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South Africa's HIV and AIDS Policy and Legislation: An Analysis

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Research Article

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ABSTRACT

In contrast with the HIV and AIDS policy formulation trend in first decade of attaining democracy in South Africa, recent policy and legislation regarding HIV and AIDS show great determination by Government in reversing the epidemic. The South African Government's present collaboration with civil society demonstrates an understanding that the fight against HIV and AIDS is a shared responsibility. While paying attention to various groups, women, children and men in particular, this desk review paper argues that South Africa has adopted sound HIV and AIDS policy and legislation but its main challenge remains that of implementation.

Keywords: HIV and AIDS; policy, legislation, ARVs, PMTCT, Circumcision.

1 BACKGROUND

1.1 Global and regional and national facts about HIV and AIDS

Recent studies on HIV and AIDS indicate that Sub-Saharan Africa is the worst affected region and the Southern African countries had the highest rates of infection in 2008. Out of a total of 33.4 million living with HIV and AIDS globally, Sub-Saharan Africa had contributed 22.4 million to that number. The Sub-Saharan Africa Region accounted for: 67% of HIV infections; 68% of new infections among adults and 90% among children and 72% of AIDS-related deaths. About 5.7 million people in South Africa were estimated to be infected with HIV, the highest in Southern Africa and globally (UNAIDS, 2009a). In 2007, there were about 350 000 people believed to have died from AIDS in South Africa (UNAIDSa, 2008). This could be attributed to South Africa's high population prevalence of HIV infection and high-risk heterosexual behaviour; the practice of having multiple concurrent sexual partners, unprotected sex and sexual relations with persons whose HIV status is not known; high levels of sexually transmitted infections; population mobility patterns; high HIV viral loads coupled with recent HIV infections or advanced HIV disease and high levels of vulnerability due to poor socio-economic conditions (Matjila et al, 2008).

1.2 Global and regional policies

Combating HIV and AIDS, malaria and other diseases is one of the Millennium Development Goals (United Nations, 2002), which entails stopping and reversing the spread of HIV and AIDS by 2015 and achieving universal access to the treatment for HIV and AIDS by 2010. The Joint United Nations Programme for HIV and AIDS (UNAIDS) has developed many international policies and guidelines on HIV and AIDS that nations adopt in their respective countries. The policies advocated cover a whole range of issues including orphans and vulnerable children; HIV prevention and treatment; gender and HIV; PMTCT; women and girls; testing and counselling. The following paragraphs discuss a few of these policies.

In the area of gender and HIV, UNAIDS developed in 2009, an action framework entitled the UNAIDS Action Framework: Addressing Women, Girls, Gender Equality and HIV. Published in 2009, this policy addresses women and girls taking into consideration the persistent gender inequality and human rights violations that put women and girls at greater risk and vulnerability to HIV. This policy is in view of protecting the gains that have been made in preventing the spread of HIV and increasing the rate of access to antiretroviral treatment. The Action Framework seeks, first, strengthening strategic guidance and support to national partners regarding their knowledge, understanding and response to the particular and various effects of the HIV epidemic so that they can effectively meet the needs of women and girls. Second, Action Framework is designed to help countries to ensure that national HIV and development strategies, operational plans, monitoring and evaluation systems etc address the needs and rights of women and girls in the context of HIV. Third and last, it ensures that

comprehensive measures are taken to ensure that the needs and rights of women and girls are met in the context of HIV. In the same year (2009), UNAIDS also issued the Operational Plan for UNAIDS Action Framework: addressing women, girls, gender equality and HIV, which is structured around the above-mentioned three issues. It also urges each country to identify actions relevant to their context such as "empowering leadership of women and girls, especially women and girls living with HIV, access to integrated HIV and sexual and reproductive health services, addressing violence against women and girls and addressing the needs of marginalised women and girls", (UNAIDS, 2009c, p. iv).

In collaboration with the United Nations Development Programmes (UNDP), UNAIDS has recently developed a policy entitled Criminalization of HIV Transmission (issued in August 2008). This policy serves as a guide to governments, civil society and other partners regarding the general application of criminal law to those who transmit or expose others to HIV infection. Using the human rights approach, the policy maintains that the criminal law to HIV transmission punishes harmful conduct by imposing criminal penalties and prevents HIV transmission through deterrence or changing of risk behaviours (UNAIDS, 2009b).

