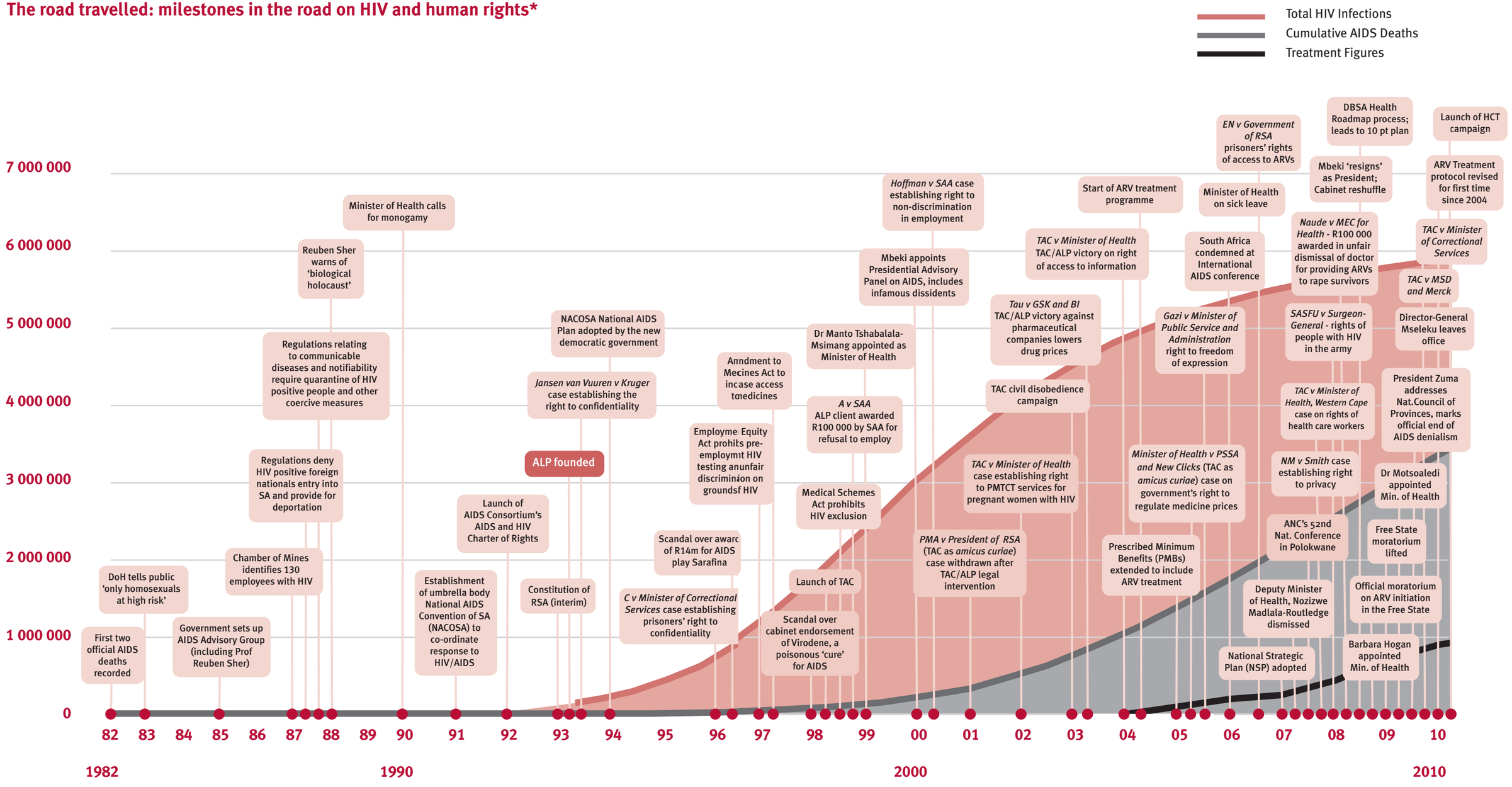
SECTION27 will retain a strong focus on human rights in relation to HIV/AIDS and access to health-care services. But in so doing, it will work on the understanding that the realisation of all rights – and socio-economic rights in particular – is fundamental to sustainable progress in reducing new HIV infections and ensuring sustained access to treatment.

Endnotes

1. Zuma's address to the NCOP is available at *http://www.pmg.org.za/node/19020*.
2. The speech is available at *http://www.anc.org.za/ancdocs/history/mbeki/1999/tm1028.html*.
3. Ibid
4. This issue is also considered in chapter 3.
5. See *http://www.info.gov.za/speeches/2010/10021715051004.htm*
6. See *http://www.gcis.gov.za/newsroom/releases/cabstate/2010/100310.htm*
7. All children under one year of age will be initiated on treatment, regardless of actual state of health. For children between one and five years, treatment will be initiated in the case of a WHO stage III or IV illness, a CD4 percentage of 25% or less, or a CD4 count of 750 or less. For children between five and 15, treatment will be initiated at WHO stage III or IV, or a CD4 count of 350 or less.
8. The revised 2010 protocol also deals comprehensively with prophylaxis options for infants born to mothers with HIV or unknown HIV status.
9. NSP at page 38
10. Circumcision was banned under King Shaka's rule.
11. In 2007, the ALP conducted research on the prevalence of some of these practices in South Africa. In this regard, see Pholokgolo Ramothwala, "AIDS, law and culture", *Mail & Guardian* (10 October 2007), available at *http://www.mg.co.za/article/2007-10-10-aids-law-and-culture*, and Pholokgolo Ramothwala, "Widows constitutional rights ignored", *City Press* (15 September 2007). See also Suzanne Leclerc-Madlala, "Virginity Testing: Managing Sexuality in a Maturing HIV/AIDS Epidemic", *Medical Anthropology Quarterly*, New Series, Vol. 15, No. 4, Special Issue: The Contributions of Medical Anthropology to Anthropology and Beyond (Dec., 2001) at 533.
12. See *http://www.mrc.ac.za/pressreleases/2009/sanat.pdf*
13. See *http://www.doh.gov.za/docs/nassps-f.html*
14. Anso Thom and Khopotso Bodibe, "Free State making little progress", available at *http://www.health-e.org.za/news/article.php?uid=20032221*
15. Vuyiseka Dubula, "TAC questions Zuma's leadership on AIDS", available at *http://www.health-e.org.za/news/article.php?uid=20032657*
16. See *http://www.health-e.org.za/news/article.php?uid=20032638*
17. According to the 2008 HSRC household survey to which this chapter has already made reference, men are five times more likely than women (30.8% v 6.0%) to report having had more than one sexual partner in the previous 12 months. See *http://www.mrc.ac.za/pressreleases/2009/sanat.pdf*

