THE CLINICAL AND HUMAN RIGHTS CHALLENGES PERTAINING TO HIV/AIDS AND TB CO-INFECTION IN SOUTH AFRICA

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DEDICATION

This dissertation is dedicated to my uncle Thomas, Mother Esperance Mukarusine, and Brother Christian. It is also dedicated to all persons living with HIV/AIDS and TB.

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ABSTRACT

Prior to 1990, HIV/AIDS and TB co-infection was not a major public health threat in South Africa (SA). The serious ignorance and negligence on the part of then SA government with regard to HIV/AIDS led to the increase of this disease. With the increase of the burden of HIV/AIDS and related infections such as TB, various international, regional and national stakeholders have strongly advocated that people living with HIV deserve special protection because of their vulnerability. In SA, laws, courts and the creation of the National Strategic Plan (NSP) on AIDS, STIs and TB have played an important role in the management and control of these diseases. However, the scarcity of the health care personnel, the persistence of stigma and discrimination and the lack of adequate infrastructure and information among the population continue to challenge government efforts. Similarly, the deficiency of healthcare equipment, drugs interaction and lack of patient compliance to the proposed therapy undermine health prevention and treatment measures. Therefore, research has shown clinical, ethical and legal challenges that arise from HIV/AIDS and TB co-infection.

Despite the international laws and guidelines and standards set by international bodies (such as the WHO and UNAIDS), the constitution of SA and various laws and government health policies for the management of these diseases, results are still mediocre in relation to government efforts, international standards and the intensity of these diseases elsewhere. Additionally, the persistent stigma and discrimination in different areas, the impact of patent rights on the availability of ARV and TB drugs and poor health care service delivery have affected the management of HIV/AIDS and TB. The dissertation was prompted by the need to make a contribution to the current body of literature on HIV/AIDS and TB co-infection in SA by investigating how the management of these diseases can be improved and sustained in a way that helps to protect the rights of those people living with HIV and TB co-infection.

As a result of the analysis conducted, it is evident that the efficacy of the management and control of HIV and TB co-infection programme also depends on the revision of patent laws to promote manufacturing of medications and materials, consolidating counselling to encourage patients, community, and healthcare workers, among others. Additionally, the increase in spending on these diseases and in human resources as well as in political commitment are essential to the management of these infections.

ABBREVIATIONS AND ACCRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Clinic
ART	Antiretroviral Therapy
ARV	Antiretroviral
CC	Constitutional Court
CDC	Centre for Disease Control and Prevention
CSW	Commercial Sex Worker
DOH	Department Of Health
HAART	Highly Active Antiretroviral Therapy
HC	High Court
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
HPCSA	Health Professions Council of South Africa
HRSC	Human Sciences Research Council
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social, and Cultural Rights
ICTD	Invariant Chain Transmembrane Domain
IDU	Intravenous Drug User
ILO	International Labor Organization
KSOI	Kaposi ’s Sarcoma and Opportunistic Infections
KZN	Kwazulu-Natal
MARP	Most At Risk Population
MCCSA	Medicines Control Council of South Africa
MDR-TB	Multi-Drug Resistant Tuberculosis
MMC	Male Medical Circumcision
MSM	Men Who Have Sex with Men
NGO’s	Non-Government Organisations
NHA	National Health Act
NSP	National Strategic Plan
NVP	Nevirapine

PEP	Post-Exposure Prophylaxis
PMTCT	Prevention of Mother To Child Transmission
RSA	Republic of South Africa
SA	South Africa
SANAC	South African National AIDS Council
TRIPS	Agreement on Trade-Related Aspects of Intellectual Property Rights
UDHR	Universal Declaration of Human Rights
UN	United Nations
USA	United States of America
WHO	World Health Organisation
WIPO	World Intellectual Property Organisation
WTO	World Trade Organisation
XDR-TB	Extensively-Drug Resistant Tuberculosis

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CHAPTER ONE:

GENERAL INTRODUCTION

1.1. Background and Statement of Purpose

The Human Immunodeficiency Virus (HIV) is a virus which causes Acquired Immunodeficiency Syndrome (AIDS).[1] This is a disease of the human immune system and has become a global pandemic killing many people, especially in the developing countries. This virus is a global health concern especially when it is associated with tuberculosis (TB).[2] HIV/AIDS as a disease which attacks the human immune system facilitates the propagation of TB; and the high prevalence of TB infection can justify the dangerous association of both diseases.[3] TB is caused by bacteria and is a deadly but curable disease. It has been proven that negligence in the management and the control of this disease has greatly contributed to its development.[4] Thus, in developing countries in particular, this human made problem[5] leads to the development of the multi-drug resistant tuberculosis (MDR-TB) and extensively drug-resistant tuberculosis (XDR-TB).[6] South Africa has many people living with HIV/AIDS. In 2014, approximately 10.2% of the population was affected by HIV of whom 70% were affected by TB.[7] HIV/AIDS is manageable with access to antiretroviral therapy (ART) which minimizes immune deterioration and improves TB treatment outcomes such as reduction of the mortality rates among patients.

In South Africa (SA), the character of HIV/AIDS and TB is defined by the conditions brought about by historical racism and gender discrimination.[8] The conditions that black people, women, gays and sex workers lived under during the apartheid regime facilitated the

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[1] Mano Rajam, RC & Muhammad GM, (2013), *A Study on HIV co-infection among pulmonary tuberculosis at a private medical college hospital, Asian Student Medical Journal 13.6, p1.*

[2] *Idem.*

[3] Studies have shown that TB prevalence among HIV patients is 16 times more than that of the other people. See Ormerod L. P, (2005), *Multidrug-resistant tuberculosis (MDR-TB): epidemiology, prevention and treatment, British medical bulletin, 73(1), 17-24.*

[4] Ibiden.

[5] As said above the poor control of this disease can be associated to the physician errors or negligence and patient already treated with TB who fails to follow proposed treatment. See Note 3 above.

[6] MDR-TB is a kind of TB which resist to the two most effective drugs treatment such as isoniazid and rifampicin. Its treatment become expensive as it requires more sensitive drugs and individual regimen compliance. See Note 3 above.

[7] Statistics South Africa (2014), *Mid-year population estimates 2014*, available at http://beta2.statssa.gov.za/publications/P0302/P03022014.pdf, accessed on 27 February 2015.

[8] Karim, SSA, Churchyard, GJ. et al. (2009), *HIV infection and tuberculosis in South Africa: an urgent need to escalate the public health response, The Lancet, 374(9693), 921-933.*

development of these diseases. They lived under inhumane conditions with overcrowding and poor health services.[9] In addition, they suffered discrimination which was also a contributing factor.[10]

The association of HIV/AIDS and TB raises some clinical and legal challenges at local, national and global levels. These diseases present difficulties in diagnosis and treatment because of the requirement of sensitive tests, drugs interaction, as well as the lack of patients' therapy compliance and the provision of healthcare support equipment.[11] The issue regarding the isolation of TB patients for their treatment can raise possible violations of fundamental human rights.

It is these human rights that are the focus of the Universal Declaration of Human Rights (UDHR), which aims at promoting, developing and protecting human rights among member states, seeking to define, protect and respect human values after the terrors caused by World War II.[12] This declaration serves as a universal standard guideline for the elaboration and insertion of a bill of rights in the member states.[13] These rights are strongly persuasive under customary international law for the protection of human dignity for all people and cannot be violated.[14] Everyone has the right to life (which includes the right to health) and states are the protectors of human beings.[15] The UDHR focuses on the protection of fundamental rights, including those of HIV and TB affected patients from any discrimination in health care service and in any other area, thus providing support, care, protection and promotion of human rights.[16] These rights have been incorporated in the Constitution of South Africa 1996 and constitute the cornerstone of democracy, with the state having the duty to promote and protect them.[17] However, it has been observed that the SA government has in some cases failed to meet its obligations to create conditions that are consistent with human rights promotion, such as

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[9] Idem.
[10] Skinner D., & Mfecane S. (2004), *Stigma, discrimination and the implications for people living with HIV/AIDS in South Africa: original article, SAHARA: Journal of Social Aspects of HIV/AIDS Research Alliance, 1(3), p-157.*
[11] See Note 4 above.
[12] Preambule of the UDHR.
[13] It provides the ICESCR and ICCPR which constitutes international bill of rights and constitutes guidelines for states.
[14] Kohi T.W., Makoae L., Chirwa, et al., (2006), *HIV and AIDS stigma violates human rights in five African countries, Nursing Ethics, 13(4), 404-415.*
[15] World Health Organization (WHO), *All human rights for all*, Fiftieth Anniversary of the Universal Declaration of Human Rights 1948/1998, cited by Kohi T.W., Makoae L., Chirwa, et al., *op cit*, Note 13.
[16] Article 2 of the UDHR.
[17] Chapter two.

sufficient protection and treatment measures.[18]

Although the spread of HIV/AIDS continues, South Africa as one of the most developed countries in Africa continues to try and overcome the challenges presented by the disease through the utilization of its resources. Thus, in 2011, the SA government expanded the NSP on AIDS, STIs and TB (NSP-2012-2016) for purposes of better controlling these diseases.[19] The NSP target the reduction of the new infections, stigma, deaths and the provision of the required treatments among patients.[20] These plans made an effective contribution in dealing with these diseases and in helping the state fulfil its duties,[21] such as ensuring the right to health and the right to medicines, support, care and provision of good health care services,[22] as well as generally good coordination and implementation of HIV/AIDS and TB control efforts.[23] Although there have been improvements, the Plan continues to face challenges associated with political will and the poor delivery of health care services.[24] HIV/AIDS and TB constitute a threat to the national health initiative and economic growth in SA.

Another challenge is the fact that the strict protection of patent rights can have a negative impact on medicines and other medical equipment necessary for the diagnosis and treatment of diseases.[25] There is a strong indication that the production of generic drugs for HIV/AIDS and TB at a low price is possible only in countries where those medications are not under patent rights.[26] Thus, advocacy is needed to challenge the patent law in SA for the promotion of sustainable health care services by giving priority to the rights of patients.[27]

1.2. The scope of the study

This dissertation will set out to identify the clinical, ethical and human rights challenges

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[18] Refer to the case *EN and Others v Government of RSA and Others* (2006) AHRLR 326 (SAHC 2006), the court argued that the government failed to provide sufficient measures to provide ART to the prisoners and qualified this as cruel, inhuman and a threat to the right to health, para 29. Also in *Dudley v City of Cape Town* (2004) 25ILJ 305 (LC), the court ruled that the DCS was indeed responsible for Lee becoming infected with TB and that it should pay compensation to him, para 11.

[19] Equal treatment*, Magazine of the treatment Action Campaign,* April 2013, p1.

[20] Dr Norbert Ndjeka (2014), Director of Drug-Resistant TB, TB and HIV Anti-Drug Resistant Tuberculosis, *Strategic Overview on MDR-TB care in South Africa*, available at http://www.health-e.org.za/wp-content/uploads/2014/03/Strategic_overview_of_MDR_TB_RSA.pdf, accessed at 17 May 2014.

[21] See Note 8 above.

[22] Idem.

[23] See Note 6 above.

[24] Equal treatment*, Magazine of the treatment Action Campaign,* April 2012, p1.

[25] Hestermeyer H., (2008), *Human rights and the WTO: the case of patents and access to medicines*, Oxford: Oxford University Press, p 8.

[26] Idem.

[27] See Note 8 above.

pertaining to HIV/AIDS and TB co-infection. The evaluation and analysis of policies, mechanisms, rules, regulations and laws provided by the South African government for the control of the HIV/AIDS and TB co-infection, as well as their relevant ethical and legal implications, will help to address these issues for appropriate prevention and management of these diseases.

1.3. Aim of the study

This study aims to ascertain to what extent existing policies, and laws achieve the protection of the rights of those living with HIV/AIDS and TB, particularly with regard to patents' rights, and whether these policies and laws comply with international standards.

Thus, for example, a balance between respect for fundamental rights, such as the freedom of movement of people affected by HIV and TB co-infection and the protection of the health of the general population in SA, needs to be ensured. This challenge is outlined in the case of *Minister of Health, Western Cape v Goliath & Others* 2009(2) SA248(C). In order to protect the public against infectious diseases, there are various policies and mechanisms in place for the effective control of HIV/AIDS and TB co-infection. It is important that the right of access to health care and to public health protection is balanced against fundamental human rights such as the right to freedom of movement. This study will assist in interpreting how the courts have applied the law and policies for the general welfare of the population and whether or not this is adequate.

1.4. Research questions

In order to achieve the aim outlined above, the following questions are investigated:

1. What are the clinical issues involved in the protection and promotion of human rights of people living with HIV/AIDS and TB co-infection?
2. What are ethical and human rights challenges pertaining to the promotion and protection of human rights of people living with HIV/AIDS and TB co-infection?
3. What might be implications of patent rights on the enjoyment of human rights by people living with HIV/AIDS and TB co-infection?
4. To what extent do SA policies and laws for the management and control programme of HIV/AIDS and TB co-infection comply with international standards?

1.5. Research methodology

This dissertation uses desktop research. There is a significant body of legal documents relevant to the issue of patients' rights and the development of policy, such as the Constitution, various statutory laws, case law and policies in SA as well as international laws, and these documents require further analysis with a particular focus on HIV/AIDS and TB co-infection. Thus, while collection of empirical data would provide additional insight into contextual factors, this is not attempted here and the study is limited to the area of policies and laws in relation to HIV/AIDS and TB co-infection.

1.6. Structure of dissertation

This chapter has introduced the aim of the study and listed the research questions. Chapter Two comprises a literature review and provides definitions and a discussion of the relevant medical conditions and associated clinical and ethical challenges. Chapter Three deals with South African and international law with a focus on human rights in the area of health and on patents. Chapter Four goes on to analyze policy. The final chapter presents conclusions and recommendations.