In line with the Millennium Development Goals of both reducing chronic hunger and halting and reversing the spread of HIV by 2015, UNAIDS in collaboration with the World Food Programme (WFP) and World Health Organization (WHO) developed the HIV, Food Security and Nutrition policy in 2008. This policy was meant to guide governments, civil societies and other partners on how to deal with issues of food and nutrition in the context of HIV. Since HIV impairs nutritious status by undermining the immune system and nutrient intake, absorption and use in particular, the policy states that food and good nutrition should be available for people living with HIV so that they can both be in a position to resist opportunistic infections such as tuberculosis and to achieve the full benefits of antiretroviral treatment. Given that malnutrition increases fatigue and reduces physical activity in people living with HIV, eroding their household livelihoods since they become too weak to earn an income for food, the policy calls stakeholders to put care, support and impact mitigation measures in response to this need (UNAIDS, 2008b).

In 2000, the region of Southern African Development Countries (SADC) issued a policy entitled Managing the Impact of HIV and AIDS in SADC in 2000 (SADC, 2000). Using the multi-sectoral approach to tackling the epidemic, the policy provided a strategic framework for strengthening the response to the HIV and AIDS epidemic in the region. The framework was developed in the context of achieving the SADC HIV and AIDS overarching goal of "decreasing the number of HIV and AIDS infected and affected individuals and families in the SADC Region so that HIV and AIDS is no longer a threat to public health and to the socio-economic development of Member States", (Southern African Development Countries, 2000, p. 2). This goal was to be achieved through four main objectives: first, reducing and preventing the incidence of HIV infection among the most vulnerable groups in the region; second, mitigating the socio-economic impact of HIV and AIDS; third, reviewing, developing and harmonising policies and legislation regarding prevention and control of HIV and AIDS transmission; fourth, mobilizing and coordinating resources for the HIV and AIDS multi-sectoral response in the region. The policy recognised Governments, Non-Governmental Organisations (NGOs) and the private sector as the main actors in the HIV and AIDS response in the region (Southern African Development Countries, 2000).

South Africa, like most of the countries, participates in the formulation of these global and regional policies. It also adopts and adapts these policies within its national context.

1.3 National Policies on HIV and AIDS

Since its attainment of democracy, South Africa has formulated several policies and legislative acts that address the HIV and AIDS epidemic. The policies in the first decade of attaining democracy are well documented and authors are generally critical of the poor response of the Government to the epidemic. Butler (2005), Johnson (2005) and Schneider (2002) discuss some of these policies at length. In contrast, recent policies have indicated a shift in policy as government and civil society demonstrate more collaboration than before. According to Stevens et al. (2007), the HIV & AIDS and STI Strategic Plan for South Africa 2007-2011, represents a broad consensus for an effective national response to the HIV and AIDS as well as other epidemics.

2 POLICIES RELATING TO WOMEN

The Prevention-of-Mother-to-Child-Transmission (PMTCT) programme, Voluntary Counselling and Testing (VCT) and Antiretroviral therapy (ART) and their implementation challenges constitute the main debate regarding women and HIV and AIDS policy and legislation.

2.1 National PMTCT policy

2.1.1 Priorities

In 2008, the National Department of Health released a document on the Policy and Guidelines for the Implementation of the PMTCT Programme in order to provide an update on the approach to the implementation

of the National PMTCT programme. The updated policy outlines four stages of PMTCT, in line with the international standards for a comprehensive PMTCT strategy, namely:

- Primary prevention of HIV especially among women of childbearing age;
- Preventing unintended pregnancies among women living with HIV;
- Preventing HIV transmission from a woman living with HIV to her infant;
- Providing appropriate treatment, care and support to women living with HIV and their children and families. (National Department of Health, 2008, p. 13).

While these four goals are international basic recommendations, the recent National PMTCT programme prioritises the primary prevention of HIV among women of childbearing age and the providing of appropriate treatment, care and support to women living with their children and families. The policy considers it important to involve civil society in the implementation programme, (National Department of Health, 2008). In July 2008, dual therapy with Niverapine and AZT was introduced for the PMTCT.