18. In this regard see *http://www.tac.org.za/community/BEMF*
19. The report of this meeting is available at *http://www.tac.org.za/community/files/ReportOnMeetingOf21August2009-WebsiteVersion.pdf*
20. The report of this meeting is available at *http://www.tac.org.za/community/files/bemf/BEMFReport-20100205.pdf*
21. For more information on the JCSMF, see *http://www.jcsmf.org.za*. The JCSMF, which was formed in June 2004 and was made up of several leading civil society and private sector organisations, was dedicated to monitoring the implementation of the ARV treatment plan.
22. Presentations made to the meeting (including a transcript of Adila Hassim's presentation) are available at *http://www.tac.org.za/community/BEMF#meeting-1*
23. Presentations made to the meeting are available at *http://www.tac.org.za/community/BEMF#meeting-2*.
24. At the time of going to print, it remained unclear if the DoH's approach to the 2010 ARV tender would indeed prevail.
25. The review has yet to be released publicly.
26. NSP at page 120
27. The ALP is a member of the SANAC Intersectoral Working Group on Sex Work and has been involved in a wide range of related processes. In this regard, see M. Richter and D. Massawe, "Report on Consultation on HIV, Sex Work and the 2010 Soccer World Cup: Human Rights, Public Health, Soccer and beyond", available at *http://www.sweat.org.za/images/docs /consult%20meet%20report%20web%20singles2.pdf*.
28. The ALP works closely with ProBono.Org and its partner law firms on a number of HIV-related cases. In this regard, see chapter 2. For more on ProBono.Org, see *http://www.probono-org.org/*
29. Section 34. For a discussion on this, see Mark Heywood and Adila Hassim, "Remedying the Maladies of 'Lesser Men or Women': The Personal, Political and Constitutional Imperatives for Improved Access to Justice", (2008) *South African Journal on Human Rights* (24:2) 263.
30. Section 7(2)
31. LASA was formerly known as the Legal Aid Board.
33. This will become increasingly important if and when HIV/AIDS status is added to the list of protected grounds in the Promotion of Equality and Prevention of Unfair Discrimination Act, 2000 ("the Equality Act"). In this regard, see the ALP's submission on proposed amendments to the Equality Act that seek – amongst other things – expressly to recognise HIV/AIDS status. Our submission is available at *http://www.section27.org.za*
35. See *http://www.un.org/ga/aids/docs/aress262.pdf*
36. See *http://aids2008.org/Web/WebContent/File/Media%20Release%20-%20JML%20AIDS%20Leadership%20Award%20FINAL%20-%20March%209%202010.pdf*

The road travelled: milestones in the road on HIV and human rights*



*Source: Derived using ASSA2003 outputs

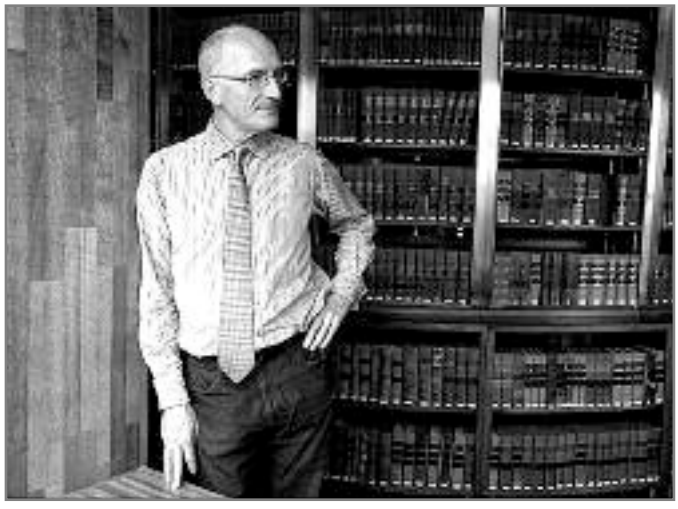
Epilogue

AIDS Law Project: a sweet and sad farewell

By Edwin Cameron

When the AIDS Law Project began in 1993, the epidemic was much smaller than now, though its explosive growth was already evident. Its direst features were inevitable illness, suffering and death: there was no treatment for AIDS. And the fear and prejudice were incomparably greater. Starting the ALP seemed imperative both morally and practically.

It was only in 1996 that the medical near-miracle of antiretroviral therapy was announced – and only ten years after the ALP started – that government, sorely prodded, committed itself to public treatment. It could do so because well-directed activist outrage forced corporate patent-holders to grant huge price reductions.



Edwin Cameron

And now, in 2010, a new mass testing drive betokens government's freshly invigorated sense of purpose and commitment.

All this is exhilaratingly different from 1993.

The AIDS Law Project was a front-rank fighter in each of these breakthroughs, alongside its activist allies, principally the Treatment Action Campaign.

The ALP was founded in the seemingly precarious conviction that the law should be central to alleviating the effects of the epidemic, and that the management of AIDS should be lodged firmly within the then-burgeoning culture of human rights.

Its achievements over the next decade and a half offer vindication for both beliefs.

Yet the beneficial changes the ALP's own efforts wrought now invite a fresh start. The project's founding premise was that the exceptional prejudice, fear, ignorance and stigma surrounding the disease necessitated an exceptional response.

Yet each victory, rightly and paradoxically, has brought us closer to the controversion of that premise. The new testing drive focuses on HIV – but rightly includes also other transmissible and treatable pathogens. The success of mass treatment itself lessens the need for special provision: by doing what it should be doing, government is at last treating an exceptional health calamity as it would any other. And treating the disease normally itself helps counter stigma.

All this the privileged few who, like myself, enjoyed early access to life-restoring antiretroviral medication have watched with relief and joy. The struggle is far from over. Too many deaths from AIDS; too many still fearing diagnosis; too much continuing discrimination and ignorance.

Yet partly through the successes the ALP and its allies claimed, it has become right and necessary to merge the special energies the epidemic spurred into a greater struggle for social justice and health rights in our country.

Yet partly through the successes the ALP and its allies claimed, it has become right and necessary to merge the special energies the epidemic spurred into a greater struggle for social justice and health rights in our country.

As one who has lived with HIV for nearly 25 years, and who has improbably survived the epidemic, I note with a special sweet sadness and joy that this will be the ALP's last review.

And as a judge I await with special though naturally dispassionate interest the challenges with which the ALP's birth product, SECTION27, will confront me and my colleagues.

Edwin Cameron
Constitutional Court of South Africa
23 April 2010

Appendix A: legal services and referrals

Legal services provided

CASE/CLIENT	DESCRIPTION OF ISSUE
K v SARS	Forced disclosure and infringement of the right to privacy
RP v Nashua North	Advice in relation to a review application in terms of section 158(1) of the Labour Relations Act, 1995
GA v Mooikloof Estates (Pty) Ltd	Unfair dismissal on the basis of HIV status – ALP to act as *amicus curiae*
NHM v Minister of Police and Others	Employment discrimination. The matter has been referred to the LRC in Durban, where the client resides.
DD v SANDF	Employment discrimination in the military
VT v HPCSA	Registration of medical specialist (foreign national with permanent residency) to practice in South Africa
Equal Education	• Access to information request to the Western Cape Education Department – information supplied within 30 days of formal request • Legal advice concerning a contractual dispute
LM v SpectraMed	Violation of privacy and unlawful marketing of insurance product. Council for Medical Schemes rules in client's favour on 27 March 2009.
MK v Discovery Health	Urgent access to new generation antiretroviral (ARV) medicine for which Medicines Control Council had authorised use in terms of section 21 of the Medicines Act, 1965
Legal Aid South Africa	Co-operation with Justice Centre (Port Elizabeth) on matter involving isolation of patients with MDR-TB
Other TB related interventions	• Engagement with school authorities at Sizwe Hospital, Gauteng Department of Health, and various health authorities regarding DR-TB treatment failures. • Legal advice to BV on potential claim for damages following incorrect diagnosis of DR-TB.
PM	Legal and psycho-social support to mother of deceased child
Pfaff and Blaylock	Finalision of matter of unfair disciplinary action at Manguzi Hospital – cases reported in detail in previous review
TAC	• Legal advice concerning a contractual dispute – matter referred to Probono.Org • Assistance on challenging the failures of the criminal justice system in a case (*S v Ntumbukane*) involving rape and murder of TAC member
CMT v SABC	Action to ensure that CMT's Siyayinqoba-Beat It! – an educational TV series on HIV – was broadcast as per agreement with SABC
PW v Netcare	Occupationally acquired HIV infection
LV v Department of Social Development	Access to social grant in the Free State
Sacred Heart College	Written opinion on an issue of HIV infection in school
Thapelo Mlonyeni	Child's access to ARV treatment in the Free State
MSF South Africa	• Purchasing essential medicines at prices lower than single exit prices in the private sector • Seeking clarity from innovator company on patent status of essential medicine used by MSF to treat DR-TB