CHAPTER TWO

THE ETHICAL AND CLINICAL ISSUES OF HIV/AIDS AND TB CO-INFECTION IN SOUTH AFRICA: EXPLORING THE CHALLENGES

2.1. Literature review

Various scholars have discussed the challenges of HIV/AIDS co-infections and have set out particular views which illuminated this study, though it may differ in the field of analysis undertaken. These articles are discussed below.

Governments have a responsibility to ensuring the health of their people and must provide adequate health and social measures.[1] An international HIV review on HIV/AIDS programmes has demonstrated that South Africa's actions for the control of the disease were not better than those in some other countries in the region.[2] Abdool Karim and others have analyzed SA's efforts for the control of these diseases and conclude that they are not effective; they have suggested four steps for the prevention and treatment control programme of HIV/AIDS and TB co-infection.[3] These recommendation, however, do not include counselling as part of the strategic plan control programme for the diagnosis and treatment of the HIV/AIDS and TB affected people.

Skinner and Mfecane discuss stigma and discrimination with regard to HIV/AIDS and TB-affected people in SA.[4] They argue that these challenges not only have an impact or effect on individuals but also have consequences for these epidemics and more broadly the society as a whole. Kohi, Makoae and Greeff pursue the same argument in their publications.[5] These authors suggest that the actions to eradicate stigma and discrimination should be taken seriously. This dissertation pursues the same argument, basing it, however, on the duties of South African government and focusing on the laws concerning stigma and discrimination.

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[1] The preamble of the Constitution of WHO read with the ICESCR and ICCPR which constitutes international bill of rights and constitutes guidelines for states.

[2] Karim, SSA, Churchyard, GJ. et al. (2009), *HIV infection and tuberculosis in South Africa: an urgent need to escalate the public health response, The Lancet, 374(9693), 921-933.*

[3] Ormerod L. P, (2005), *Multidrug-resistant tuberculosis (MDR-TB): epidemiology, prevention and treatment*, *British medical bulletin, 73(1), 17-24.*

[4] Mano Rajam, RC & Muhammad GM, (2013), *A Study on HIV co-infection among pulmonary tuberculosis at a private medical college hospital, Asian Student Medical Journal 13.6,* p1.

[5] Kohi T.W., Makoae L., Chirwa, et al., (2006), *HIV and AIDS stigma violates human rights in five African countries, Nursing Ethics, 13(4), 404-415.*

Vawda and Baker discuss the impact of patent rights on the access of medicines in general.[6] They argue that any public policy which does not advance human rights is meaningless and suggest advocacy and lobbying for law reform measures as well as training and rights based education to reach the objectives of access to medicines for all.[7] Adusei discusses pharmaceutical patent rights in the Sub-Sahara context but does not discuss the impact of patent rights on availability of ARVs and TB drugs which is an important issue.[8]

The work of Gostin and Porter discusses the negligence of states in not prosecuting violations of rights of HIV/AIDS and TB affected people, stating that the SA Constitution provides for fundamental human rights and the right to public health,[9] and that the courts have to maintain these rights.[10] These scholars have criticized courts' decisions which require the forced isolation of TB infected people, while at the same time the government policies do not provide social welfare benefits for this duration of hospitalization.[11] However, the refusal of appropriate treatment due to this cancellation of social benefits by the patient can increase the risks of spreading these diseases.[12] Ndjeka argues that a holistic treatment programme comprising social, nutritional and psychological support should be administered to hospitalized patients.[13] It appears that no scholars have yet dealt with the issue of how the government can maintain the social benefit or even increase it for such patients as an additional measure for the best treatment of HIV/AIDS and TB co-infection.

International law provides guidelines for the protection of the fundamental human rights by the member states. Thus, all their health policies should comply with them.[14] The research literature deals with recommendations, strategies and approaches presented in the National

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[6] Vawda YA., & Baker BK. (2013), *Achieving social justice in the human rights/intellectual property debate: Realising the goal of access to medicines*, *African Human Rights Law Journal, 13(1), 01-27.*
[7] Idem.
[8] Adusei P., (2013), *Right to Health and Constitutional Imperatives for Regulating the Exercise of Pharmaceutical Patent Rights in Sub-Saharan Africa*, *in African Journal of International and Comparative Law,* Edinburgh University Press, p 4.
[9] Gostin L.et al (1992), *International law and Aids: International response, current issues and future directions*, American bar Association (Section of International Law and Practice), Chicago, p 235.
[10] Pieterse M., & Hassim A. (2009), *Placing human rights at the centre of public health: a critique of Minister of Health, Western Cape v Goliath: notes*, *South African Law Journal, 126(2), 231-245.*
[11] Idem.
[12] Ibidem.
[13] Dr Norbert Ndjeka (2014), *Strategic Overview on MDR-TB care in South Africa*, available at http://www.health-e.org.za/wp-content/uploads/2014/03/Strategic_overview_of_MDR_TB_RSA.pdf, accessed on 29 March 2014.
[14] It provides the ICESCR and ICCPR which constitutes international bill of rights and constitutes guidelines for states.

Strategic Plan (NSP), international bodies such as the World Health Organization (WHO), International Labor Organization (ILO) and United Nations AIDS (UNAIDS). Thus, Jarvis, [15] Burris[16] and Harron[17] discuss the international instruments that protect the rights of the HIV/AIDS and TB affected people. They also emphasize the efforts of the international community to enforce international law, treaties and covenants. Harron, Burnside and Beauchamp also follow the same argument.[18]

This section has introduced some of the issues dealt with in the literature. The next section will focus on explaining the nature and status of HIV/AIDS and TB.

2.2. The national status of HIV/AIDS AND TB

2.2.1 Introduction

HIV/AIDS and TB co-infection constitute a serious threat to the national health initiative. There are clinical and ethical challenges regarding diagnosis and treatment due to the shortage of healthcare equipment, drugs interaction and poor patient compliance to the proposed therapy. These challenges will be further discussed in the following section. In addition, this chapter includes an overview of the national status of HIV/AIDS and TB, and a discussion of the role of counseling for the better management of co-infection.

2.2.2 The nature of HIV/AIDS.

HIV/AIDS was found for the first time in South Africa in 1983[19] and, because of the lack of attention by the then apartheid government, developed quickly to reach the pandemic stage by 1995.[20] HIV is composed of two types of virus known as HIV-1 and HIV-2[21] and it is known that HIV is the cause of AIDS, although not all HIV-positive patients have AIDS. HIV can stay

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[15] Jarvis R.et al (1996), *Aids Law 2ed*, In a nutshell, west publishing CO., St Paul, Minnesota, p 195.
[16] Burris S., (1993), *Aids Law today: A new guide for the public,* Yale University Press, London, p345.
[17] Harron F et al. (1983), *Health and Human Values*: *A guide to making your own decisions,* Yale University Press, p 272.
[18] Idem.
[19] Rash GJ and al., (1983), *Acquired immune deficiency syndrome*. A report of 2 South African cases, *South African Medical Journal 1983 Jul 23; 64(4): 140–2.*
[20]Govender T. (1996), *Epidemiology of HIV/AIDS in South Africa,* available at http://www.kznhealth.gov.za/arv/arv11.pdf, accessed on 8 May 2014.
[21] HIV-1 and HIV-2 can be transmitted by the same way and cause opportunistic infections and AIDS; but HIV-2 is less communicative early in the process of infection and immune defiency develop slowly while HIV-1, the duration of increased infectiousness is shorter. See Swierzewski S.J (2014), *The difference between HIV1 and HIV2*, available at http://www.healthcommunities.com/hiv-aids/virus.shtml, accessed on 17 August 2014.

in the body for many years without developing into AIDS, which is defined by opportunistic infections or the possession of a CD4+ lymphocyte count under 200 cells.[22]

The AIDS pandemic is a health preoccupation worldwide and especially in SA, as about 10.8% of the country's population is affected by this disease.[23] According to the HIV treatment guidelines of WHO, countries are advised to provide ART as soon as possible; this helps to reduce the virus concentration and slow the development of the disease.[24] In 2007, 28% of affected people were receiving ART nationwide,[25] although its efficacy still depended on compliance with the medication guidelines. An additional benefit was that the medication resulted in 96% of them being less likely to transmit the virus.[26] There has been progress in certain areas such as Prevention of Mother To Child Transmission (PMTCT), ART rollout, and Male Medical Circumcision (MMC). Nevertheless, the challenges are still there and the disease is considered as a threat to national economic growth.[27]

2.2.3 The MDR/XDR-TB: Scale and nature of the disease

Tuberculosis (TB) is an infectious disease, and its bacteria are transmitted through respiratory fluids by coughing and sneezing. Some infections do not manifest symptoms and are known as latent tuberculosis (LTB).[28] In addition, multidrug and extensively resistant tuberculosis (MDR/XDR-TB) are two types that continue to be a health problem especially in developing countries like SA. MDR-TB is a kind of TB characterized by high level resistance to the TB drugs such as isoniazid and rifampicin, while XDR-TB, which is the extension of MDR-TB, resists both of these drugs and also other second line-drugs.[29] Additionally, XDR-TB has a

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[22] See Note 4 above.
[23] Statistics South Africa (2010), *Mid-year population estimates*, available at http://www.statssa.gov.za/publications/P0302/P03022010.pdf, accessed on 8 May 2014.
[24] World Health Organization (WHO), (2013), *Recommendations on ART*, Geneva, Switzerland, available at http://www.who.int/hiv/pub/guidelines/arv2013/download/en/ accessed on 17 August 2014.
[25] The SA health service, health-E, *20% of ARV patients*, September 2010, available at http://www.health-e.org.za/2010/09/28/20-of-arv-patients-in-sa/, accessed on 17 August 2014.
[26] Idem.
[27] For GDP, per-capita growth would be higher than if there were no HIV/AIDS in SA. See Booysen FLR., et al., (September, 2003), *The impact of HIV/AIDS on the South African economy:* A review of current evidence, In TIPS/DPRU conference on 'The Challenge of Growth and Poverty: The South African economy since democracy (pp. 8-10).
[28] WHO (2015), *Guidelines on the management of latent tuberculosis infection*, available at http://apps.who.int/iris/bitstream/10665/136471/1/9789241548908_eng.pdf?ua=1&ua=1, accessed on 10 August 2014.
[29] See Note 3 above.

higher mortality rate than MDR-TB due to limited relevant therapy options.[30]

The development of these diseases can be explained in relation to the historical conditions during the time of apartheid, when living and working conditions led to the spread of these diseases, and also to the current poor management programme and treatment. These challenges are also intensified by the increasing rate of HIV/AIDS.[31] Furthermore, the spread of these diseases can be explained in relation to healthcare practitioners' mistakes and the non-adherence of patients to treatment plans.[32] In 2010, TB represented 12% of the country's deaths and the disease incidence rate was ten times higher than the level of emergency.[33] These statistics indicate the severity of this disease and the challenge it presents to the country's heath programme.

2.3. HIV/AIDS and TB co-infection: Clinical challenges to the treatment and diagnosis

2.3.1. Introduction

In the clinical sphere, HIV/AIDS and TB co-infection can lead to difficulties in diagnosis and treatment due to the nature of these diseases. This section explores these challenges and discusses the importance of counselling for the better management and prevention of both diseases, which are associated with high risk of death.

2.3.2. Diagnosis and treatment

Once HIV has reduced the capacity of the human immunity, TB finds an opportunity to progress due to the defective immune system. This combination becomes more dangerous in the case of MDR and XDR-TB. Due to the nature of these diseases, the healthcare professional can experience some difficulties in the detection and the treatment of the co-infection. HIV/AIDS infections are the most important factor in the increase in morbidity and death among TB patients and *vice versa*, as both infections have a close link as one causes the other to progress.[34] The incidence of co-infection is high and around 70% of TB patients are also

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[30] Gandhi N R., et al., (2010), *Multidrug-resistant and extensively drug-resistant tuberculosis: a threat to global control of tuberculosis, The Lancet, 375(9728), 1830-1843.*

[31] Dheda K., et al., (2010), *Early treatment outcomes and HIV status of patients with extensively drug-resistant tuberculosis in South Africa: a retrospective cohort study*, *The Lancet, 375(9728), 1798-1807.*

[32] *Ormerod L.P; op cit., p 3.*

[33] Statistics South Africa (2010), *Mortality and causes of death in South Africa*: *Findings from death notification*, available at http://www.statssa.gov.za/publications/P03093/P030932010.pdf, accessed on 10 August 2014.