This recent PMTCT policy update is in line with the current HIV and AIDS and STI National Strategic Plan in which PMTCT also features as the third goal to be achieved through two main objectives: firstly, the broadening of existing mother to child transmission services so that they include other related services and target groups and secondly, increasing coverage and improving quality of PMTCT to reduce MTCT to less than 5% by 2011 (South African National AIDS Council, 2007). In 2010, the Department of Health and the South African National AIDS Council issued guidelines on the management of PMTCT entitled Clinical Guidelines: PMTCT (Prevention of Mother-to-Child Transmission). According to the Minister of Health, Dr Aaron Motsoaledi, these guidelines are meant "to serve as a new guide to health practitioners with regard to the comprehensive management of pregnant women who are HIV positive," (Department of Health and South African National AIDS Council, 2010, p.1). This document gives an update of the national PMTCT policy guidelines and intends to provide continual guidance regarding reducing the vertical transmission of HIV, building on work done since the launching of the programme and the 2008 Policy and Guidelines document (Department of Health and South African National AIDS Council, 2010).

2.1.2 PMTCT Implementation

Although South Africa now has the largest PMTCT programme in Africa, with more than 90% of its primary health care centres offering PMTCT services by 2008 (National Department of Health, 2008), effective implementation remains a challenge. While access to PMTCT increased from 6.9% in 2001/2 to 69.2% in 2006/7, access to ART among adults only increased from 3.8% in 2002/3 to 34% in 2006/7 (Johnson, 2009). The Department of Health's annual antenatal survey for HIV and AIDS showed that on its 2008 sample of 33, 488 women attending 1, 415 antenatal clinics in all the nine provinces, 28% were estimated to be living with HIV. Provinces of KwaZulu-Natal, Mpumalanga and Free State recorded the highest HIV rates, while the Northern Cape and Western Cape recorded the lowest prevalence (National Department of Health, 2009).

The success of the present policy will be measured by its ability to address challenges that have, for long, negatively impacted on the implementation of PMTCT. According to Paradath et al. (2006), there was poor postnatal follow-up, especially in rural areas. A significant proportion of women attending PMTCT services were not offered testing due to shortages of counsellors, testing supplies and consent forms (Nkonki et al., 2007). Poor implementation was also due to the fact that the programme was implemented vertically and without any proper integration into the health care system (Beksinska et al., 2006). Furthermore, the majority of South African HIV-infected women lacked proper information for decision making regarding pregnancy and childbirth issues since there were some negative factors and obstacles to pregnancy prevention and others were unable to access condoms and contraception consistently (Ramkissoon et al, 2006).

2.2 New HIV and AIDS Policy

The recent HIV and AIDS policy announced by President Jacob Zuma on the World AIDS Day of 2009 shows how determined the South African Government is to prevent the transmission of HIV from mother-to-child. Within the old policy, HIV positive pregnant women were eligible for treatment if their CD4 count was less than 200, whilst the new policy, which came into effect on 1st April 2010, states that all pregnant HIV positive women with a CD4 count of 350 or who merely show symptoms regardless of CD4 count, can access treatment. The policy also provides that all other HIV positive pregnant women who do not fall under this category can now access treatment at 14 weeks of pregnancy in order to protect the baby, instead of at the last term of pregnancy as per the old policy (Zuma, 2009). With this policy, South Africa shifted from the ART rationing model recommended by WHO (that of CD4 count of 200) to the one recommended by the US Department of Health and Human Services (of CD4 count of 350) which would increase access to ART from 9.5% to 56.3% (Rosen et al., 2005).

2.3 Legislation

2.3.1 The National Health Act (Act 61 of 2003)

In general, the National Health Act (Act 61 of 2003) provides a framework for a structured uniform system within South Africa according to the obligations imposed by the Constitution and other laws on the national, provincial and local governments with regards to health services, (Republic of South Africa, 2004). Chapter one reaffirms the right of access of pregnant women and children below the age of six to free health services and of all persons to free primary health care services, unless they are covered by a medical aid scheme. However, Government's delay in implementing certain sections of the Act can defeat the original purpose intended; for example, the delay in implementing Certificates of Need provided for in Section 36 (Gray and Jack, 2008). The Certificate of Need is meant to increase the coverage of health establishments in the country.