Referrals

Breakdown by month and issue: 5 January 2009 to 17 March 2010

ISSUE / MONTH	LABOUR	DISCLOSURE	WILFUL TRANSMISSION	INSURANCE	TESTING	TOTAL
January 2009	7	1	1	1	0	10
February	5	1	1	0	0	7
March	6	0	1	0	0	7
April	4	1	1	0	0	6
May	8	2	1	1	1	13
June	7	1	0	0	1	9
July	14	4	0	0	1	19
August	7	5	0	0	0	12
September	8	4	2	0	2	16
October	9	8	4	1	1	23
November	18	6	2	2	1	29
December	4	1	1	0	0	6
January 2010	1	2	0	0	0	3
February	15	8	1	0	0	24
March	8	4	0	0	0	12
TOTAL	121	48	15	5	7	196

Appendix B: ALP participation in SANAC: January 2009 – March 2010

Mark Heywood	*Deputy Chairperson and member of Law & Human Rights Sector (L&HR sector)*
Adila Hassim	*Member of L&HR sector and (until September 2009) of Human Rights and Access to Justice Technical Task Team ("human rights TTT")*
Dan Pretorius	*Member of L&HR sector and community care worker working group*
S'khumbuzo Maphumulo	*Member of L&HR sector and community care worker working group*
Paul Booth	*Coordinator of L&HR sector and human rights TTT (until September 2009)*

Ella Scheepers	*Coordinator of L&HR sector and human rights TTT (from September 2009)*
Jonathan Berger	*Commissioned to prepare memorandum on options for establishing SANAC as a legal entity*

5 February 2009	**Programme Implementation Committee (PIC) meeting** Major points discussed: • *Voluntary medical male circumcision (VMMC) as a prevention strategy research* • *Chronic illness grant* • *Free State antiretroviral (ARV) treatment moratorium* • *Condom shortages* • *Stigma Mitigation Framework*
24 March 2009	**Plenary meeting** Major points discussed: • *Policy on VMMC* • *Prevention of mother-to-child transmission of HIV (PMTCT) campaign* • *TB/HIV integration*
6 July 2009	Human rights TTT sends letter to South African Law Reform Commission endorsing decriminalisation of sex work
8 July 2009	**Annual L&HR sector consultation** Developed sector strategy with particular focus on following key areas: • *Progress on NSP targets on violence against women* • *Access to legal services* • *Children's rights* • *Scaling up training programmes on HIV/AIDS and the law*
31 July 2009	**Plenary meeting** Major points discussed: • *Joint review of TB programme* • *Provincial, district and local AIDS councils* • *Mid-term review of National Strategic Plan on HIV & AIDS and STIs (NSP)* • *Decriminalization of sex work* • *Preparations for 2010 FIFA World Cup* • *ARV treatment guidelines* • *National Health Insurance (NHI)*

6 September 2009	**Induction for L&HR sector representatives** Aim of induction working session was to introduce sector and SANAC, with particular focus on SANAC structures and current focus areas of L&HR sector
17 September 2009	**PIC meeting** Major points discussed: • *Accelerated PMTCT plan* • *Feedback on National Health Council decision on eligibility for accessing ARV treatment* • *Update on proposals for nurse-initiated ARV treatment* • *Inclusion of two new SANAC sectors: sex worker and lesbian, gay, bisexual, transgender and intersex (LGBTi)*
10 November 2009	Human rights TTT makes written submission on draft HIV Counseling and Testing (HCT) policy
17 November 2009	Human rights TTT comments on draft VMMC Implementation Guidelines
20 November 2009	**Consultation on sex work and 2010 FIFA World Cup: "Human Rights, Public Health, Soccer and Beyond"** Major concerns discussed: • Sex work, HIV and increase in international tourism during World Cup • Dangers attached to conflation of sex work and trafficking • Strategies for dealing appropriately with sex work in context of big sporting events • Abuse of human rights in context of sex work
27 November 2009	Human rights TTT comments on final Stigma Mitigation Framework
1 December 2009	ALP participates in various SANAC events for World AIDS Day Mark Heywood shares platform with President Zuma
24 February 2010	ALP presents findings to secretariat on options for establishing SANAC as a legal entity
1 March 2010	ALP submits final memorandum on legal options for establishing SANAC as a legal entity
5 March 2010	SANAC Plenary leaders meet to announce launch of the HCT campaign
25 March 2010	SANAC hosts international press conference to announce details of HCT campaign

Appendix C: Key developments in politics, law and AIDS

DATE	KEY DEVELOPMENTS IN SOUTH AFRICAN POLITICS	KEY DEVELOPMENTS IN LAW	KEY DEVELOPMENTS IN HIV/AIDS POLICIES AND PROGRAMMES	KEY ALP DOCUMENTS, MEETINGS, SUBMISSIONS AND SEMINARS
JANUARY 2009		**12 January 2009:** Supreme Court of Appeal reinstates corruption charges against Jacob Zuma, reversing September 2008 decision of Nicholson J in the High Court. **30 January 2009:** Judgment in *Treatment Action Campaign v Minister of Correctional Services and Another* [2009] ZAGPHC 10 (30 January 2009), ordering Minister to provide access to report of Judicial Inspectorate of Prisons on investigation into AIDS-related death of ALP client "MM" (Westville Correctional Centre)		**21 January 2009:** ALP writes letters to health and finance ministers and MECs regarding moratorium on ARV treatment in the Free State – earlier letters of 19 December 2009 remain unanswered
FEBRUARY 2009			**5 February 2009:** SANAC PIC meeting discusses ARV treatment moratorium in the Free State	**3 February 2009:** 7th meeting of ALP Board of Directors. Board endorses plan to refocus and restructure the ALP **11 February 2009:** ALP releases its report on the ARV treatment moratorium in the Free State.

DATE	KEY DEVELOPMENTS IN SOUTH AFRICAN POLITICS	KEY DEVELOPMENTS IN LAW	KEY DEVELOPMENTS IN HIV/AIDS POLICIES AND PROGRAMMES	KEY ALP DOCUMENTS, MEETINGS, SUBMISSIONS AND SEMINARS
				20 February 2009: ALP and others meet with Health Minister Barbara Hogan to discuss ARV treatment moratorium in the Free State
MARCH 2009			**23 March 2009:** ARV treatment moratorium in Free State ends. **24 March 2009:** SANAC Plenary meeting.	**24 March 2009:** Launch of *ALP 18-month Review: July 2007 – December 2008* at Constitutional Court addressed by Health Minister Barbara Hogan.
APRIL 2009	**22 April 2009:** General Election – ANC wins 65.90% of vote; DA 16.6%; COPE 7.4%. ANC wins outright majority in all but one of the provinces. DA wins outright majority in the Western Cape.	**6 April 2009:** National Prosecuting Authority decides to drop all charges against Jacob Zuma regarding allegations of corruption.		**15 April 2009:** Annual members' meeting of the ALP
MAY 2009	**9 May 2009:** Jacob Zuma sworn in as the 4th democratically elected President of South Africa. Kgalema Motlanthe becomes Deputy President.		**6 May 2009:** Edendale Hospital suspends initiating new patients onto ARV treatment due to alleged lack of capacity.	

DATE	KEY DEVELOPMENTS IN SOUTH AFRICAN POLITICS	KEY DEVELOPMENTS IN LAW	KEY DEVELOPMENTS IN HIV/AIDS POLICIES AND PROGRAMMES	KEY ALP DOCUMENTS, MEETINGS, SUBMISSIONS AND SEMINARS
	11 May 2009: New cabinet appointed. Dr Motsoaledi replaces Barbara Hogan as Health Minister. Dr Sefularo remains Deputy Minister of Health. Jeff Radebe appointed as Minister of Justice & Constitutional Development. Andries Nel becomes Deputy Minister of Justice & Constitutional Development.			
JUNE 2009		**1 June 2009:** Publication of draft Constitution 18th Amendment and State Liability Bills for public comment		**12 June 2009:** Jonathan Berger appointed to the Medicines Control Council (MCC) on the basis of his knowledge of the law. **25 June 2009:** ALP and partners make joint submission to Department of Justice & Constitutional Development on draft Constitution 18th Amendment and State Liability Bills
JULY 2009	**3-4 July 2009:** JMPD and SAPS arrest people sleeping outside the Central Methodist Mission for		**19 July 2009:** 5th IAS Conference on HIV Pathogenesis, Treatment and Prevention begins in Cape Town.	