[34] TB represents around 13% among HIV patient's deaths worldwide. See Sharma S. K., (2005), *HIV-TB co-infection: epidemiology, diagnosis & management*, *Indian Journal of Medical Research, 121(4), 550-567.*

HIV positive in SA.[35]

The diagnosis of suspected co-infected patients involves skills and the availability of medical materials, such as protective equipment. The NSP and WHO policies, recommend rapid HIV testing for TB patients for good treatment coordination.[36] In addition to these tests, TB requires further screening tests, such as chest X-rays, molecular diagnosis, blood cultures tests and adenosine deaminize for the detection of mycobacteromia. [37] TB can be confused with other opportunistic pulmonary diseases in HIV patients and can thus complicate the diagnosis process.[38] The tests are necessary to help the healthcare system to undertake appropriate measures for the control of both diseases.[39] However, the carrying out of these tests continues to be a major problem due to the number of tests and resource constraints. This problem continues to undermine the quality of the diagnostic service.[40] The country needs sufficient laboratories and other related equipment for early diagnosis of TB, which constitutes a dangerous opportunistic infection among HIV patients.[41]

The treatment of HIV and TB should be concomitant as the infections have biological and epidemiological links. There should be a deep understanding of the co-infection and appropriate skills in order to take relevant measures and reduce mortality.[42] However, the high price or even the lack of medications, materials and personnel needed for HIV and TB testing, and specialized clinics for the co-infection continue to challenge the achievement of diagnosis and treatment of these infections.[43] The mismanagement and disorientation of available resources in public health institutions also contribute to the lack of laboratories and beds for hospitalization necessary for diagnosis and treatment and complicate the management of these infections.[44] Sufficient beds and other means of the hospitalization are important in order to

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[35] HSRC (2012), South Africa National HIV Prevalence, Incidence, Behaviour Survey. Available at http://www.hsrc.ac.za/uploads/pageContent/4565/SABSSM%20IV%20LEO%20final.pdf, accessed on 8 November 2014.
[36] World Health Organization, (2014), *Interim policies on collaborative TB/HIV activities*, Geneva, Switzerland, available at http://apps.who.int/iris/bitstream/10665/78705/1/WHO_HTM_TB_2004.330_eng.pdf?ua=1, accessed on 12 August 2014.
[37] Corbett EL., Elizabeth L., et al. (2006), *Tuberculosis in sub-Saharan Africa: opportunities, challenges, and change in the era of antiretroviral treatment, The Lancet 367.9514 (2006): 926-937.*
[38] Sharma SK., (2005), *op cit.,* p3.
[39] See Note 4 above.
[40] See Note 30 above.
[41] Idem.
[42] See Note 4 above.
[43] Sharma SK, et al., (2005), *op cit,* p 4.
[44] O'Donnell M.R., et al. (2009), *Improved early results for patients with extensively drug resistant tuberculosis and HIV in South Africa, The international journal of tuberculosis and lung disease: the official journal of the International Union against Tuberculosis and Lung Disease 13.7 (2009): 855.*

reduce the transmission of TB in the community and to strengthen control of patient compliance with the treatment.[45]

The challenges of insufficient medical training and lack of proper health infrastructure in medical facilities are further impediments that contribute to the failure of the control programme in the country. These challenges have a negative impact on the existing personnel, who have to work under pressure in order to manage the great number of patients.[46] Furthermore, the lack of colleges of nursing, insufficient training in the science of HIV and TB co-infection, and mismanagement of resources in public health hospitals lead to health care personnel possessing inadequate skills. Moreover, qualified doctors and nurses are moving to work in private hospitals or in other countries and this creates a burden on public hospitals which the majority of people rely on for treatment.[47]

There are also issues with the management of the diseases. In the control of MDR and XDR-TB among people living with HIV, patient isolation is of great importance. The diagnosis and treatment of TB among people living with HIV can be difficult and, therefore, necessitates some restrictive measures to reduce its transmission. However, conditions for, and the period of, detention constitute a problem at some public hospitals.[48] However, the hospital detention can be supplemented by the "community based isolation" in case of the scarcity of beds at the hospitals to reduce the risks of transmission of TB.[49] A different kind of issue is raised by the very notion of detention. While the Constitution provides for respect, promotion and protection of fundamental human rights, such as the right to freedom of movement and dignity,[50] the High Court has affirmed that these rights can be restricted in the public interest.[51] However, patient

[45] In order to improve treatment and control TB among HIV positive patients, there is a need of enough infrastructure to deliver HIV care in SA. See Ormerod L. P, (2005), *op cit.,* p 5.
[46] Vawda YA., &Variawa F., (2012), *Challenges confronting health care workers in government's ARV rollout: rights and responsibilities*, *PER: Potchefstroomse Elektroniese Regsblad, 15(2), 01-36.*
[47] See Note 4 above.
[48] See Note 10.
[49] Singh, J. A., et al. (2007), *XDR-TB in South Africa: no time for denial or complacency,* PLoS Medicine, *4*(1), e50. The author argues that "community-based isolation" can help to reduce the risks of transmission of the XDR-TB in developing countries in case of scarcity of beds at the hospitals. However, those patients and their families will need to be supported socially and financially.
[50] Section 21 (Freedom) and 10 (Dignity) of the Constitution of the RSA, Act 108 of 1996.
[51] In *Minister of health, Western Cape v Goliath & others* 2009(2) SA248(C), the Cape High Court authorized the forced isolation of four patients infected with XDR-TB at Brooklyn Chest Hospital. This was serving to advance and reinforce Public health by ensuring fairness and balance the protection of human right of the affected people and the community. Para 19. See Kohi T.W., Makoae L., Chirwa, et al., (2006), *HIV and AIDS stigma violates human rights in five African countries, Nursing Ethics, 13(4), 404-415.*

isolation must be avoided unless there is a high risk to the general population.[52] Thus, the Court had a reason to limit the rights of the respondents suffering from XDR-TB in *Minister of Health v Goliath*[53] by ordering their detention at the hospital to reduce the transmission of TB up until they were deemed to constitute no threat to the public health. This case shows the importance of the limitation of some fundamental human rights in order to promote and protect public health in general. It also testifies to the role of the courts in the management of HIV and TB co-infection.

2.3.3. Counselling: Consolidating the management of the co-infection

The NSP as well as the WHO recommend routine counselling for HIV testing among HIV and TB patients in order to consolidate efforts for prevention and better control and management of both diseases.[54] In fact, testing of the general population will lead to better diagnosis. It has been noticed that many people are ignorant of their HIV status and have no access to early initiation of ART, which can explain the high mortality rate among co-infected patients.[55] However, the inefficiency of the voluntary counselling and testing (VCT) in some areas countrywide continues to undermine collaborative efforts in the HIV-TB preventive control programme due to the lack of infrastructure, personnel, means of treatment if tested positive as well as fear of stigma and lack confidentiality.[56] In these instances, it is advisable to include appropriate counselling as part of the available treatment and care options.[57]

The consolidation of VCT, not only for the prevention as provided for by NSP but also for diagnosis and treatment, should be one of the mechanisms used to reduce transmission and improve therapy outcomes. The counselling can be used as a method to deal with patients' adherence to treatment. The communication used by health care personnel during counselling should focus on the risks that hinder adherence and the nature of these infections that create barriers to diagnosis and treatment. Because HIV and TB are communicable diseases that scare many people, this requires a change of belief about them. Counselling has to extend and

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[52] *Enhorn v Sweden (2005) E.C.H.R.* 56529/00.
[53] *Minister of Health of the Province of the Western Cape v Goliath and Others* 2009 (2) SA 248 (C).
[54] See also, WHO, (2003), *Guidelines for implementing collaborative TB and HIV programme activities,* Geneva, Switzerland.
[55] Hudspeth J., et al. (2004), *Access to and early outcomes of a public South African adult antiretroviral clinic*, *South African Journal of Epidemiological Infections 19 (2004): 48-51.*
[56] Bassett I.V., et al., (2007), *Routine voluntary HIV testing in Durban, South Africa: the experience from an outpatient department*, *Journal of acquired immune deficiency syndromes (1999), 46(2), 181.*
[57] Counselling can be defined as "A type of talking therapy that allows a person to talk about their problems and feelings in a confidential and dependable environment". See The Free Medical Dictionary, available at http://medical-dictionary.thefreedictionary.com/counselling, accessed on 22 March 2015.

include strategies targeting psycho-social challenges, such as depression, attached to these diseases; it needs to help drug users to change the attitude which led them to addiction. It will then have a positive impact on adherence to treatment of these infections.

Methodologically, counselling education for health care professionals should include an appropriate technical approach and comprehensive didactic materials and this, together with the patients' self-engagement and reporting timeously themselves for healthcare service, may contribute to the management of HIV and TB. The training should focus on the reduction of stigma and use of drugs as well as combatting the gender related barriers[58] and provide the skills need in order to encourage patients to access health care services. Most patients doubt that health care professionals will keep confidentiality and respect their right to privacy, as they are worried about the disclosure of their health status which could cause stigma and discrimination in their community.[59] Therefore, issues around confidentiality must be included in the training. Countrywide, especially in the rural areas where healthcare services are limited and people are less informed on these diseases, strengthening counselling can be an effective strategy and an advocacy tool in promoting knowledge on the diagnosis and treatment of the diseases.

There are, however, challenges associated with the provision of counselling. Even if patients manifest interest in counselling, there can at times still be some resistance due to factors such as the duration of the session, the location of the testing site, as well as the skills and strategies employed by the healthcare professionals. [60] However, the community can play a significant role in the acceptability of counselling for the treatment of these infections. In most cases, some families help patients to hide their health status and this can increase the incidence of transmission of these infections within the community.[61] Thus, strategy of this counselling should be extended to traditional chiefs as ambassadors of their communities regarding beliefs attached to these infections and use their influence within the community to educate and spread awareness of prevention and treatment. Church authorities and traditional healers also have

[58] This refers to the trainings that reflect the impact of the social practices, occupational segregation, inequalities in workplace that have impact on women's attitude to seek treatment.
[59] These are results obtained from a study carried by Centre for the AIDS Programme of Research in South Africa, on the processes of decision making for HIV testing and disclosure of the serostatus by TB patients in SA. See Daftary A., et al., (2007), *HIV testing and disclosure: A quantitative analysis of TB patients in South Africa,* AIDS care 19.4, 572-577.
[60] See Note 56 above.
[61] See Note 59 above.

power in their community and should be targeted as they are consulted by many people for guidance on problems as well as being a source of diagnosis and treatment for various illnesses, especially in rural areas, where accessing health care services is made difficult due to costs and distance associated with travelling to a health care facility.

Finally, public health interventions should target vulnerable communities that pose a high risk of transmitting infections;[62] thus, counselling should be directed specially to individuals such as sex workers, miners, families of the patients, migrant workers and those living in communities where polygamy is widely practiced. Interventions should invite communities to reflect on and change their attitude and behavior around such issues as engagement in multiple sexual relationships, the role of regular HIV testing and TB tests, the use of condoms and ARV's, voluntary medical male circumcision and environmental issues that favour the transmission and progression of TB.This strategic approach, however, will need strong collaboration of different health partners such as private health partners, NGO's, healthcare providers and health authorities and sufficient healthcare resources.

2.4. HIV/AIDS and TB co-infection: Ethical challenges

2.4.1. Introduction

HIV/AIDS and TB co-infection do not only lead to physical suffering but also have ethical consequences. The mode of therapy for communicable diseases to which patients can at times be subjected leads to the restriction of their social rights, such as freedom of association, which can lead to psychological problems.[63] The importance of medical ethics to healthcare practitioners is fundamental to their understanding and remedying of moral and ethical problems concerning medical procedures, methodologies and techniques in medical practice.[64] In SA, health professionals have their ethical code of conduct.[65] However, healthcare professionals may be confronted with ethical challenges during healthcare service delivery

[62] Uphsur, R., (2002*), Principles for the justification of public health intervention*. Canadian Journal of Public Health, 93:101–3.
[63] Jerene D. et al.,(2007), *Acceptability of HIV counselling and testing among tuberculosis patients in south Ethiopia*, BMC international health and human rights 7.1 (2007): 4.
[64] '*Ethics*' can be defined as a theory or a system of moral values', 'the study of the general nature of morals and of the specific moral choices to be made by a person' and 'the rules or standards governing the conduct of a person or the members of a profession'. In American Heritage Dictionary (2000).
[65] Health Professions Council of South Africa, (2002), The National Patient's Rights Charter (Booklet 13) of the Guidelines for Good Practice in Medicine, Dentistry and the Medical Sciences, available at www.hpcsa.co.za, accessed on 22 August 2014.

related to HIV-TB co-infection. These challenges will be discussed below within the framework of basic biomedical ethics in healthcare delivery service.[66]

2.4.2. Principle of autonomy

This principle requires health professionals to seek an informed consent from their patients before performing any medical treatment, and this involves the patients being informed of all possible ways of treatment, consequences, benefits and even possible hidden risks.[67] Thus, patients have choice and participate in decision making.[68] Similarly, patients have the right to determine for themselves what they want to do with their bodies and need relevant information concerning HIV and TB tests as well as being assured of confidentiality in order for them to make an autonomous (and respected) decision.[69]

This principle also provides for the full protection of patients who are incapable of making informed decisions, such as the mentally disabled, and guarantees benefits to all patients from the healthcare service.[70] The National Health Act (NHA),[71] the Health Professions Council South African (HPCSA)[72] as well as common law[73] also make provisions for informed consent and confidentiality. The courts have held that extensive individual pre-test counselling must be performed in the *opt-in* approach as espoused in the case of *C v Minister of Correctional Services.*[74]

However, the beliefs and attitudes associated with these diseases and lack of protection of the patients' confidentiality at TB clinics continue to undermine the diagnosis and treatment process of these infections[75] and undermine this principle. Obtaining a patient's informed consent and respecting his or her privacy and right to confidentiality require good medical

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[66] Beauchamp TL, Childress JF, (1994), *Principles of Biomedical Ethics*, 3rd ed, Oxford: Oxford University Press, 1994: 67-113 (autonomy), 194-249 (beneficence), 120-184 (non-maleficence) and 256-302 (Justice).
[67] Ibidem.
[68] Patent's charter, section 9.
[69] Beauchamp TL, Childress JF (1994), Principles of Biomedical Ethics, 3rd ed, Oxford: Oxford University Press, 1994: 67-113 (autonomy).
[70] Idem, p 68.
[71] Section 7 (consent) and 14 (confidentiality) of the National Health Act No 61 of 2003.
[72] Health Professions Council of South Africa: *Guidance for good practice in Health Professionals*: Consent: Ethical principles (Booklet 15) and Confidentiality: Protecting and providing information (Booklet 14) 2002, available at www.hpcsa.co.za, accessed on 22 August 2014.
[73] See *Jansen van Vuuren v Kruger* 1993 (4) SA 842 (A).
[74] 1996 (4) SA 292 (T).
[75] Corneli A., Jarrett NM., Sabue M., Duvall S., (2009), *Patient and provider perspectives on implementation models of HIV counselling and testing for patients with TB, International Journal of Tuberculosis and Lung* Diseases *2008, 12:79-84.*

practice and a safe environment. Good medical practice in terms of treating HIV and TB aims at protecting patients against stigma by respecting their right to confidentiality and to promote the protection of their privacy.[76] Hence, in order to respect this ethical principle, healthcare institutions should provide for all necessary means to protect patients' rights, such as ensuring a secure environment for counselling. Healthcare workers should act ethically without fear of contamination and avoid unnecessary disclosure of the seropositive status of patients as this can undermine the patient's trust in the healthcare service.