DATE	KEY DEVELOPMENTS IN SOUTH AFRICAN POLITICS	KEY DEVELOPMENTS IN LAW	KEY DEVELOPMENTS IN HIV/AIDS POLICIES AND PROGRAMMES	KEY ALP DOCUMENTS, MEETINGS, SUBMISSIONS AND SEMINARS
	"loitering" in terms of "Operation Chachamela". Arrested persons released on 6 July 2009 with assistance from ALP, Lawyers for Human Rights and Legal Resources Centre.	**19 July 2009:** Jacob Zuma appoints Ismail Semenya SC, Dumi Ntsebeza SC, Vas Soni SC and Andiswa Ndoni to the JSC replacing George Bizos SC, Kgomotso Moroka SC, Seth Nthai SC and John Ernstzen. **20 July 2009:** JSC decides to hold a "preliminary investigation" - rather than continue with a formal open hearing – on the dispute between Cape Judge President Hlophe and the justices of the Constitutional Court. **30 July 2009:** JSC sub-committee holds open hearing after media companies successfully challenge prior decision to hold closed hearing	**31 July 2009:** SANAC Plenary meeting	**20 July 2009:** ALP consultation with key partners on future of the ALP and its work.
AUGUST 2009	**6 August 2009:** Jacob Zuma nominates Justice Sandile Ngcobo to be Chief Justice.	**12 August 2009:** Constitutional Court hearing in *Minister for Justice and Constitutional Development v Nyathi and Others*		**13 August 2009:** Launch of the Rural Health Advocacy Project, a partnership between the ALP, the Centre for Rural Health at Wits University & RuDASA.

DATE	KEY DEVELOPMENTS IN SOUTH AFRICAN POLITICS	KEY DEVELOPMENTS IN LAW	KEY DEVELOPMENTS IN HIV/AIDS POLICIES AND PROGRAMMES	KEY ALP DOCUMENTS, MEETINGS, SUBMISSIONS AND SEMINARS
		14 August 2009: Submission to the Competition Commission on behalf of TAC. Commission ultimately imposes a condition on GSK/Aspen merger – the granting of multiple voluntary licenses for abacavir **28 August 2009:** JSC panel decides against referring Hlophe matter to a formal hearing.		**21 August 2009:** Launch of the Budget and Expenditure Monitoring Forum (BEMF)
SEPTEMBER 2009	**11 September 2009:** Minister of Health establishes the Ministerial Advisory Committee on National Health Insurance. **30 September 2009:** Thami Mseleku leaves the Department of Health	**30 September 2009:** Judgment delivered in *Minister of Justice and Constitutional Development v Chonco and Others* [2009] ZACC 25.	**1 September 2009:** Nono Simelela appointed CEO of SANAC. **17 September 2009:** SANAC PIC meeting. **28 September 2009:** Sgt. Sipho Mthethwa deployed to Sudan as first known HIV positive soldier to be deployed externally by SANDF.	**12-13 September 2009:** Students for Law and Social Justice hold annual conference in Hermanus. **29 September 2009:** ALP written submission to National Treasury on Draft Preferential Procurement Regulations
OCTOBER 2009	**11 October 2009:** Chief Justice Pius Langa and Justices Yvonne Mokgoro, Kate O'Regan and	**1 October 2009:** Justice Sandile Ngcobo appointed as Chief Justice, taking office on 12 October 2009.	**22 October 2009:** SANAC PIC meeting	**9-25 October 2009:** Mark Heywood and Adila Hassim visit China

DATE	KEY DEVELOPMENTS IN SOUTH AFRICAN POLITICS	KEY DEVELOPMENTS IN LAW	KEY DEVELOPMENTS IN HIV/AIDS POLICIES AND PROGRAMMES	KEY ALP DOCUMENTS, MEETINGS, SUBMISSIONS AND SEMINARS
	Albie Sachs retire from the Constitutional Court. Jacob Zuma appoints Justices Johan Froneman, Chris Jafta, Sisi Khampepe and Mogoeng wa Mogoeng as replacements, as of 12 October 2009.	**8 October 2009:** Judgment delivered in *Mazibuko and Others v City of Johannesburg and Others* [2009] ZACC 28. **9 October 2009:** Judgment delivered in *Minister for Justice and Constitutional Development v Nyathi and Others* [2009] ZACC 29 and *Joseph and Others v City of Johannesburg and Others* [2009] ZACC 30. **14 October 2009:** Freedom Under Law launches application challenging decision of JSC not to pursue formal hearings on the dispute between Cape Judge President Hlophe and the justices of the Constitutional Court. **14 October 2009:** Judgment delivered in *Abahlali Basemjondolo Movement SA and Another v Premier of the Province of Kwazulu-Natal and Others* [2009] ZACC 31.		**16 October 2009:** ALP written submission to Parliament on the draft Green Paper on National Strategic Planning

DATE	KEY DEVELOPMENTS IN SOUTH AFRICAN POLITICS	KEY DEVELOPMENTS IN LAW	KEY DEVELOPMENTS IN HIV/AIDS POLICIES AND PROGRAMMES	KEY ALP DOCUMENTS, MEETINGS, SUBMISSIONS AND SEMINARS
		30 October 2009: LRC (with assistance of ALP) launches application challenging constitutionality of loitering by-law in Johannesburg		
NOVEMBER 2009				**5 November 2009**: Mark Heywood appointed to Ministerial Advisory Committee on NHI **20 November 2009:** ALP assists LRC in drafting submission to the Gauteng Portfolio Committee on behalf of the Central Methodist Mission.
DECEMBER 2009	**1 December 2009:** President Zuma's speech on World AIDS Day announces key policy and programme shifts, including a new ARV treatment protocol			**8 December 2009:** Civil society statement issued on the refugee crisis at the Central Methodist Mission. Statement is endorsed by over 30 organisations. **10-12 December 2009:** ALP co-hosts African Judge's Conference on HIV and the law in Johannesburg

DATE	KEY DEVELOPMENTS IN SOUTH AFRICAN POLITICS	KEY DEVELOPMENTS IN LAW	KEY DEVELOPMENTS IN HIV/AIDS POLICIES AND PROGRAMMES	KEY ALP DOCUMENTS, MEETINGS, SUBMISSIONS AND SEMINARS
JANUARY 2010		**5 January 2010:** ALP launches application in South Gauteng High Court for appointment of a curator to represent the interests of unaccompanied minors living at the Central Methodist Mission. Dr Ann Skelton from the Centre for Child Law appointed as *curatrix ad litem*.		
FEBRUARY 2010		**8 February 2010:** Dr Skelton delivers her report to the court.		**5 February 2010:** 2nd BEMF meeting focuses on upcoming 2010 ARV tender
MARCH 2010	**15 March 2010:** Dr Yogan Pillay appointed as acting Director-General of Health. Dr Kamy Chetty joins Gauteng as Head of Department: Health and Social Development.	**15 March 2010:** Julius Malema found guilty of hate speech by the Equality Court in case brought by Sonke Gender Justice.	**5 March 2010:** SANAC Plenary meeting	**3 March 2010:** ALP publishes report on Edendale Hospital ARV treatment moratorium. **4 March 2010:** ALP written submission on the Division of Revenue Bill, 2010