Patients' decision-making processes and decisions can be related to cultural differences and this should be considered by medical professionals when disseminating information and administering treatment. In the treatment of children, the duty of disclosure may conflict with the right of the child to confidentiality.[77] Disclosure can destroy the trust relationship between patient and health professionals, which is based on the truth telling and dispelling of the deception.[78]

2.4.3. Principle of beneficence

The principle of beneficence refers to "*positive obligation"* by the healthcare professionals.[79] It requires of them the exercise and the promotion of others' interests and welfare.[80] Healthcare professionals need to do good for the patient. The principle requires them also to protect and defend their patients against any threat or bad conditions that can cause harm, to act beyond their normal rights and obligations to prevent possible harm and to use kindness and help those who need it.[81] Early HIV testing and TB tests will enhance patient compliance and will thus facilitate access to treatment and lifestyle changes. The Constitution reflects this principle by the provision that "everyone has the right to access healthcare services."[82] The NHA also

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[76] Perumal R., Padayatchi N., Stiefvater E., (2009), *The whole is greater than the sum of the parts: recognizing missed opportunities for an optimal response to the rapidly maturing TB-HIV co-epidemic in South Africa*, in BMC Public Health 9.1 (2009): 243.

[77] This happen in case of doubt that the parents or guardian's consent can harm the treatment process for the children with the STI's under the age of treatment consent. See Singh J.A, Karim SSA., Karim QA., Mlisana K., (2006), *Enrolling adolescents in research on HIV and other sensitive issues: Lessons from South Africa, PLoS medicine* 3.7 (2006): e180.

[78] American Nurses Association, (1991), *Ethics and Human Rights,* available at http://www.nursingworld.org/, accessed on 22 August 2014.

[79] Beauchamp TL, Childress JF (1979), *op cit,* p121.

[80] MacQuoid Mason, DJ& Dhai A., (2011), *Bioethics, Human rights and Health Law: Principles and practices,* Juta&Company Ltd, Cape Town, South Africa, p 14.

[81] Idem, p195.

[82] Section 27 (1) (a) of the Constitution of the RSA 108 of 1996.

requires state-sponsored health facilities to provide health care services according to the available resources.[83]

The accomplishment of this principle in their service delivery requires professional competence and experience within their profession.[84] Additionally, due to the stigma associated with HIV-TB, this principle needs to be upheld by healthcare providers whilst maintaining the patient's right to confidentiality.[85] Thus, the diagnosis and treatment process, as well as the acknowledgement of the right to confidentiality and privacy are "prima facie" rules of healthcare ethics. However, in the case of therapeutic privileges, a health care professional can refuse to disclose some information to the patient when this can cause psychological harm or can be medically contraindicated.[86] The refusal can be based on ethical grounds with the intention of protecting their patients' rights.[87] On the other hand, they can opt to disclose such information in order to protect their patients and the community they serve.[88]

However, refusing to disclose the serostatus or the TB status to the patient's family members may undermine the treatment process or even the management of these diseases due to the high risks associated with transmission in the community where they are living. Additionally, certain practices, such as a 'secret' treatment area for patients and marking beds of patients at clinics, do not serve patients' confidentiality but create negative behaviors and greatly harm the control of HIV and TB.[89] Such practices offend a patient's autonomy and necessitate a professional approach by health care professionals in order to balance the benefits and risks associated with their decision without any external influence.

As noted above, the detection of HIV-TB co-infections for its better treatment and management requires many tests, which also involve informed consent. However, the lack of healthcare workers and information and the short time allowed for the discussion between them and the

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[83] Section 3 (a) of the National Health Act No 51 of 2003.
[84] Pera, SA. (2011), *Ethics in healthcare*, Juta and Company Ltd.
[85]Armes, P.J. & Higginson, I.J., (1999), *What constitutes high-quality HIV and AIDS palliative care? Journal of Palliative Care 15 (4), 5–12.*
[86] Section 6(1)3 of the National Health Act of 2004.
[87] Pera, SA. (2011), *Ethics in healthcare*, Juta and Company Ltd.
[88] The healthcare professionals have moral and ethical duty to tell to the HIV-TB patients, the importance of the disclosure of their status to their sexual partners at risks of infection. See South African Medical and Dental Council, (2003), *Guidelines for the Management of Patients with HIV Infection or AIDS,* SAMDC, Pretoria, 1994 and also Gebrekristos H., (2003), *Disclosure of HIV status for patients on HAART: implications for treatment adherence and sexual behavior*. South African AIDS Conference; 3-6 August 2003.
[89] Daftary A., et al., (2007), *HIV testing and disclosure: A quantitative analysis of TB patients in South Africa,* AIDS care 19.4, 572-577.

patients are often insufficient to obtain informed consent. Sometimes, to obtain informed consent on the treatment needs a long discussion, or even negotiation, as patients would not view the medical practitioner as having their best interests at heart but view them as wanting to exercise authority over them.[90] Therefore, these challenges undermine this ethical principle and render the health service delivery ineffective.

2.4.4. Principle of non-maleficence

The principle of non-maleficence refers to the "*negative obligation*" of healthcare professionals.[91] It requires that health care workers avoid possible harm or reduce harm to the minimum. This simply means that they should work to their level best to adhere to best practice standards by avoiding medication errors or intentionally inflicting pain or offending the patient. Patients know their status early, they can take the necessary steps to access treatment early as well as protect those around them by not exposing them to an environment that may be harmful to their health or wellbeing.

However, being trained to promote health, health professionals may willingly or unknowingly focus on the benefits of HIV testing whilst skimming over the patients' rights and possible negative consequences of testing. Notwithstanding the clinical and public health benefits associated with HIV testing, patients have the right to refuse testing and, even if given counselling, the reality of a positive HIV test result could sometimes be difficult to deal with.[92] Another inconsistency with the non-maleficent principle is when it is applied to the rape survivor's right to know the status of the accused offender.[93] Healthcare professionals in the interest of avoiding transmission by patients diagnosed HIV-positive, sometime undertake measures that are less appropriate given the degree of the imposed threat. The encouragement of the isolation of patients as a public health measure and appropriate strict follow up of the administration of drugs and ARVs, though prescribed to reduce risks of contamination, harm patients who might experience stigma in their communities.

2.4.5. Principle of justice

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[90] Rennie S. & Behets F. (2006), *Desperately seeking targets: The ethics of routine HIV testing in low income countries*, *Bulletin of the World health Organization 84:52-54.*
[91] Beauchamp TL, Childress JF (1979), *op cit,* p 257.
[92] See Note 75 above.
[93] McQuoid-Mason DJ, Dhai A, & Moodley J (2003), *Rape survivors and the right to emergency medical treatment to prevent HIV infection, South Africa Medical Journal 2003: 93; 41-44.*

The principle of justice provides equal and fair treatment for all patients.[94] It focuses on the prioritization of vulnerable patients in the treatment process by healthcare professionals and the balance between those who must be treated and refused treatment.[95] This principle is strengthened by the Constitution which provides that no one can be unfairly discriminated against[96] and that HIV status may be seen as grounds of discrimination.[97] The Employment Equity Act further reiterates that unfairly discriminating on the basis of HIV status is a forbidden kind of discrimination, as it has also been confirmed by the Constitutional Court in the case of *Hoffman v South African Airways.*[98]

Intensive counselling and treatment of HIV and TB co-infection, like other chronic illnesses (for example, diabetes), has been said to fuel stigma, discrimination, ignorance and also injustice. If patients were routinely tested, they could make lifestyle changes and interventions without the stress and fear often associated with confidential dreaded illnesses. However, the attitudes and beliefs of health professionals could be in conflict with the religious or moral values in the community, particularly with the treatment of HIV-TB co-infected patients due to the stigma associated with these conditions. This dilemma constitutes a challenge to this ethical principle and undermines the control programme of these transmitted diseases. It has been demonstrated that sometimes society plays a great role in the development of the character of its individuals;[99] therefore, it is important to strengthen the HIV-TB education programme targeting societal beliefs, not only amongst members of the public but also members of the healthcare profession. Changing the perceptions of healthcare professionals regarding the stigma of HIV-TB co-infection will bolster the efficiency of healthcare service delivery, access to justice and the sustainability of the control programme initiated for HIV-TB co-infection.

The behavior and attitude of healthcare professionals working within the South African health system has been observed in some studies not to be reflective of ethical principles and not supportive of the control programme for HIV-TB co-infection.[100] Ethical challenges associated with HIV and TB co-infection clinical treatment and management will be reduced in the

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[94] Beauchamp TL, Childress JF (1979), *op cit.,* p 257.
[95] Idem, p 205.
[96] Section 9.
[97] *Hoffman v SAA* 2001 (1) SA 1 (CC).
[98] Idem. In this case, the plaintiff was suitable for the job and tested HIV positive. He was declared unsuitable for the job as it was against the policy of SAA to employ HIV positive attendants.
[99] Bloom S.W. (2002), *The Word as Scalpel: A History of Medical Sociology*. New York, NY: Oxford University Press, p 35.
[100] See Note 75 above.

country if healthcare professionals seriously reflect on the ethical values and guidelines relevant to medical practice.

2.5. Conclusion

In concluding this chapter, it can be asserted that a well targeted public health strategy has long term effects because it creates a stable health care environment where new infections are reduced progressively, and which encourages economic growth through the promotion of a healthy and productive population. Therefore, counselling can help as a tool to improve the diagnosis and treatment of HIV and TB co-infection. Similarly, inadequate working conditions challenge and constitute a threat to the existing healthcare system, which is already weak.[101] Thus, this can have a negative impact on the control of these diseases because of the exposure of health care personnel like physicians, nurses among others to contract HIV/AIDS and or TB because of the lack of proper personal protective equipment (PPE) and poor infrastructure.[102] For the matter of clinical challenges, health care workers should have adequate knowledge on the ethical and legal matters related to medical practice, especially those focusing on HIV and TB transmission, as they pose a major challenge to the national health initiative. Fulfillment of ethical duties also includes treatment to be accessed by all patients.

[101] O'Donnell et al., (2010), *op. cit.,* p 2.
[102] Vawda YA. and Variawa F., (2012), *op cit,* p 20.

CHAPTER THREE:
THE HUMAN RIGHTS ISSUES INVOLVED IN HIV/AIDS AND TB CO-INFECTION

3.1.Introduction

The situation of HIV/AIDS and TB co-infection worldwide necessitates a strong response by international institutions and governments, not only because of its high prevalence, but also due to the massive number of affected people.[1] This chapter therefore discusses both international and South African law, focusing specifically on the human rights domain of health. Laws concerning fundamental human rights, including socio-economic rights, and those focusing on stigma and discrimination are discussed in this chapter. Also, the impact of patent rights on the availability of medicines for the management and treatment of HIV/AIDS and TB co-infection are discussed.

3.2. International legal compliance law: Why and how rights work in the context of HIV and TB co-infection

3.2.1. Introduction

The history of medicine demonstrates that infectious diseases have been of great concern and different countries have put in place measures to curb the burden accruing from this. Quarantine has been used to protect the general population from infectious diseases.[2] Public health initiatives respecting human rights have been implemented to promote the right to health through control of different diseases and have led to interactions among states in their response to the spread of many infections. The following section focusses on the UDHR and the review of constitutions of certain international organizations in relation to human rights involved by these infections.

3.2.2. Universal Declaration of Human Rights and the UN Charter

The Universal Declaration of Human Rights (UDHR) was adopted on the 10th of December 1948 by the United Nations General Assembly and it has become a pillar for the establishment of fundamental rights in many countries. The Declaration is aimed at promoting and developing

[1] Karim, SSA, Churchyard, GJ. et al. (2009), *HIV infection and tuberculosis in South Africa: an urgent need to escalate the public health response, The Lancet, 374(9693), 921-933.*
[2] Fidler, D. P., (1999), *International law and infectious diseases*, Oxford: Clarendon Press, p 8.

human rights among member states, seeking to define, protect and respect human values after World War II.[3] It, together with the ICCPR and ICESCR, may be regarded as the International Bill of Human Rights and serves as a universal standard guideline for the elaboration and insertion of such a bill of rights in the member states.[4] This Declaration is reinforced by the United Nations Charter, which serves as the Constitution of the organization of the United Nations. Members of this organization have agreed on the promotion and development of fundamental rights, such as the standards of life adequate for health, medical care and access to necessary social services.[5] The ICESCR emphasises this by providing for "the highest attainable standard of physical and mental health."[6] The states, therefore, are bound to take progressive measures for the promotion and improvement of healthcare services.[7]

The promotion of equality[8] and access to healthcare services will reduce discrimination and stigma in the society, create awareness of equality measures and help to reduce the global burden of the disease.[9] Therefore, states must implement government health plans in order to ensure adequate medical care and social support. Additionally, the control of infectious diseases, such as cross-border diseases like HIV/AIDS and TB, is important to the fulfilment of the right to health,[10] and this has been one of the constitutional cornerstones for many states. Thus, the application of the principle of human rights must be consistent with established health policies and guarantee openness and access to health care, fighting against discrimination and developing new health technologies. In particular, HIV/AIDS and TB co-infection poses a major health threat, thus calling for different countries to set appropriate health measures in accordance with international standards of human rights in the management of these diseases.[11] The mobilization of involved actors will lead to the empowerment of health

[3] Idem, p 10.
[4] It provides the ICESCR and ICCPR which constitutes international bill of rights and constitutes guidelines for states.
[5] Art 25 of the UDHR.
[6] Art 12 of the ICESCR.
[7] The UN Declaration of Commitment on HIV "*Global Crisis; global action*" signed in 2001 by 189 countries with a purpose to reduce HIV prevalence among young people by 25% by 2010.
[8] Art 7 of the UDHR.
[9] The world expressed its health initiative by elaborating Millennium Development Goals (MDG's) which three of them insisting on health issues especially communicable diseases. See WHO, *MDG's*, available at http://apps.who.int/gb/ebmr/PDF/E/Millenium%20development%20goals%20and%20health%20targets.pdf, accessed on 08 September 2014.
[10] Art 3 of the UDHR.
[11] Kinney, E.D., (2000), *International Human Right to Health: What Does this Mean for Our Nation and World, The Indian Law Review 34 (2000): 1457.*

care service delivery[12] and educate people on the protection of their rights with regard to access to health care services. Public health interventions should focus on the management and control of HIV/AIDS and TB co-infection both nationally and internationally.

3.2.3. The Constitutions of WHO and UNAIDS

The UN Charter provides for the creation of different UN agencies with the purpose of realizing the objectives of the organization.[13] It is from this perspective that the WHO has been created.[14] The constitution of this organization provides for health care in accordance with the right by all for the highest attainable standard of physical and mental health and requires governments to provide all necessary means in order to ensure adequate health care. In addition to this, the WHO offers technical assistance to states in emergency situations regarding medical assistance for the management of diseases, especially communicable diseases such as HIV and TB.[15] It also provides standards for diagnosis procedures,[16] assists governments in the elaboration of health policies[17] and the dissemination of information and counselling in order to fulfill the right of access to information.[18] Therefore, since 1987, WHO has initiated mechanisms to control HIV/AIDS and TB co-infection and this has included improving access to healthcare, education and dissemination of information.[19] In addition, the Joint United Nation programme on HIV and AIDS (UNAIDS) created in 1994 and launched in 1996 has had the responsibility to coordinate global activities on HIV/AIDS.[20] This coordination involves advocacy and provision of necessary support in an attempt to prevent transmission of HIV.[21] The major purpose of the UNAIDS is to develop rapid response to the HIV/AIDS pandemic.

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[12] Chirwa, D.M. (2003), *The right to health in international law: Its implications for the obligations of state and non-state actors in ensuring access to essential medicine*, *South African Journal on Human Rights 19.4 (2003): p 54.*

[13] Preamble of the Charter of the United Nations.

[14] Preamble of the Constitution of the WHO.

[15] The Constitution of the WHO, art 2 (d).

[16] Idem, art 21 (c).

[17] Idem, art 2 (c).

[18] Idem, art 2 (q).

[19] Gruskin, S & Tarantola D., (2008), *Universal access to HIV prevention, treatment and care: assessing the inclusion of human rights in international and national strategic plans,* AIDS (London, England) 22.Suppl 2 (2008): S123.

[20] Knight L. (2008), *UNAIDS: the first 10 years, 1996-2006*, Joint United Nations Programme on HIV/AIDS.

[21] The Economic and Social Council (ECOSOC) resolution 1994/24 of 26 July 1994 creating the Joint UNAIDS.

WHO and UNAIDS created in 2003 a universal programme for the treatment of HIV/AIDS and human rights development.[22] The purpose of this document was to consolidate commitment between states for the establishment of a core document for the global mobilization of government for the creation of a national and regional effective HIV/AIDS and TB control programme with respect to international standards, norms and legal instruments.[23] These two international organizations are currently working hand in hand to manage HIV/AIDS and opportunistic diseases by the creation of sustainable living conditions, and also to ensure the level of accountability among states. The WHO has, however, been criticized for ineffective health regulations which have not challenged trade and aviation fields or taken into account the migration of populations in public health policies because of political and economic interests of some organizations and countries.[24]

3.2.4. The International Labour Organisation

The International Labour Organization (ILO) is an agency of the United Nations and a member of the UN Development Group (UNDG) and carries responsibilities for labour issues with regard to standards of labour on an international level.[25] This organization plays a great role in providing technical assistance to developing countries and ensuring sustainability of and access to justice for workers in the world.[26] It has responsibilities for monitoring and evaluating institutions within country members with regards to labour situations and the required standards whilst identifying gaps and violations without sanctioning governments.[27]

The ILO in collaboration with WHO created the "Code of Practice on HIV/AIDS and the World of Work*"* which provides "policy development and practical guidelines for programmes at enterprise, community and national levels" and this has helped in the coordination and efficacy of its activities.[28] The objective of this document is the prevention of the transmission of HIV/AIDS whilst supporting and giving help such as social assistance to those affected and infected with HIV/AIDS. It also helps fight stigma and discrimination against HIV/AIDS status

[22] WHO/UNAIDS, *'3 by 5' Initiative*, available at http://www.who.int/3by5/en/, accessed on 07 September 2014.
[23] Idem.
[24] See Note 19 above.
[25] ILO, (1996-2014), *Decent work agenda*, available at http://www.ilo.org/global/about-the-ilo/decent-work-agenda/lang--en/index.htm, accessed on 04 September 2014.
[26] The Constitution of the ILO adopted on 1st November 1945, art 10.
[27] Idem, Preamble of the Constitution of the ILO.
[28] ILO, *Code of Practice on HIV/AIDS and the World of Work*, available at http://www.ilo.org/aids/Publications/WCMS_113783/lang--en/index.htm, accessed on 04 September 2014.

among workers in their communities and enterprises in order to protect and promote their rights.

All the above constitutions, institutions and international documents refer to different human rights, especially those related to stigma and discrimination. They seek to promote access to health care and the right to health in general, as well as the respect of the right to confidentiality, respect and participation in decision making in the health care framework and reduction of stigma and discrimination. Therefore, the promotion and protection of these rights by international community is crucial for the management and control of HIV/AIDS and TB co-infection. The technical and financial assistance provided in developing countries have facilitated the access to health care and promotion of other rights of many of those who are living with these diseases.

Importantly, many states have applied international human rights principles and health guidelines in their Constitutions and referred to them in their national health plans. However, countries apply human rights principles with reservations and in different ways in their health care systems and their public health policies.[29] The main reason is that they fear taking full responsibility to ensure the right to treatment and care with their current lack of means. The rights based approach created in the 1990s by the United Nations Development Programme (UNDP)[30] and commitment and advocacy of civil society have challenged the governments' initiative in its health policies and contributed to the establishment of reflexive plans in the field of HIV/AIDS and TB. Therefore, South Africa has the duty to pursue the fulfillment of fundamental human rights arising from both the constitution and international instruments; especially the right to the health of its citizens.

3.3. The duties of the SA government: Legal challenges in HIV/AIDS and TB co-infection

[29] Fidler D P., (2001), *Geographical Morality Revisited: International Relations, International Law, and the Controversy over Placebo-Controlled HIV Clinical Trials in Developing Countries*, *Harvard International Law Journal 42: 299.*

[30] United Nations, *UN statement of common understanding of the human rights-based approach to development,* available at www.undp.org/governance/docs/HR_Guides_CommonUnder-standing.pdf, accessed on 07 September 2014.

3.3.1. Introduction

In accordance with the international human rights agreement,[31] the government of SA has the duty to protect the lives of its citizens and fulfil its obligations (both positive and negative) under domestic and international law. These rights should be fulfilled by limiting governments' interference with the criminal justice system and protecting the citizens under the criminal law system and also undertaking appropriate health measures to reduce diseases.[32] The international norms need to be domesticated at national level. SA is mandated under international laws to comply and be consistent in the creation of laws and health policies and to take precautionary measures towards health threats.

3.3.2. The right to health care

The most important human rights issue facing the SA government is access to health care.[33] This includes the access to reproductive health care and other necessary medical treatment or services, adequate sanitation, food, housing, comfortable working conditions and a healthy environment.[34] Furthermore, it should also provide a health system that offers protection to all citizens, and available, acceptable and accessible hospitals' services as well as medicines of good quality. Therefore, it is the responsibility of the government to provide these necessities in order to improve lives of those who are living with HIV/AIDS and TB co-infection. However, limited resources, the lack of the government's will in the field of these infections and the spread of these infections in the country continues to challenge the full realization of this right for those who are living with HIV/AIDS and TB.

The Constitutional Court has interpreted the principle of "progressive realization" to justify ensuring that the right to health care under the South African Constitution is achieved within the availability of resources.[35] Thus, the government is required to put in place effective and appropriate health policies and actions for the management and control of these infections in line with this right.[36]Moreover, in order to fight for the rights of people living with HIV/AIDS and TB, the TAC has also engaged the government on the matter of the separation of powers,

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[31] ICCPR, art. 6(1).
[32] Idem.
[33] The Constitution of RSA of Act 108 of 1996, Section 27 (1) a.
[34] Idem, sect 27 read with sect 24.
[35] *Minister of Health v Treatment Action Campaign No 2 2002 (5) SA 721 (CC)*.
[36] The Constitution requires the government to undertake different measures for the promotion and realization of the socio-economic rights. Section 27 (2) of the Constitution of RSA of Act 108 of 1996.

by asking the courts to examine government health policies and constitutional duties.[37] In the *Minister of Health and Others v Treatment Action Campaign and Others*,[38] the respondents sued the government because it failed to ensure the right of access to health care services including reproductive health care by providing Nevirapine[39] to curb mother to child transmission (MTCT) of HIV/AIDS among pregnant mothers living with HIV/AIDS. The High Court argued that the government's programme harmed the progressive realization of the right to health care services.[40]

In the case of *Van Biljon and Others v Minister of Correctional Services and others*[41], the four applicants (all prisoners) living with HIV sought orders declaring that "the right to adequate medical treatment" entitled them to receive anti-viral medication at state expense. The state has a duty to fulfil the right to dignity of detainees by providing them good health conditions such as adequate medical treatment[42] and this can be enforced by the constitutional right to health care services.[43] The courts held that the Department of Correctional Services had failed to justify why HAART has not been provided to the applicants and that such failure constitutes a breach to their constitutional rights. The reason for this is that antiretroviral medicines reduce a person's viral load.[44]"

Thus, when the government fails to meet its constitutional duties, the courts remind them to undertake adequate, understandable and open public health policies and measures with the purpose of accomplishing the right to accessing health care.[45] These cases affirm the commitment of courts and civil society in general to the implementation of adequate measures and policies in an attempt to protect the rights of people, especially those living with

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[37] Cullinan K., (2014), *AIDS conference returns to Durban in 2016*, in Health-e magazine, The SA Health service, available at http://www.health-e.org.za/2014/08/01/aids-conference-returns-durban-2016/?utm_source=rss&utm_medium=rss&utm_campaign=aids-conference-returns-durban-2016, accessed on 20 September 2014.

[38] *Minister of Health and Others v Treatment Action Campaign and Others* (No2) 2002 (5) SA 721 (CC).

[39] This drug is registered by Medicines Control Council of South Africa (MCCSA) since 1998 as an ARV which is used to prevent MTCT.

[40] *Minister of Health and Others v Treatment Action Campaign and Others* (No2) 2002 (5) SA 721 (CC), Para 35.

[41] 1997 (4) SA 441 (C).

[42] Section 35 (2) (e) of the Constitution of the RSA.

[43] Idem, Section 27 1(a).

[44] HPTN 052 is an important study which showed recently that when an HIV-positive person takes HAART, that person's partner is 96% less likely to become HIV-positive. See Cohen S.M (2011), *Prevention of HIV-1 by Early Antiretroviral Therapy, in New England Journal of Medical 2011; 365: 493-505.*

[45] *Minister of Health and Others v Treatment Action Campaign and Others (TAC)* (2002) 5 SA 721 (CC). Also with the same logic, in the case of *EN v Government of South Africa* 2007 1 ALL SA 74 (D), the court ordered the government to provide ARV for the treatment of prisoners in the Westville Prison.

HIV/AIDS, from acquiring opportunistic diseases such as TB.

3.3.3. Addressing socio-economic rights

South Africa's history has been marked by poverty, racial and economic inequalities which posed a range of difficult socio-economic and legal challenges to the new democratic state. It is, therefore, with the purpose of achieving social justice with equal rights to all, and fundamental human rights that these rights have been adopted within the Constitution.

The management of HIV and TB co-infection does not require only treatment but requires a holistic approach covering both the physiological and socio-economic dimensions. People living with HIV/AIDS are susceptible to opportunistic infections due to the crippling effect the virus has on the immune system. It is, therefore, important for them to live in a healthy environment that promotes good health.[46] The citizens' socio-economic rights are upheld by the Constitution, and evidence of the state's responsibility to fulfill its obligation in this regard is well documented in case law. In *Government of RSA and Others v Grootboom and Others*,[47] the Constitutional Court issued a declaratory order requiring the state to offer housing programmes to desperate citizens and noting that their realization of socio-economic rights helps citizens to enjoy other rights mentioned in the Bill of Rights.[48] Good housing,[49] food and water[50] is seen as a support to the reduction of infections transmitted due to living in overcrowded houses which can be associated with the overwhelming numbers of HIV/AIDS and TB co-infections countrywide.

Moreover, population health studies have clearly described the pathway linking the transmission of communicable diseases, in this case, HIV/AIDS and TB, to socio-economic issues, such as poverty, inadequate sanitation, overcrowded living conditions and poor nutrition.[51] The denial of good living conditions, education, children's nutrition and sanitation for HIV/AIDS and TB patients perpetuates inequality in society and also accelerates the transmission of these infections, which compromise with the achievement of social justice. A

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[46] Sect 24 of the Constitution of RSA, Act 105 of 1997.
[47] 2001(1) SA 46 (CC).
[48] Para 17.
[49] The Constitution of RSA, Act 105 of 1997, sect 26.
[50] Idem, sect 27.
[51] Garnett G P., & Anderson R M., (1993), *No reason for complacency about the potential demographic impact of AIDS in Africa,* Transactions of the Royal Society of Tropical Medicine and Hygiene, *87*(Supplementary 1), 19-22.

case in point is *Lee v Minister of Correctional Services,*[52] where the rights to prisoners to dignified prison conditions were violated.[53] The court held that it is a duty of the state to ensure that prisoners are not held in conditions which cause them to contact disease.[54] This could open the door for other litigation based on HIV/AIDS or TB transmission cases in public institutions where preventative measures or dignified living conditions are not adequately put in place. Another case worth mentioning is that of *Frank v The MEC for Health in KwaZulu-Natal,*[55] among the first cases of medical negligence resulting in HIV/AIDS transmission that was not related to other transmission means, for example, contaminated blood transfusion.[56] Although not directly related to socio-economic rights,[57] there is an emphasis on emergency treatment, access to health care services and the responsibilities of the state for its institutions and employees to provide adequate health conditions and protect its citizens.