Appendix D: publications

- Auvert, Bertrand et al (including Nathan Geffen), "Key facts on male circumcision", (2009) 99(3) *South African Medical Journal* 150
- Berger, Jonathan (ed.), *AIDS Law Project 18-month review: July 2007 to December 2008* (AIDS Law Project, Johannesburg: 2009)
- Berger, Jonathan, "Bye-bye Balfour", *Thought Leader* (1 February 2009), available at: *http://www.thoughtleader.co.za/jonathanberger/2009/02/01/bye-bye-balfour/*
- Berger, Jonathan, "Exorcising the ghosts of Dr. No's war on science: exploring what the Constitution means for the institutions that regulate medicines", available at: *http://papers.ssrn/abstract=1353944*
- Berger, Jonathan, "Regulating medicines in South Africa", (2009) 31 *Equal Treatment* 20, available at *http://www.tac.org.za/community/files/file/etmag/ET31/ET31English.pdf*
- Berger, Jonathan, "Remembered, but not missed", *Business Day* (22 December 2009)
- Geffen, Nathan, "Beyond HAART: scientists and activists need to work together", (2009) 374(9693) *The Lancet* 860
- Geffen, Nathan, *Debunking Delusions: The Inside Story of the Treatment Action Campaign* (Jacana, Johannesburg: 2010)
- Geffen, Nathan, "Justice after AIDS denialism: Should there be prosecutions and compensation? (2009) 51(4) *Journal of Acquired Immune Deficiency Syndromes* 454
- Geffen, Nathan, "Jack Bloom, the Pope and Condoms", available at: *http://www.politicsweb.co.za/politicsweb/view/politicsweb/en/page71619?oid=123908&sn=Detail*
- Geffen, Nathan and Zethu Cakata, Renay Pillay and Paymon Ebrahimzadeh, "Mobilising gay and lesbian organisations to respond to the political challenges of the South African HIV epidemic", *From Social Science to Social Silence: Same-sex Sexuality, HIV & AIDS and Gender in South Africa* (Human Sciences Research Council, Pretoria: 2009)
- Geffen, Nathan and Edwin Cameron, "The deadly hand of denial: Governance and politically-instigated AIDS denialism in South Africa", (2009) CSSR Working Paper 257, available at *http://www.cssr.uct.ac.za/publications/working-paper/2009/257*
- Hassim, Adila, "Lack of oversight has led to a health emergency", *Business Day* (9 February 2009)
- Hassim, Adila and Marius Pieterse, "Placing human rights at the centre of public health: a critique of *Minister of Health, Western Cape v Goliath*" (2009) 126 *South African Law Journal* 231
- Heywood, Mark, "Civil Society and Uncivil Government: The Treatment Action Campaign (TAC) versus Thabo Mbeki, 1998 – 2008", in Daryl Glaser (ed.), *Mbeki and After*, (Wits University Press, Johannesburg: 2010) (forthcoming)"
- Heywood, Mark, "Free State health crisis needs urgent national intervention", *Cape Times* (14 September 2009)
- Heywood, Mark, "Justice, Inequality and Health: Looking Beyond the Mbeki Years", forthcoming in 2010
- Heywood, Mark, "NHI – A Step in the Health Direction", (2009) 10 *Amandla* 8
- Heywood, Mark, "The Victims of 'Success'", *Cape Times* and *The Star* (11 March 2009)

- Heywood, Mark, "Where cries of the sick go unheard", *The Star* (30 September 2009)
- Heywood, Mark and Ralf Jurgens, Jonathan Cohen, Daniel Tarantola and Robert Carr, "Universal voluntary HIV Testing and immediate antiretroviral therapy", (2009) 373(9669) *The Lancet* 1079
- Pretorius, Dan and Mark Heywood, "Disclosure in the workplace", *A best practice guide to HIV disclosure* (Open Society Foundation for South Africa, Cape Town: 2009)
- Versteeg, Marije, "Healthcare Needs Help", *Mail & Guardian* (26 February 2010)

Appendix E: written submissions and reports

ALP submissions and reports

- Report on the ARV treatment moratorium in the Free State: November 2008 – February 2009 (11 February 2009)
- Briefing document on impact of programmatic response to drug-resistant TB on children for inter-departmental meeting between health and education (March 2009)
- Report on protecting public health and human rights in the response to TB in South Africa (31 March 2009)
- Submission on constitutional duties for the determination, expenditure, oversight and rationing of available financial resources for the delivery of health care services to the Health Financing Technical Task Team, Ministerial Advisory Committee on Health (24 April 2009)
- Submission on the Millennium Development Goals (MDGs) and the realisation of economic and social Rights in South Africa to the South African Human Rights Commission (SAHRC) (2 June 2009)
- Briefing note on civil society's position on community care workers (CCWs) to Department of Labour (29 June 2009)
- Civil society submission on the draft 18th Constitution Amendment Bill and draft State Liability Bill to the Department of Justice & Constitutional Development (1 July 2009)
- Submission on the draft Preferential Procurement Regulations to the National Treasury (29 September 2009)
- Submission on the Green Paper: National Planning Commission to Parliament's Ad Hoc Committee on the Green Paper: National Strategic Planning and the Presidency (15 October 2009)
- Civil society submission on CCW Management Policy Framework: Version 6 to SANAC (11 November 2009)
- Memorandum on the draft South African Health Products Regulatory Authority Bill for the task team advising the Minister of Health (24 December 2009)
- Report on suspension of ARV treatment initiation at Edendale Hospital: 6 May - 20 July 2009 (February 2010)
- Report on recommendations for establishing the South African National AIDS Council (SANAC) as a legal entity (1 March 2010)

Other submissions and reports

Jonathan Berger

- Legislative review for the Medical Products Technical Task Team (MPTTT) (2 April 2009)
- Opinion on the constitutionality of the Medicines and Related Substances Amendment Bill, 2008 [B 44D—2008] for the MPTTT (5 April 2009)
- Report on the legislative framework for public procurement for the task team advising the Minister of Health (21 January 2010)

Nathan Geffen

- "The backlash against HIV funding: briefing for African Judges Conference on HIV and the Law" (1 December 2009)
- "The state of HIV in several sub-Saharan African countries: briefing for African Judges Conference on HIV and the Law" (1 December 2009)

Adila Hassim and Mark Heywood

- "Assessment and Observations Arising from a Visit to Beijing and Chengdu, China, to look at Human Rights, Civil Society and Aspects of the Chinese Government's Response to HIV/AIDS" (January 2010)

Appendix F: presentations

Jonathan Berger

- 26 January 2009. Biko Centre for Bioethics, School of Public Health, University of the Witwatersrand, Johannesburg. "The Constitution, legal action and the right to health: the Treatment Action Campaign (TAC) experience"
- 10 March 2009. Centre for Human Rights, University of Pretoria. LLM class: "Social movements and socio-economic rights: a focus on TAC's use of legal action to ensure the realisation of the right to health"
- 11 March 2009. World Bank workshop on HIV/AIDS and vulnerable groups, Cape Town. "Addressing stigma and discrimination: ensuring access to comprehensive prevention and treatment services in prisons"
- 1 April 2009. Southern African AIDS Conference, Durban: abstract-driven presentation: "Getting the balance right: towards a comprehensive framework for the regulation of medicine prices"
- 15 April 2009. Southern African Development Community (SADC) workshop on the development of regional guidelines on pooled procurement and licensing, Ekhurhuleni. "Using TRIPs flexibilities to ensure access to a sustainable supply of affordable medicines"
- 15 April 2009. SADC workshop on the development of regional guidelines on pooled procurement and licensing, Ekhurhuleni. "Free trade agreements and TRIPs flexibilities"

- 17 April 2009. School of Law, University of the Witwatersrand, Johannesburg. LLB class: HIV/AIDS and the Law. Access to health care services (1): "The story of the TAC case"
- 24 April 2009. School of Law, University of the Witwatersrand, Johannesburg. LLB class: HIV/AIDS and the Law. Access to health care services (2): *"EN and Others v Government of the RSA and Others"*
- 5 May 2009. World Health Organization (WHO) and World Council of Churches (WCC), Geneva. Civil society consultation on the WHO Global Strategy and Plan of Action. Input on cross cutting issues
- 7 May 2009. Centre for Human Rights, University of Pretoria. Workshop on IP and access to medicines: "Competition law strategies to promote access to medicines: South African strategies for using competition law"
- 14 May 2009. SADC Parliamentary Forum. Workshop on Intellectual Property, Trade and Access to Medicines, Pretoria: "Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property"
- 26 May 2009. Socio-economic Rights Project, Community Law Centre, University of the Western Cape. Seminar on litigating socio-economic rights at the international level – introducing the Optional Protocol to the ICESCR: "Prisoners and the right to health: learning from the ALP experience at Westville Correctional Centre"
- 25 June 2009. WHO/UNDP/UCT training course on IPRs and public health, Cape Town. "The use of competition law as a tool to avoid abuses of IPRs: a South African case study"
- 8 October 2009. TAC leadership training, Johannesburg. All-day training on medicines, rights and regulation
- 26 October 2009. Public hearings, Parliament's Ad Hoc Committee on the Green Paper: National Strategic Planning, Cape Town. Oral presentation of written submissions
- 5 November 2009. World Trade Organization (WTO) workshop on the TRIPs Agreement and public health, Geneva. "TRIPs and wider action to address public health problems: using competition law in South Africa".
- 10 November 2009. Royal Netherlands Embassy, Pretoria. "Introducing Health, Democracy and Justice (HDJ), incorporating the AIDS Law Project"
- 16 November 2009. Bonela workshop – Botswana's ART programme: past lessons and future outlook, Gaborone. "Access and the law: the Industrial Property Act, international trade rules and Botswana's ability to procure affordable drugs"
- 18 November 2009. United Nations Office on Drugs and Crime (UNODC) regional consultation: Africa HIV in Prisons Partnership Network (AHPPN). "Introducing the Southern African HIV Clinicians Society (SAHCS) guidelines for the prevention and treatment of HIV in arrested, detained and sentenced persons"
- 12 December 2009. HIV/AIDS and the Law in the 21st Century: Meeting of Eminent African Jurists, Johannesburg. "Using the law to ensure, expand and sustain access to treatment in Africa"
- 5 February 2010. Budget Expenditure and Monitoring Forum (BEMF), Johannesburg. "The legislative framework for public procurement: implications for the 2010 antiretroviral (ARV) tender"
- 23 February 2010. Socio-economic Rights Course, Centre for Human Rights, University of Pretoria. "Social movements and socio-economic rights: a focus on TAC's use of legal action to ensure the realisation of the right to health"
- 24 February 2010. South African National AIDS Council (SANAC) secretariat, Midrand. "Establishing SANAC as a legal entity: summary of recommendations"

- 22 March 2010. MAC AIDS Fund Leadership Initiative, Dullstroom, Mpumalanga. "HIV, human rights and the law"

Nathan Geffen

- 1 May 2009. TAC Community Health Advocates, Cape Town. "What medical interventions do we need?
- December 2009. Treatment Action Group (TAG) satellite conference, International Union Against TB and Lung Disease World Conference, Cancun. "Accessing TB drugs"
- January 2010. TAC Leadership School, Cape Town. "Understanding TB Treatment" and "Understanding TB Diagnostics"
- 5 February 2010. BEMF, Johannesburg. Report back on BEMF activities
- 5 March 2010. Parliament, Cape Town. Submission on Division of Revenue Bill
- 9 March 2010. Launch of *Debunking Delusions*, Cape Town
- 15 March 2010. SWEAT Conference, Cape Town. "Campaigning for the decriminalisation of sex work"

Adila Hassim

- 11 March 2009. Free State Civil Society Coalition, Bloemfontein. "Using the Constitution to advocate for the right to health"
- 23 March 2009. TAC National Council. "National Health Insurance (NHI)"
- 27 March 2009. Department of Health (DoH) meeting on ARV costing, Pretoria
- 15 May 2009. School of Law, University of the Witwatersrand, Johannesburg. LLB Class: HIV/AIDS and the Law. "Gender, HIV and the Law"
- 30 May 2009. KZN Managed Care Coalition Conference, Durban. "Health Reform in South Africa"
- 22 June 2009. *The Big Debate: NHI*, eTV. Panellist
- 23 June 2009. University of Witwatersrand School of Law, Human Rights Winter School. "Litigating the Right to Health"
- 21 August 2009. BEMF, Johannesburg. "The legal implication of poor budgeting and expenditure"
- 8 September 2009. Ford Foundation, Braamfontein. "The Past and Future of the ALP"
- 12 September 2009. Students for Law and Social Justice (SLSJ) Annual Seminar, Onrus. "The methodology of litigation and advocacy at the ALP" and "Independence of the Judiciary"
- 6 October 2009. TAC Leadership Training, Braamfontein. "Health Rights and Law"
- 12 October 2009. Joint United Nations Programme on HIV/AIDS (UNAIDS) China staff briefing. "Introduction to ALP"
- 13 October 2009. China AIDS and Human Rights Forum, Beijing. "Role of civil society"
- 14 October 2009. Korekata Law Centre, Lawyers' Salon, Beijing. "South Africa's experience of using the law to advance access to health services"
- 17 October 2009. NGO and People Living with HIV/AIDS (PLHA) Country Coordinating Mechanism (CCM) Working committees, Beijing. "The role of civil society"
- 23 October 2009. School of Public Health, University of Witwatersrand, Johannesburg. "Budgeting for Health"

- 10 November 2009. Royal Netherlands Embassy, Pretoria. “The Work of the ALP”.
- 17 November 2009. *Third Degree*, eTV. “The effects of AIDS denialism”
- 26 November 2009. Mandela Institute, University of the Witwatersrand, Johannesburg. “Race and the Legal Profession: Are We Talking Past Each Other?”
- 12 December 2009. HIV/AIDS and the Law in the 21st Century: Meeting of Eminent African Jurists, Johannesburg. “HIV in the military”.
- 8 March 2010. SAIFAC, Braamfontein. “Strategic Impact Litigation”
- 26 March 2010. Princeton University. “Access to medicines in South Africa”

Brian Honermann

- 16 February 2009. Steve Biko Centre for Bioethics, School of Public Health, University of the Witwatersrand, Johannesburg. Masters class (health law module): "The South African Constitution and the Right of Access to Health Care Services"
- 20 February 2009. School of Law, University of the Witwatersrand, Johannesburg. LLB class: HIV/AIDS and the Law. "Human Rights-based Approach to HIV"
- 6 March 2009. School of Law, University of the Witwatersrand, Johannesburg. LLB class: HIV/AIDS and the Law. "Right to Equality"
- 13 March 2009. School of Law, University of the Witwatersrand, Johannesburg. LLB class: HIV/AIDS and the Law. "Informed Consent, Testing and Confidentiality"
- 29 March 2009. TAC Policy, Communications and Research (PCR) Department Induction Training. "Health & Democracy"
- 29 April 2009. TAC Community Health Advocates (CHA) Training. “The Public Finance Management Act"
- 8 May 2009. School of Law, University of the Witwatersrand, Johannesburg. LLB class: HIV/AIDS and the Law. "Criminalisation of Harmful HIV-Related Behaviour" (with Edwin Cameron)
- 13 May 2009. TAC: Women's Rights Leadership Training. "Criminal Law (Sexual Offences and Related Matters) Amendment Act and Criminalisation of HIV Transmission"
- 22 May 2009. School of Law, University of the Witwatersrand, Johannesburg. LLB class: HIV/AIDS and the Law. "Customary Law and HIV"
- 16 May 2009. TAC: Inner Provinces Leadership Training. "National & Provincial Budgeting Processes and the Public Finance Management Act"
- 18 June 2009. MAC AIDS Fund Leadership Initiative Training, Pretoria. "HIV/AIDS and Legal Rights"
- 2 July 2009. Free State Health Coalition, Bloemfontein. “Introduction to the Constitution, National Health Act, and Health Systems”
- 30 July 2009. Free State Health Coalition, Bloemfontein. “Introduction to the Public Finance Management Act and Constitutional Budgeting Processes”
- 21 August 2009. BEMF meeting, Johannesburg. “Case Study: Budget Irregularities and Shortfalls in the Free State”
- 27 August 2009. Students' Law Forum, Johannesburg. “Constitutional budgeting – entering a new phase in advocating for the right of access to health care”
- 12 September 2009. SLSJ Annual Seminar, Onrus. “State Duties when Budgeting for Rights”