There are other considerations which are important in the achievement of health care rights. One of these is the manner in which rape is dealt with. The Sexual Offences Amendment Act[58] provides HIV testing in case of sexual abuse in order to protect victims against trauma and to help them to make life decisions through access to PEP and termination of pregnancy. The Criminal Law Amendment Act[59] provides also for a higher minimum sentence (life imprisonment) for a rapist who knows he is HIV positive at the time of the rape. It also makes it more difficult for him to get bail. These measures help to discourage the spread of HIV/AIDS. Another issue is the achievement of good living conditions, such as good nutrition and good sanitation, which help to improve health for those who are taking ARVs and TB treatment drugs. The full realization of these rights is a successful key to the management of HIV/AIDS and TB co-infection. The state should take reasonable steps to improve access to socio-economic rights by the implementation of laws, policies and programmes for the enjoyment of these rights by those suffering of HIV/AIDS and TB despite the lack of resources.

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[52] Case CCT 20/ 12 (2012) ZACC 30.
[53] The Constitution of RSA, Act 105 of 1997, sect 35.
[54] Para 25.
[55] 2010, Case No 2958/02.
[56] *S v South African Blood Transfusion Services*, Strauss 1991, South African Practice Management 18.
[57] The Constitution of RSA, Act 105 of 1997, sect 27.
[58] Chapter 5 of the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007.
[59] Section 51(1&3) and part 1 of Schedule 2 to the Criminal Law Amendment Act 105 of 1997. See also *S v Snoti* 2007 1 SACR 660 (E).

3.3.4. Stigma and Unfair Discrimination

Stigma refers to a mark of disgrace or reproach on one's reputation,[60] while unfair discrimination refers to the imposition of burdens or withholds benefits or opportunities from any person on one of the prohibited grounds such as race, gender, sex, social origin, as stated in the Constitution.[61] However, both concepts refer to an action which is negative towards a person or a group of people and will be used interchangeably here. Stigma can be manifest in different dimensions in the domain of HIV/AIDS and TB. People associate this disease with death which leads to shame and fear for those affected and pushes them not to seek support, help, treatment and care.[62] Consequently, these external factors lead to the internal factors which can also constitute a dimension of this infection and creates isolation and psychological problems.[63] This is the case of many who have support from their families and communities, access to adequate health care services but who choose isolation as a way of living, seriously harming their health condition.[64] Stigma is also reinforced by poverty[65] and some medical procedures for diagnosis and treatment in the clinical area, which can also have a negative impact on the management of these infections. Moreover, it can be manifested by gestures and acts that need attention; stigma may be expressed by gossiping, defamation, or even attitude.[66]

Furthermore, both stigma and unfair discrimination have effects on HIV or TB diagnosis, adherence to treatment and fundamental human rights. Therefore, HIV/AIDS and TB patients may refuse to access health care services or even to disclose their status as they fear the stigma and discrimination exercised against them by society.[67] The Bill of Rights guarantees the recognition and protection of all citizens against stigma and unfair discrimination, regardless of their life status, race, sex and sexual orientation.[68] However, the rights of people vulnerable to

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[60] Oxford Dictionary available at http://www.oxforddictionaries.com/definition/english/stigma, accessed on 11 April 2015.
[61] Section 9 (3) of the Constitution of the RSA.
[62] Cameron E., (2005), *Normalising Testing, Normalising AIDS,* Forum Lecture, University of KwaZulu Natal, 4 May 2006.
[63] Idem.
[64] UNAIDS (2005), *Righting stigma: exploring a rights-based approach to addressing stigma*, AIDS and Human Rights Research Unit, Centre for the Study of Aids.
[65] Judge Cameron mentioned that he was only able to come out and disclose his HIV positive status without fear of both discrimination and stigma, because he was financially stable. However, he mentions that for the typical poor South African the fear of stigma and discrimination prevent that. See Cameron E., (2005) *Normalising Testing, Normalising AIDS,* Forum Lecture, University of KwaZulu Natal, 4 May 2006.
[66] Viljoen F., (2005), *Righting stigma: exploring a rights-based approach to addressing stigma*, AIDS and Human Rights Research Unit, Centre for the Study of Aids, University of Pretoria, Pretoria, p 89.
[67] Ibidem.
[68] Section 9(3) of the Constitution of the RSA.

HIV/AIDS, such as prisoners, drug users, (DU) commercial sex workers (CSW), women and homosexuals,[69] continue to be threatened by current policies and practices.[70] Mostly relating to HIV/AIDS and TB, stigma and discrimination reflect the "victimization and exclusion" of people infected by these infections in society.[71] This leads also to isolation, anger, frustration and, finally, the refusal to adhere to ART or TB treatment by those living with these diseases. Additionally, it has been also realized that stigma and unfair discrimination create negative effects[72] which can relate to the perception of the use of condoms among population, their sexual education, HIV/AIDS testing, support and treatment and, therefore, undermines the existing control of HIV/AIDS pandemic and its opportunistic infections such as TB.

Another form of unfair discrimination can occur in the workplace. The Employment Equity Act reinforces the Constitution [73] by prohibiting unfair discrimination based on HIV/AIDS status in the working area.[74] Similarly, the Promotion of Equality and Prevention of Unfair Discrimination Act[75] provides explicitly that no person may unfairly discriminate against an employee "in any employment policy or practice" on the basis of, amongst others, "HIV status".[76] The Labour Court may only permit HIV testing if testing is justifiable in the light of "medical facts, employment conditions, social policy, and the fair distribution of employee benefits or the inherent requirements of a job".[77] The Labour Court permits only anonymous voluntary HIV testing of employees.[78] However, HIV/AIDS patients can be subjected to unfair discrimination.[79] In *Hoffman,*[80] the plaintiff was found HIV positive, which was against policy by SAA. The Constitutional Court confirmed that SAA's refusal to employ based on an HIV-positive status was unfair discrimination and ordered that the plaintiff should be reinstated.[81]

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[69] I use this word to mean "*Gays and lesbians*".
[70] SA government argued that prostitution involves transmission of HIV and other STDs and has acted in favor of the prohibition of CSW. This attitude explain the beliefs in many people in the society towards CSW which may lead them to be discriminated. See *S v Jordan* 2002 6 SA 642 (CC), para 86.
[71] Gostin LO & Lazzarini L. (1997), *Prevention of HIV/AIDS among injection drug users: The theory and science of public health and criminal justice approaches to disease prevention*, *46 Emory Law Journal 587-644 648 677-682pp.*
[72] Viljoen F., (2005), *op cit*, p 46.
[73] Preamble of the Employment Equity Act No 55 of 1998 read with Section 9 of the Constitution of RSA of 1996.
[74] Employment Equity Act No 55 of 1998, sect 54(1).
[75] Act 4 0f 2000.
[76] Idem, sect 54(1).
[77] The Employment Equity Act No 55 of 1998, sect 7(1) (b).
[78] *Joy Mining Machinery Division of Harnischfeger SA v National Union of Metal Workers of South Africa* (2002) 4 BLLR 372 (LC).
[79] *Hoffman v SAA* 2001 (1) SA 1 (CC).
[80] Idem.
[81] Ibidem, para 15.

Although the law provides punishment for stigma and unfair discrimination against people living with this infection, nevertheless these issues persist across the country. Therefore, this calls for changing the mentality, behavior, and misconception around these diseases and for overcoming the "fear and shame" associated to HIV/AIDS and TB in the promotion of the HIV/AIDS and TB testing.[82] This can lead to the early treatment with HIV/AIDS and reduce the impact of opportunistic diseases such as TB among HIV positive patients.

3.4. The SA patent regime: The impact on ARV and TB drugs

As HIV/AIDS and TB continue to spread countrywide, there is a need for a sustainable and strong health care system in order to provide a basis for better management of these infections. Thus, the improvement of citizens' health conditions necessitates the availability of medicines and other materials for diagnosis and treatment of diseases. However, the relatively easy protection of patent rights,[83] which leads to the lack of affordable medicines for treatment of HIV and TB patients, continues to undermine the management and control programme for these diseases.[84] The limitation to patent rights and promotion of the access to good health care services through the availability of ARVs and TB drugs are important for the improvement of the health status of those who need them. This is crucial in the implementation of a good health programme which gives priority to human dignity and good health conditions over patent rights.

The majority of people worldwide are suffering from different diseases and still lack essential medical means for treatment.[85] In SA, the largest ARV programme worldwide is provided. While the world is still waiting for the cure for HIV/AIDS, effectiveness of ARVs has been

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[82] Ibidem.

[83] A patent right which is a form of intellectual property can be defined as "a set of exclusive rights granted by a sovereign state to an inventor or assignee for a limited period of time in exchange for detailed public disclosure of an invention". Moreover, an invention is a solution to a specific technological problem and is a product or a process which is protected under Intellectual property law. See WIPO (2008), Intellectual Property Handbook: Policy, Law and Use. Chapter 2: Fields of Intellectual Property Protection, available at mhttp://www.wipo.int/export/sites/www/about-ip/en/iprm/pdf/ch2.pdf, accessed on 30 March 2015.

[84] TAC (2014), *Campaigning Pro-Public Health Reform of South Africa's Patents Act*, available at http://www.tac.org.za/news/campaigning-pro-public-health-reform-south-africas-patents-act, accessed on 22 September 2014.

[85] Bezuhly M.et al (1997), *International Health Law*, 31 International Law 645, 657. The WHO estimates the lack of essential medicines by one third of the world's population especially in Africa and Asia. See WHO (2002), *The Rationale of Essential Medicines* (11 November 2002), available at http://www.who.int/medicines/rationale/shtml, accessed on 22 September 2014.

proved as the most important factor in the reduction of deaths among HIV/AIDS patients.[86] However, many people suffering from MDR and XDR-TB are struggling to access treatment. The lack of research to develop drugs for the treatment of MDR and XDR-TB and the strong protection of patent rights continue to undermine the effectiveness of the management of this infection among people living with HIV.[87] This is because patents create monopolies, and in the absence of competition from generic medicines manufacturers, the patent holders are able to inflate their prices to unaffordable levels. Further, most of the pharmaceutical companies awarded these patents rights are in developed countries and the research investment for new and improved medical products is likely to respond to health needs in their countries.[88]Therefore, achievement of the right of access to essential medicines as a fundamental right for the protection of HIV and TB patients necessitates the intervention of the state, pharmaceutical companies, research institutions, and trade companies.[89]

SA, like any other developing country, relies on an increasing amount of generic drugs [90] for treatment of HIV and TB. These medicines are cheaper than medicines under patent rights. However, the SA government has been accused of negligence in the implementation and respect of standards for granting patent rights.[91] As a result of this attitude, more patents have been granted in SA than in any other developing country, and most of these pharmaceutical companies receive "evergreening".[92] This means that a pharmaceutical company can obtain

[86] AIDS Law Project & The AIDS Legal Network (2001), *HIV/Aids and the Law: A Resource Manual* (2ed) 2001, p 25.

[87] A typical is that Zyvoxid of Pfizer costs R700/Pill. The registration of Linezolid of Hetero drug, a Zyvoxid's generic version is delaying and this limit access to treatment for MDR and XDR-TB patients. See Skelton D., (2014), *Medical council urged to speed up registration of generic drug for TB*, available at http://www.bdlive.co.za/national/health/2014/10/31/medical-council-urged-to-speed-up-registration-of-generic-drug-for-tb, accessed on 15 November 2014.

[88] This can be explained by the fact that 1,3 millions of patients died in 2012 because of TB; and on the other hand, its only drug come to the market since 1960. Also the pharmaceutical industries are interested by the health needs of rich people able to pay for their medicines than poor people, such is the case of ARV's and cancer drugs. See Vawda, Y. A. (2013), *13.Patent law in emerging economies: South Africa*. Emerging Markets and the World Patent Order, p 285.

[89] WHO (1996), *Evolving Public-Private Roles in the Pharmaceutical Sector,* A Report of an Informal Consultation, Geneva, Switzerland (15-18 April 1996), available at http://whqlibdoc.who.int/hq/1997/WHO_DAP_97.10.pdf, accessed 22 September 2014.

[90] Generic medicines are kind of medical products which are made and sold after the end of 20 years patent rights by other pharmaceutical companies. See also WIPO Intellectual Property Handbook: Policy, Law and Use, *Op cit.,* p 53.

[91] TAC (2014), *An activist guide to the fix the Patent Laws Campaign,* available at www.msf.org.za/fix-patent-laws, accessed on 24 September 2014.

[92] A crucial example is that in 2008, SA granted 2,442 patent rights to pharmaceutical companies in the country while Brazil granted 278 between 2003-2008. See Correa C. (2011), *Pharmaceutical innovation, incremental patenting and compulsory licensing*. Research Paper, South Centre.

several patents on the same product.[93] Hence, the prices of the necessary medicines for the treatment of these diseases are high and cannot be afforded and accessed by the state and by the majority of patients countrywide.[94] However, health problems in those developed countries are different from those identified in developing countries such as SA. Therefore, the strict control of patent rights is necessary to guarantee accessibility to medicine and curb the spread of these infections in the country, which will make effective the control programme and contribute to the achievement of social justice.

The protection of patent rights in SA has been inspired by the introduction of an international agreement, namely, the Trade-Related Aspects of Intellectual Property Rights (TRIPS) in 1997.[95] The WTO has recognized the impact of patent rights on the availability of medicines in developing countries and has agreed that the interpretation of the TRIPS agreement at the national level should be done in such a manner as to promote access to medicines for all people.[96] However, the limitation of patent rights in SA in order to protect the lives of its people and ensure social welfare especially those suffering from HIV and TB co-infection, continues to pose challenges to the control programme. This is the case with Abacivir, Zidovudine and Nevirapine, for example, which are necessary medications for the treatment of HIV and other linked diseases. After a long fight involving the TAC, the companies holding patent rights have agreed to deliver a license for generic pharmaceutical industries in order to create competition and reduce prices.[97] In 2003 companies with patents agreed, after a competent Commission investigation, to grant licenses to generic pharmaceutical companies to produce some ARVs, and in later negotiations, drugs for TB.[98] This is an important issue which can help the

[93] WIPO Intellectual Property Handbook: Policy, Law and Use, *op cit,* p 52.
[94] TAC (2014), *Campaigning Pro-Public Health Reform of South Africa's Patents Act,* available at http://www.tac.org.za/news/campaigning-pro-public-health-reform-south-africas-patents-act, accessed on 22 September 2014.
[95] TRIPS is an international agreement set by the World Trade Organization (WTO). It elaborates standards for the regulation of intellectual property (IP) for WTO member states. Therefore, SA as a member of the World Trade Organization (WTO) has signed TRIPS, which obliges country members to have some patent laws.
[96] After long mobilization of different activists, the WTO adopted the Doha Declaration on TRIPS in November 2001. See Vawda, Y. A. (2013), *op cit.*, p 285.
[97] The TAC launched complaints in 2002 and 2007 against different pharmaceutical companies with the Competition Commission (case no. 2012 Sep 226) concerning the excessive pricing of ARV's in SA. This lead to the deliverance of licenses to generic companies which contributed to the prices' reduction and lifesaving of HIV among patients. Abbott F.M et al (2013), *Emerging Markets and the World Patent Order*. Edward Elgar Publishing (eds).
[98] Eli Lilly allowed to supply of its technology to the world market of cycloserine and capremycin. See Woolman S., & Sprague C., *Aspen Pharmacare: How a Major Pharmaceutical Company Created a Sustainable Supply of Low Cost Generic ARVS for South Africa*. Available at ftp://ftp.emeraldinsight.com/Case/Case%20submissions%20by%20Region/Africa/Under%20review%20or%20awaiting%20revision/GIM%20final%20paper%201%20-%20Aspen%20Pharmacare,%20South%20Africa.doc,

government reduce the impact of HIV/AIDS, ensure realization of socio-economic rights countrywide.

Different strategies have been developed to bring about solutions in developing countries.[99] A price reduction has been proposed to pharmaceutical companies from Western countries for the promotion of access to ARV and TB drugs in developing countries.[100] It has also been recommended to states that they use "compulsory licenses" to promote generic production of ARV and other essential drugs.[101] The third strategy is to develop HIV vaccines and new HIV therapies and therapy regimens that are less expensive and easier to implement than existing treatments.[102]

The interpretation of the right to life recognised by the SA Constitution and its fulfilment raises the state's duties to guarantee to citizens access to essential medicine.[103] However, the patent right seeks to favour the process of investment and creation of new products by avoiding competition which leads to the maintenance of high prices.[104] It has been proven that competition law, use of courts and public mobilization are the most powerful means to achieve a price reduction in SA and to help the government to fulfill the constitutional right of access to medicine by all.[105] Therefore, this can be explained by the fact that the price of first line ARV's such as Zidovudine, Lamivudine and Nevirapine has reduced from R5 000 to R50 per month.[106]

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accessed on 15 November 2014.

[99] Fidler DP., (1999), *International law and infectious diseases*, Oxford: Clarendon Press, p 269.

[100] UNAIDS (2000), Report on the global HIV/AIDS Epidemic, supra note 1, Discussing price reductions for ARV's for use in developing countries at 100, in World Health Organization, (2011), *Global HIV/AIDS response: epidemic update and health sector progress towards universal access: progress report 2011*, Geneva, Switzerland.

[101] Idem, supra note 1, at 102-03. Discussing compulsory licensing in connection with HIV/AIDS drugs. This has been effective in Brazil and India. See also Rosenberg T (2001), *Look at Brazil*, New York Times, January 28, (magazine), at F26 "Reporting on Brazil's successful use of compulsory licensing in producing cheap generic HIV therapies and distributing them freely and widely to Brazilians living with HIV"; and G. McNeil Jr. D (2001), *Indian Company Offers to Supply AIDS Drugs at Low Cost in Africa*, New York Times, February 7, at Al "Reporting on Indian pharmaceutical company's offer to sell HIV therapies at a price far below that offered by Western pharmaceutical companies".

[102] Lurie P. & Wolfe S. (1997), *Unethical Trials of interventions to Reduce Perinatal Transmission of the Human Immunodeficient Virus in Developing Countries, 337 New England Journal of Medicine, p 853.*

[103] Article 11 of the Constitution of RSA. The fulfilment of the right to life necessitates undertaking positive measures by SA government. See UNHRC, General Comment 6 on the right to life (16 July 1982) in Garnett G P., & Anderson R M., (1993), *No reason for complacency about the potential demographic impact of AIDS in Africa,* Transactions of the Royal Society of Tropical Medicine and Hygiene, 87(Supplementary 1), 19-22.

[104] Donald C. & Michael J. (1992), *Understanding intellectual property law*, New York: Matthew Bender, p. 2-15.

[105] I refer this to the results brought by different activities of TAC for the patent rights revision.

[106] TAC (2014), *Campaigning Pro-Public Health Reform of South Africa's Patents Act,* available at http://www.tac.org.za/news/campaigning-pro-public-health-reform-south-africas-patents-act, accessed on 22

3.5. Conclusion

SA, as a developing countries with health care challenges, must reform its patent laws to facilitate access to the ARV and TB drugs necessary in the prevention and treatment of the HIV/AIDS and TB. The promotion and protection of the right to health and access to health care will continue to challenge the effort concentrated in the management of these infections until the economic development of the country reaches another stage and satisfies the expenses. Economic development will also increase resources and will allow the government to accelerate the progressive realization of socio-economic rights guaranteed by the constitution. Moreover, it is necessary also to understand the attitude of fear, guilt and hopelessness suffered by people living with HIV and TB co-infection which also creates stigma and discrimination against them in their community.

September 2014.

CHAPTER FOUR:
THE SA GOVERNMENT'S RESPONSE TO HIV/AIDS AND TB CO-INFECTION

4.1. Introduction

As discussed above, it is necessary for the government to create health policies which comply with international standards and guidelines for the reduction of the impact of these diseases in the country. Hence, the government has developed a National Strategic Plan (NSP) 2012-2016 with the purpose of preventing HIV, TB and STDs, basing it on well restructured targets. This chapter discusses the NSP and its compliance with international guidelines, provides challenges to and critiques to this plan and then suggests possible responses to this plan for the good management of these diseases.

4.2. The National Strategic Plan (NSP): Discovering SA efforts for the control of the HIV and related infections

The government's initiatives for the management and control of HIV/AIDS and its opportunistic infections have been the subject of criticism. However, the creation of the NSP 2012-2016 as an HIV/AIDS and related infections prevention programme has been a crucial response to this health challenge. This plan has been conceived with the purpose of ensuring progressive realisation of the rights provided by the Constitution based on available resources[1] and participating in the global health initiative for the control and management programme of HIV and related infections.[2] Moreover, it also upholds human rights with the purpose of meeting the achievement of universal access to treatment. This public health prevention, care and support programme includes actions such as education, management of STD's, counselling and testing of HIV, and the provision of preventative strategies.[3] The NSP aims for the fulfilment of four objectives:

1) "Addressing social and structural barriers that increase vulnerability to HIV, STI and TB prevention;
2) Preventing new HIV, STI and TB infections
3) Sustaining health and wellness; and

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[1] *Minister of Health and Others v Treatment Action Campaign and Others (TAC) (2002) 5 SA 721 (CC),* as well as also *Soobramoney v Minister of Health KZN 1998 (1) SA 765 (CC).*
[2] UNAIDS (2010), *Country progress report,* available at http://data.unaids.org/pub/report/2010/southafrica_2010_country_progress_report_en.pdf, accessed on 23 September 2014.
[3] South African National AIDS Council, (2011), p 16.

4) Increasing the protection of human rights and improving access to justice."[4]

The NSP 2012 - 2016 has a long-term vision for the country and refers to the universal standards and vision of UNAIDS.[5] This is the expression of the country's initiative and commitment to the world's partnership and vision for a better future characterized as having, "NO new HIV, TB and sexual transmission diseases (STDs), NO transmission of HIV and other STDs from a parent to an unborn baby, NO deaths caused by HIV, TB and STDs infections and finally NO discrimination of anyone based on their HIV, TB or STDs".[6] The vision of the NSP complies also with the priorities of the National Health Department, whose aim is the promotion of a healthy life, increased life expectancy, reduced maternal and child mortality, the fighting of HIV/AIDS and the reduction of the burden of infections like TB amongst the South African population and all those who live in the country.[7] A review of international and national strategic plans for HID/AIDS concluded that the NSP 2012 - 2016 has tried to redress the errors that occurred with the previous plan and that it plays a significant role in the fight against these diseases.[8] The monetary and human resources have increased as well as the mobilization of people living with HIV/AIDS; community participation strategy has been enhanced, which has reduced the gap between the intention and implementation of this policy. Hence, these improvements have contributed in the fight and reduction of the impact of these diseases countrywide.

4.3. The NSP and International Guidelines and Standards

As mentioned previously, UNAIDS acknowledged that there is no common understanding and practice which can be used as a guideline for supporting the standard of care and treatment on an international level.[9] The evaluation of the country's standard of care, prevention and treatment of HIV and TB co-infection can be complicated by comparing the principle of progressive realization of rights. However, international health guidelines provide minimum standards for this evaluation. These standards are constituted through consideration of fundamental human rights, community participation and consideration of vulnerable groups of

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[4] *Minister of Health and Others v Treatment Action Campaign and Others (TAC) (2002) 5 SA 721 (CC),* as well as also *Soobramoney v Minister of Health KZN 1998 (1) SA 765 (CC).*
[5] Ibidem.
[6] Ibidem.
[7] Department of Health, *Health priorities*, http://www.health.gov.za/index.php, accessed on 10 September 2014.
[8] Gruskin, S., & Tarantola, D. (2008), *Universal access to HIV prevention, treatment and care: assessing the inclusion of human rights in international and national strategic plans*, AIDS (London, England), 22 (Suppl 2), S123. Available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3356157/pdf/nihms313903.pdf, accessed 4 September 2014.
[9] UNAIDS (2000), *Ethical considerations in HIV preventive vaccine research, supra* note 64, at 41.

people in order to undertake effective measurement of the management of the HIV and TB co-infection.[10] Similarly, the NSP also recognizes the role of community participation in decision making concerning management of HIV and TB co-infection.[11] This involves educating many people through mass mobilization, sharing of information concerning HIV/AIDS and delivery of condoms to the population in need.[12]

Most international organizations such as UNAIDS and the ILO suggest strict respect of the right to privacy and confidentiality in the clinical area in order to reduce stigma and discrimination.[13] This is highlighted by the promotion of the access to justice and human rights as one of the objectives of the NSP for the management and control of HIV and opportunistic diseases. Hence, the presence of stigma and discrimination can be used as an indicator for the monitoring and evaluation of the respect and promotion of fundamental human rights in the strategic plans of the states.

Another indicator in the global health initiatives against HIV/AIDS is the emphasis on the coordination of activities for international participation in the development of strategic planning and operational guidance on the national and international level.[14] Therefore, the NSP has also been elaborated after consultation with different stakeholders. The fact that this plan aims to inform and educate the community proves that it targets vulnerable or marginalized groups at high risk of transmission of infection because of the lack of adequate health care infrastructures or even cultural barriers.[15] While the WHO standards recommend to countries a goal of 80 % for the successful completion of TB treatment completion, the SA rate was 60 % in 2009.[16] This seems to indicate the necessity of the government's taking of serious measures to reduce deaths among people living with HIV/AIDS, whilst reducing the occurrence of new infections and opportunistic infections like TB.

In conclusion, it also requires public health policies for these infections to put into practice sexual education and information, access to health care services, and respect and promotion of

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[10] See Note 8 above.
[11] The protection of Human rights in order to improve the access to justice. See The National strategic Plan (NSP) 2012-2016, p 15, available at http://sanac.org.za/nsp/the-national-strategic-plan, accessed on 09 September 2014.
[12] Idem.
[13] ILO (2001), *Code of Practice on HIV/AIDS and the World of Work*, available http://www.ilo.org/aids/Publications/WCMS_113783/lang--en/index.htm, accessed on 04 September 2014.
[14] Pieterse, M., (2011), *Disentangling illness, crime and morality: Towards a rights-based approach to HIV prevention in Africa, African Human Rights Law Journal 11.1.*
[15] Idem.
[16] Gandhi N.R., et al., (2009), *Op cit,* p12.

human rights. Consequently, these issues continue to undermine public health policies for HIV prevention and necessitate the putting of much effort for these implementation.[17] These issues are discussed in the following section.

4.4. Challenges to the NSP

Over a long period of time, SA efforts have been challenged by lack of participation by vulnerable communities, the discrimination against different groups of people and the lack of justice in accessing healthcare.[18] In *Minister of Health and others v Treatment Action Campaign*,[19] the Constitutional Court has proposed minimum criteria for the evaluation of health measures taken by the government, if they are reasonable to achieve socio-economic rights identified in section 26 and section 27 of the Constitution on a progressive basis.[20] Therefore, these criteria are important as they help to determine whether public health policies undertaken by the state respond to reasonable health needs and to the degree of threat of infections.[21] Similarly, the Court's decisions [22] can also help to evaluate the degree shown for the respect of a public health policy towards the issues of the stigma and discrimination and other human rights.