- 10 October 2009. Zimbabwe Lawyers for Human Rights workshop, Kariba, Zimbabwe. "HIV/AIDS and human rights issues among vulnerable populations: opportunities for litigation – case studies from South Africa"

Mark Heywood

- 14 January 2009. Soul City One Love campaign launch, Johannesburg. Keynote speaker
- 20 January 2009. Inter Parliamentary Union (IPU) workshop of African Parliamentarians on HIV/AIDS, Cape Town. Respondent
- 22 January 2009. IPU Review Committee on SANAC and South Africa's response to HIV/AIDS, Cape Town
- 29 January 2009. SANAC committee leaders' meeting on progress in 2008, Johannesburg
- 7 February 2009. South African Society of Psychiatrists: Human Rights Psychiatric Care, Weskoppies Psychiatry Hospital, Pretoria
- 27 February 2009. School of Law, University of the Witwatersrand, Johannesburg. LLB class: HIV/AIDS and the Law. "Politics of AIDS"
- 6 March 2009. Meeting convened by the SANDF/SA Military Health Services, Pretoria. "Response on proposed new Health Classification Policy"
- 12 March 2009. Private sector seminar on monitoring & evaluation, Johannesburg. Keynote presentation
- 24 March 2009. SANAC Plenary meeting. Presentation of civil society report
- 24 March 2009. Public launch of the ALP's 2007/2008 18-month review, Constitutional Court, Johannesburg
- 26 March 2009. Sunday Times/Soul City debate on HIV policy with political parties, Johannesburg. Panellist
- 27 March 2009. DoH meeting on ARV costing, Pretoria
- 30 March 2009. Department of Political Studies symposium on Mbeki's legacy. University of the Witwatersrand, Johannesburg. Panellist discussing "Mbeki and civil society"
- 1 April 2009. Discussion on HIV testing, Southern African AIDS conference, Durban. Panellist
- 1 April 2009. Launch of ARASA report on HIV and human rights in the SADC region, Durban
- 1 April 2009. UNAIDS satellite conference, Southern African AIDS conference, Durban. "Implementation of the NSP"
- 2 April 2009. Discussion on Legal and Ethical Dimensions of the New Road to Health Chart, Durban. Panellist
- 2 April 2009. Press conference on funding for HIV hosted by ALP, TAC, Médecins Sans Frontières (MSF) and the SAHCS, Durban
- 2 April 2009. Launch of Department of Provincial & Local Government handbook on HIV and local government, Durban. Keynote speaker
- 3 April 2009. DoH meeting on proposed social mobilisation on PMTCT, Durban. SANAC representative
- 3 April 2009. Community forum on *Durban II Declaration*, Durban
- 20 April 2009. MSF launch of the Diploma on Humanitarian Assistance, Johannesburg

- 21 May 2009. *Radio Today/Pro Bono* programme on HIV and the Law
- 1 June 2009. TAC partners meeting. "Are we meeting NSP targets?"
- 5 June 2009. Atlantic Philanthropies international videoconference on supporting social movements. Panelist
- 8 June 2009. Council on Foreign Relations/UNAIDS Roundtable: Politics and Evidence in the Global AIDS Response: Can UNAIDS be a Global Referee? New York. "Human Rights and HIV"
- 8 July 2009. SANAC Law and Human Rights sector consultation. Keynote address
- 15 – 17 July 2009. UNAIDS HIV and Human Rights Reference Group, Geneva. "Reference Group recommendations to the Executive Director"
- 19 August 2009. EU+ group of donors, Pretoria. "Progress with SANAC"
- 19 August 2009. University of the Witwatersrand, Johannesburg: Human Rights – Perspectives course. "Political and legal uses of rights – the case of TAC"
- 26 August 2009. Launch of SANAC children's sector scorecard, Cape Town
- 28 August 2009. Workshop on Health Advocacy, Rural Doctors Association of Southern Africa (RuDASA) 13th National Rural Health Conference 2009, Broederstroom
- 11 September 2009. Debate on public impact litigation. SLSJ Annual Seminar, Onrus. Panellist
- 7 October 2009. TAC leadership school. "Health systems and NHI"
- 12 October 2009. Lunchtime briefing for UNAIDS China staff, Beijing. "Introduction to the ALP"
- 13 October 2009. Advisory meeting on establishing a China AIDS and Human Rights Forum, Beijing. Introductory remarks
- 14 October 2009. Korekata Law Centre, Lawyers' Salon, Beijing. "Work of the ALP"
- 15 October 2009. NGO Networks Salon (facilitated by UNAIDS), Beijing. "Role of civil society"
- 17 October 2009. Meeting with NGO and PLHA CCM Working committees, Beijing. "Role of civil society"
- 19 October 2009. Meeting with Chengdu Disease Transmission Hospital, Chengdu. Introductory remarks
- 20 October 2009. Meeting with PLHA and NGO activists in Chengdu. "AIDS, human rights and activism"
- 21 October 2009. Students at Peking University. "The Right to Health"
- 22 October 2009. Director of National Center for AIDS/STD Prevention and Control (NCAIDS), Beijing. "Summary of Findings and Suggestions from Visit"
- 23 October 2009. Lunch time discussion with UNAIDS China staff. "Thoughts and funding arising from visit to China"
- 24 October 2009. Staff and volunteers of Aizhixing Institute, Beijing. "Work of the ALP and AIDS activism"
- 6 November 2009. Positive Convention, Johannesburg
- 11 December 2009. HIV/AIDS and the Law in the 21st Century: Meeting of Eminent African Jurists, Johannesburg. "Litigating before African Courts: a civil society perspective"
- 24 January 2010. National Health Leaders Retreat, Muldersdrift. "HIV/AIDS: a Litmus Test for the South African Health System"

- 4 February 2010. Enhancing Children's HIV Outcomes (ECHO) Learners' Day, Johannesburg. "The influence of policy on the spread of HIV"
- 12 February 2010. Ministerial Advisory Committee on NHI, Johannesburg. "Communication Strategy"
- 5 March 2010. Extraordinary meeting of SANAC Plenary (together with former Presidents Chissano and Mogae), Pietermaritzburg. Opening remarks
- 19 March 2010. Private health sector business leaders. "HIV Counselling and Testing (HCT) campaign"
- 25 March 2010. International press conference with Minister of Health to launch HCT campaign
- 29 March 2010. South African business leaders. "HCT campaign"
- 30 March 2010. Higher Education AIDS conference, Johannesburg. Panellist

Dan Pretorius

- 20 March 2009. School of Law, University of the Witwatersrand, Johannesburg. LLB class: HIV/AIDS and the Law. "HIV and employment issues"
- 27 March 2009. School of Law, University of the Witwatersrand, Johannesburg. LLB class: HIV/AIDS and the Law. "HIV, social assistance and insurance"
- 27 March 2009. HIV counselling course Helen Joseph Hospital, Johannesburg. Input on HIV and the Law (with Shalom Ncala)
- 6 May 2009. Right to Care HIV management course for doctors, Johannesburg
- 24 June 2009. Magistrates' training, Justice College. "HIV and the Law"
- 8 July 2009. SANAC Law & Human Rights Sector conference. "Access to justice and human rights"
- 14 September 2009. Peer educators, Aveng Group for Lifeline. "HIV and the Law"
- 16 October 2009. HIV counsellors at Helen Joseph Hospital. "HIV and the Law"
- 13 November 2009. HIV counsellors at Helen Joseph Hospital. "HIV and the Law"
- 18 November 2009. Magistrates' training, Justice College. "HIV and the Law"