However, the results of the government's response and commitment to HIV management since 2007 in terms of the implementation of the NSP has shown negligence and a lack of will and coordination between the government and different actors over three decades.[23] The government has tried to cut the budget of the programme, which has resulted in the unsustainability of the project.[24] Moreover, the limited budget, which itself is not enough to realize the aims of this programme, is sometimes diverted from its real targets, thus

[17] Idem.
[18] Gruskin, S & Tarantola D., (2008), *op cit,* p 20.
[19] *Minister of Health and Others v Treatment Action Campaign and Others* (NO2) 2002 (5) SA721 (CC).
[20] Liebenberg S. (2002), *South Africa's Evolving Jurisprudence on Socio-Economic Rights: An Effective Tool in Challenging Poverty*, 6 Law Democracy and Development, 174-76.
[21] Idem.
[22] For example, SA government argued that prostitution involves transmission of HIV and other STDs and has acted in favor of the prohibition of CSW. This attitude explain the beliefs in many people in the society towards CSW which may lead them to be discriminated. See *S v Jordan* 2002 6 SA 642 (CC), para 86. Moreover, the courts also were concerned by institutions' policies. Thus, in *Hoffman v SAA* 2001 (1) SA 1 (CC), the Constitutional Court held that the SAA's policy to disqualify people on the ground of HIV status were not reasonable and against the rights guaranteed by the Constitutional, and current employment policies. Similarly, in *Minister of health, Western Cape v Goliath & others* 2009(2) SA248(C), the High Court has affirmed that the Bill of Rights can be restricted for the protection of public health interests (para 19).
[23] Wouters E. et al, (2010), *op cit,* p 185.
[24] Idem, p 186.

undermining its implementation.[25] These challenges have been raised by NGOs and other civil society groups, who have pointed out that similar issues with previous plans prevented success. They have addressed the government in order to improve commitment for this new programme. In addition, the weak health care system in the country can delay the implementation of the NSP. The effectiveness of the programme is compromised by the lack of appropriate sanitation and adequate personnel. Finally, while the NSP identifies populations traditionally at risk, such as intravenous drug users (IDU), men having sex with men (MSM) and commercial sex workers (CSW), these vulnerable groups are not well identified in the country. For example, data collected in 1996 and 1998 on all female CSW in the Hillbrow area of Johannesburg showed a 45% HIV prevalence among this group.[26] However, according to UNAIDS, no further data on CSW has been gathered since then.[27]

4.5. Responding to the NSP challenges

The full realization of economic, social and cultural rights guaranteed by the Constitution is still a major challenge to the government with regard to the management of these infections. However, the prioritization of the respect for human rights and access to justice as major targets by the NSP is a crucial issue for better management of the HIV-TB co-infection countrywide.[28] These rights will be achieved through various activities concerning sexual education, counselling as well as information on HIV and their rights among marginalized and vulnerable groups of people such as women, children and CSW. Also, there is a need to identify those groups, and to collect data regarding their numbers and other relevant information concerning HIV and TB co-infection among them. Furthermore, there is a need for a reconsideration of sexual education, reproductive health and focus on the challenge of behavior related to sexual orientation and gender disparities.

There has been an improvement in coordination, communication and partnership between the government and civil society for the implementation of the programme.[29] However, there is a need for collaboration between the political authorities and all actors involved in order to

[25] Gruskin, S & Tarantola D., (2008), *op cit,* p 14.
[26] Rees H. et al (2000), *Commercial sex workers in Johannesburg: risk behavior and HIV status*, *In South African Journal of Science (96): 283-284.*
[27] Epidemiological Fact Sheet in HIV and AIDS (2008), *Core data on epidemiology and response* (updated).
[28] The National strategic Plan (NSP) 2012-2016, p 15, available at http://sanac.org.za/nsp/the-national-strategic-plan, accessed on 09 September 2014.
[29] Wouters E. et al, (2010), *op cit.,* p 186.

consolidate or strengthen the activities which can lead to the realization of the objectives of this programme. The NSP is the result of long discussion with different stakeholders such as representatives of government, academics, international organizations and others.[30] With the government increasing its initiatives to find adequate solutions for HIV/AIDS, sometimes as a result of the mobilization of different civil actors such as the TAC;[31] the commitment of the government is acknowledgeable for the future implementation of the HIV programme comparing to previous plans.

The NSP 2012-2016 is one of the most open programmes in the country and the accountability has been the key for the community participation in the full realization of its objectives. Thus, in this regard Médecins sans frontières (MSF) has been involved in the follow up on how the budget for health care system is used across the country and has monitored the developed programme and health care needs.[32]

4.6. Conclusion

As HIV/AIDS is a pandemic it requires collaboration between governments and different partners on national, regional and international levels. It is necessary to consider the gap between elaborated health policies concerning these infections, and its implementation. This need consolidation of the health care system where patients' rights will be protected, promoted leading to an intensive monitoring and evaluation of all activities undertaken in order to ensure the good planning of the programme.

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[30] Idem, p 180.
[31] Idem*.,* p 179.
[32] Médecins Sans Frontières, (2007), *Help wanted, confronting the health care worker crisis to expand access to HIV/AIDS treatment: MSF experience in Southern Africa*, Johannesburg: Médecins Sans Frontières. Also, TAC has suggested that the budget to fight HIV and related disease should not be reduced on the reasons of economic crisis because the pandemic is not under "recession." See also Treatment Action Campaign (TAC), (2009), *HIV is not in recession: TAC and other PWA activists demonstrate peacefully at the IV Southern African AIDS Conference,* IV Southern African AIDS Conference, Durban, South Africa.

CHAPTER FIVE:
CONCLUDING REMARKS AND RECOMMENDATIONS

5.1. Conclusion

HIV/AIDS and TB are catastrophic epidemics that have devastating effects on the health of the population and their impact extends to the denial of human rights. The effect of these infections has a ripple effect through society thereby impacting on the socioeconomic development of the country.

The devastation of HIV/ AIDS has caused more than 250,000 deaths during 2013[1] This great number of deaths can be attributed to the nature of the infection, which cripples the immune system making it susceptible to a wide number of opportunistic diseases, of which TB is the most prominent. However, the death toll due to HIV/AIDS and TB could have been minimized through targeted public health measures that emphasize adherence to interventions like PMTCT and ARV therapy, as well as better medical interventions to treat sexually transmitted infections.

Public health provisions with a twofold approach towards the prevention and treatment of HIV/AIDS and TB will ensure a safe working environment for healthcare workers. These interventions will be successful with the support of political authorities, prominent members of the communities and other change agents. Moreover, it is through a unified approach towards the transmission, prevention and treatment of these diseases that the undertakings of the public health care system will be fully realized.

The legal system has also made provision to support the initiatives of the state and state agents in dealing with the transmission, prevention and treatment of HIV/AIDS and TB co-infection. In terms of HIV/AIDS and TB, this provision of the law requires that the state, the medical fraternity as well as individuals can be held accountable for the prevention and treatment of HIV/AIDS and TB. Promoting access to justice and understanding the law is therefore critical to the promotion and protection of human rights, and important in upholding the fourth objective of the NSP, and this will be always reinforced by the interpretation of courts'

[1] Cullinan K., (2014), *AIDS still extracting a deadly price, but SA is making progress, The South African Health Service,* available at http://www.health-e.org.za/2014/07/23/aids-still-extracting-deadly-price-sa-making-progress/, accessed on 05 October 2014.

decisions.[2] Furthermore, the issues of stigma and unfair discrimination have been manifested in society in the form of various factors such as abuse, denial from participating in certain work, fear and shame by those living with HIV/AIDS and TB. The government has to enforce HIV testing policies, provide condoms, and elaborate and insert curriculum on HIV/AIDS and sexual education in schools. Moreover, further development and implementation of sexual education by educational institutions can help in the reduction of the impact of stigma and unfair discrimination on those living with HIV/AIDS and TB in clinical areas and workplaces; and also improve management of those diseases among people that are prone to infection such as drug users, CSW, prisoners and homosexuals.

The threat posed by HIV/AIDS and TB co-infection translates to a serious threat to the population's health. Without interventions that address improved quality drugs at cost effective prices that enable supply to all those who need it, the South African government is at best not upholding the right to health of all its citizens. The reinforcement of the NSP is progressively addressing socio-economic challenges that HIV/AIDS and TB co-infection pose to economic development. Once health policies are fully operational and inclusive of prevention, treatment, adequate resources and the infrastructure, the health of millions of South Africans will be preserved.[3] However, much work still needs to be done as resources need to be managed and employed in a manner which is logical and economical, so as to ensure that spending is results-driven and directed at vulnerable areas and therefore meets the human rights objectives in the face of HIV/AIDS and TB co-infection. [4]

5.2. Recommendations

5.2.1. Recommendations to political leaders

Political leaders as role models in society should increase their involvement in public activities and campaigns, which focus on informing and educating on HIV and TB, such as male circumcision, the use of condoms and health screening tests.

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[2] The protection of Human rights in order to improve the access to justice. See The National Strategic Plan (NSP) 2012-2016, p 15. Available at http://sanac.org.za/nsp/the-national-strategic-plan, accessed on 09 September 2014.
[3] Pieterse M., (2011), *op cit.,* p 15.
[4] Chirwa DM, (2003), *op cit.,* p 22.

5.2.2. Recommendations to the government

5.2.2.1. Maintaining social grants for HIV/AIDS and TB co-infection patients

It has become necessary for the South African government to recognize the vulnerability of those living with HIV/AIDS and subsequently to qualify HIV/AIDS as a disability, thus allowing them access to a "disability grant".[5] Maintaining social grants in case of hospitalization of HIV patients and those co-infected with XDR-TB or, if possible increasing the value of the grant, could in part serve as an attractive measure in diagnosis and treatment of the HIV and TB co-infection as indicated below.

Firstly, the maintenance of social grants could serve as an incentive for patients to adhere to the treatment especially in the case of hospitalization which could take a long period. The suspension of social grants in instances of hospitalization could push patients to refuse treatment or to be inconsistent in their adherence to the treatment. Secondly, increasing social grants may in this context help to improve treatment outcomes. This may be done for all people living with HIV to improve their living conditions, improve their adherence to ART treatment and thus reduce their susceptibility to opportunistic diseases such as TB.

Government needs to also pay attention to addressing structural barriers to the management of HIV and TB co-infection through increasing resource spending in the management of these diseases, sustaining and increasing health care workers qualified in the domain of HIV and TB, and possibly also increasing equipment needed for the diagnosis and treatment.

5.2.2.2. The use of "Compulsory licensing"

There is a necessity that public health should be given consideration over patent rights in order to protect the rights of those people suffering from HIV and TB co-infection. It is recommended that "compulsory licensing[6]" of pharmaceutical patents is applied as a means to save the lives of many patients.The patent offices should set strict and specific conditions on granting patents on drugs needed for the prevention and treatment of these diseases Moreover, the patent applications should be thoroughly examined by the patent office, to eliminate

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[5] Pieterse, M., & Hassim, A. (2009), *Placing human rights at the centre of public health: a critique of Minister of Health, Western Cape v Goliath: notes*, *South African Law Journal, 126(2), 231-245.*

[6] Compulsory licensing is allowed with limited conditions under Section 56 of the Patents Act. However, South Africa has never delivered "compulsory license" for any medication. See TAC, *Campaigning Pro-Public Health Reform of South Africa's Patents Act*, available at http://www.tac.org.za/news/campaigning-pro-public-health-reform-south-africas-patents-act, accessed on 22 September 2014.b

undeserving patents through ‘evergreening’. This can be inspired by the model of Brazil and Paraguay where this has contributed to the regulation of patent rights on medicines which in turn resulted in the reduction of deaths due to HIV and TB. [7]

5.2.2.3.Identification and support to vulnerable groups

Data among certain vulnerable groups is extremely limited and this in turn limits the ability to facilitate activities for the control of these infections among them. Therefore, it is recommended that data should be collected on CSW, MSM and IDU. This will help in the orientation of health activities and the undertaking of reflexive measures on their behalf.

5.2.3. Recommendations to courts

In the line of duty, the government is the first step towards the realization of the rights and it is only when it is alleged that the government has failed to fulfill its commitment that the matter is taken to court. Therefore, the role of the courts in SA is crucial to the implementation of the rights of people living with HIV and TB. The courts also should seek to enforce laws set in place to punish offenders who contravene laws created for the eradication of stigma and discrimination, than try to reduce the spread of HIV and TB. They should challenge the government by interpreting of the laws and policies to ensure the protection of rights of people living with HIV/AIDS and TB co-infection.

5.3. Conclusion

This is a descriptive, exploratory study. The study has provided insights into the challenges of HIV and TB co-infection in South Africa. It has described the challenges regarding HIV and TB co-infection in the clinical and ethical spheres and in the field of law by looking at international and domestic legislation as well as guidelines. It has linked the issue of patent rights to not only the challenges of HIV/AIDS but also of TB, which has been neglected in the literature.

The study has also considered the role of counselling in diagnosis and treatment of HIV and TB co-infection, the importance of maintenance and increase of social benefits for patients living with HIV and TB co-infection and the impact of ARV and TB drugs on management of HIV and TB. The study has interpreted the courts’ decisions for a deep understanding of the

[7] Correa, CM (2007), *Guidelines for the examination of pharmaceutical patents: developing a public health perspective*, ICTSD.

protection of human rights of those living with HIV and TB and made recommendations.

In this way this dissertation has made a contribution to the existing body of knowledge regarding the legal implications of HIV and TB co-infection with a novel focus on co-infection.

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