Agnieszka Wlodarski

- 25 February 2009. Biko Centre for Bioethics, School of Public Health, University of the Witwatersrand, Johannesburg. "The growing crisis of TB and drug resistant TB in South Africa"
- 10 October 2009. Consortium to Respond Effectively to the AIDS/TB epidemic (CREATE) workshop, Cape Town. "Tackling the chronic neglect of TB by government" and "Community-based infection control: where and how should MDR/XDR be managed?"
- 3 March 2010. TB awareness workshop, eMalahleni Local Municipality/Mpumalanga HIV/AIDS and TB Association. "TB and human rights"

S'khumbuzo Maphumulo

- 31 July 2009. School of Public Health, University of the Witwatersrand, Johannesburg. Masters class: "Community and legal perspectives of HIV programme performance"

Nonkosi Khumalo

- 14 July 2009. Regional Treatment Literacy Training, Cape Town. "Opportunities to link HIV and TB"
- 21 July 2009. International AIDS Conference (IAS), Cape Town. Community Forum: How to build partnerships between community and scientists to strengthen the response to HIV. Moderator
- 28 August 2009. Workshop on advocacy case studies, RuDASA 13th National Rural Health Conference 2009, Broederstroom
- 10 September 2009. Ford Foundation, Johannesburg. Panel of Ford grantees on "The intersection of SRHR and HIV work in terms of the approaches used by ALP and TAC in advocacy and litigation"
- 12 September 2009. SLSJ annual seminar, Onrus. "Transforming Legal Education: Relevance, Activism and Community Service". Panellist
- 15 September 2009. Public Services International Regional Seminar. "Campaigning and advocacy"
- 22 October 2009. Retreat of UN teams on AIDS, Magaliesburg. "AIDS Epidemic in South Africa and the National Response". Panellist
- 2 November 2009. WHO meeting on ARV treatment (ART) for prevention, Geneva. "Community engagement and acceptance of ART for prevention". Panellist

Marije Versteeg

- 28 August 2009. RuDASA 13th National Rural Health Conference 2009, Broederstroom. "The Rural Health Advocacy Project and the Way Forward" (with Dr. Bernhard Gaede)
- 29 September 2009. North West Family Medicine Forum. "The Rural Health Advocacy Project: A partnership between Wits Centre for Rural Health, the AIDS Law Project, and RuDASA"
- 26 October 2009. Mopani District Conference: Integrated Comprehensive HIV Care at Clinic Level, Tzaneen. "The Rural Health Advocacy Project: Supporting Rural Health Facilities"

Appendix G: positions held by staff

Jonathan Berger

- Honorary research fellow, School of Law, University of Witwatersrand, Johannesburg
- Member, Medicines Control Council
- Member, Board of Governors, Holy Family College, Parktown
- Member, Technical Task Team on Medicines Procurement in the Public Sector (August 2009 – February 2010)
- Member, Medical Products Technical Task Team, Ministerial Advisory Committee on Health (March – April 2009)

Nathan Geffen

- Committee and founder member, Open Shuhada Street
- Treasurer, Treatment Action Campaign (TAC)

- Member, Board of Directors, Equal Education
- Member, Scientific Committee, Orange Farm Circumcision Project
- Member, Community Advisory Board, INSIGHT (clinical trials group running the START study)
- Contributing and founder member, aidstruth.org
- Member, Board, Community Media Trust (CMT) (until February 2010)
- Member, Board, Sex Worker Education and Advocacy Taskforce (SWEAT) (until early 2009)

Adila Hassim

- Honorary research fellow, School of Law, University of Witwatersrand, Johannesburg.
- Member of the Johannesburg Bar
- Member, South African Law Reform Commission: Project 25: Health Advisory Committee
- Member, Technical Advisory Group, Global Commission on HIV and the Law

Mark Heywood

- Chairperson, Joint United Nations Programme on HIV/AIDS (UNAIDS) Global Reference Group on HIV and Human Rights
- Board Member, Amandla AIDS Advisory Trust
- Honorary senior research fellow, School of Law, University of Witwatersrand, Johannesburg
- Distinguished visitor, O'Neill Institute for National and Global Health Law, Georgetown University Law Center
- Deputy Chairperson, South African National AIDS Council (SANAC)
- Member, TAC secretariat
- Member, Editorial board, *Journal of Human Rights Practice*, Oxford University Press
- Member, Ministerial Advisory Committee on National Health Insurance
- Member, Steering Committee, Rural Health Advocacy Project (RHAP)
- Guest editor, special edition on Universal Access (2010), *Journal of the International AIDS Society*

Nonkosi Khumalo

- Chairperson, TAC
- Law & Human Rights Sector representative, Programme Implementation Committee, SANAC
- Board member, AIDS and Rights Alliance for Southern Africa (ARASA)

S'khumbuzo Maphumulo

- Member, Steering Committee, RHAP

Dan Pretorius

- Part-time commissioner, Commission for Conciliation, Mediation and Arbitration (CCMA)
- Board Member, Southern African AIDS Trust (SAT)

Marije Versteeg

- Board member, Ruta Sechaba Pele, Maboloka, North West
- Member, Committee, Rural Doctors Association of Southern Africa (RuDASA)

Appendix H: Financial statements

for the year ended 31 December 2009

AIDS Law Project
Association incorporated under section 21
Registration No: 2006/021659/08

Income statement

	2009 R	2007 R
Revenue		
Grant Income	**8 841 651**	**9 276 422**
Other income		
Donations	1 340	520
Donations – Support Nozizwe Madlala-Routledge	-	11 455
Interest received	191 988	368 385
Litigation costs recovered	563 259	80 658
Presentations	2 628	5 064
Sale of manuals and ALP publications	1 833	1 307
Sundry income	114 910	4 270
	875 958	**471 659**
Operating expenses		
Audit, consultations and financial fees	152 387	163 689
Bad debts	-	16 828
Bank charges	-	3
Conferences, meetings and seminars	186 348	478 685
Depreciations	150 720	151 452
Employee costs	5 378 891	5 593 693
Evaluation	-	167 370
Institutional and logistics costs	109 101	-
Legal expenses	236 059	493 979
Printing, stationery, postage and courier	137 108	179 278
Publications	178 169	564 698
Refreshments and cleaning	49 157	44 991
Rent, water, electricity, repairs & maintenance	573 399	540 236
Refund to CALS – overpayment of sabbatical	-	221 000
Resource centre	110 700	56 214
Return of donor funds	341 833	-
Training and workshops	148 475	429 465
Staff development	3 255	33 706
Sundry expenses	50 707	30 201
Telecommunications and IT support	178 073	303 022
Travel and accommodation – local and foreign	752 443	286 663
	8 736 825	**9 755 173**
Surplus/(deficit) for the year for the year	**980 784**	**-7 092**

These financial statements have been extracted from the audited annual financial statements.
The full financial statements are available on request.

Balance sheet

	2009 R	2008 R
Assets		
Non current assets		
Equipment	191 452	244 026
Current assets		
Amount due from CALS	40 062	40 062
Trade and other receivables	89 038	220 967
Cash and cash equivalents	4 336 880	2 919 435
	4 465 980	**3 180 464**
Total assets	**4 657 432**	**3 424 490**
Equity and liabilities		
Reserves		
Programmes fund	12 508	-189 474
Director's reserve fund	2 099 689	1 320 887
	2 112 197	**1 131 413**
Liabilities		
Unutilised designated programme funding	2 397 038	1 933 692
Staff benefit liabilities	64 509	254 920
Trade and other payables	83 203	103 912
Bank overdraft	485	553
	2 545 235	**2 293 077**
Total equity and liabilities	**4 657 432**	**3 424 490**

These financial statements have been extracted from the audited annual financial statements.
The full financial statements are available on request.