2.3.2 Choice of Termination of Pregnancy Act, (as amended)

The Choice of Termination of Pregnancy (Act 96 of 1996) amended in 2008 (Act 1 of 2008), (hereafter referred to as TOP), was passed in order to increase access to reproductive health care services. The Act was amended in view of delegating the monitoring, implementation and functioning of TOP from national to provincial levels.[5]

It recognises the decision to have children as fundamental to a woman's physical, psychological and social health. TOP provides that a woman does not need consent from her husband or partner before she has a termination. Section 1 of the Act defines a woman as a female of any age. This means that ages of consent in terms of the Children's Act (as amended) do not apply to girls requesting a termination of pregnancy. Important is that the woman/girl should have the capacity to give the required consent. It also implies that no parental or guardian assistance is needed at any stage unless the girl agrees to do so. The Act makes provision for an abortion up to 12 weeks gestational age and after 20 weeks but under specified conditions (Republic of South Africa, 1996).

HIV-positive women who choose to terminate their pregnancies in order to safeguard their health may find this legislation helpful; conversely, it has several implementation challenges. There has been an improvement in terms of abortion facilities since this law came in force. By 2006, 90% of the designated TOP facilities were public hospitals, though some of them were not functional (Shung King et al, 2006). Gray and Jack (2008) state that about half of the women in South Africa were still not aware of this law and the majority of those who did hardly had enough knowledge to access a legal TOP. In addition to these challenges, there are reported cases of some health workers refusing to provide TOP services due to their ethical belief system. In other cases, women with HIV suffered discrimination from health workers when seeking services related to TOP (Ramkissoon et al, 2006). There are also instances whereby HIV-women seeking TOP services were reported to have been sterilised without their permission (De Bruyn, 2006). Since HIV testing at antenatal services are normally done at about 14 weeks gestation, late termination involving labour cannot, unfortunately, be avoided by women that seek TOP services at this advanced stage (Thom, 2003).

2.3.3 Criminal Law (Sexual Offences and Related Matters) Amendment Act, 2007

The Criminal Law Amendment Act, 2007 (Act 32 of 2007) pays attention to sexual offences and HIV (Republic of South Africa, 2007). In most cases, it is women and young girls that are victims. There was an incidence of 143 per 100, 000 of the women population sexually assaulted in 1997 and only about half of that were reported to the police (Statistics South Africa, 2000). Of the 4, 000 women interviewed during a survey in 1998, 1 in every 3 was socially assaulted (BBC News, 1999). In 2002, it was estimated that a woman born in South Africa had more chances of being raped than going to school (Dempster, 2002). Police statistics show that 55, 000 rapes were reported between 2005 and 2006. However, a survey by Action Aid revealed that out of 25 men accused of rape in South Africa, 24 walk free (Hunter-Gault, H., 2009). There is also a myth that sexual intercourse with a virgin cures a man of HIV and AIDS (Govender, 1999). This belief leads to a culture that leaves the girl child vulnerable to HIV infection given the high prevalence of HIV in the country.

Chapter 5 of the Criminal Law Amendment Act, 2007 recognises the possibility of a sexual offence victim being exposed to HIV infection. For that reason, it allows for a victim of a sexual offence at risk of exposure to HIV to have access to post exposure prophylaxis but only after reporting the crime to the South African Police Service within 72 hours after the alleged sexual offence. It also gives the victim permission to have the offender tested for HIV within 90 days of the alleged offence. Survivors of unreported cases do not benefit from this legislation which is unfortunate since several sexual offences are committed in domestic relationships or subjected to gang sexual assault (Gray and Jack, 2008).

3 CHILDREN[6]

In terms of section 27 of the South African Constitution everyone has the right to have access to health-care services, while section 28(1) states that children have the right to basic nutrition, basic health care services and social services (Republic of South Africa, 1996). With its series of 'waves',[7] HIV and AIDS is thwarting these rights of children, hence the need for a swift response in terms of policy and legislation.

3.1 Policies

Policies regarding children and HIV and AIDS vary depending on their purposes. Some are geared for both prevention and treatment for example PMTCT whilst others focus on care and support.

3.1.1 Antiretroviral Therapy (ART)

The PMTCT and ART policies also apply to children since the majority of HIV positive children have been infected through mother-to-child transmission. The prevalence of HIV among infants and young children is mainly influenced by the HIV prevalence of pregnant women and interventions to PMTCT (Johnson, 2009). In the light of this, the importance of implementing the PMTCT policy, already discussed above, cannot be overemphasised. In addition, treating mothers also ensures that HIV-positive children remain in the system and are treated if need be. While there was a gradual percentage increase of access to ART in children, from 2.1% in 2002/3 to 27.2% in 2006/7 (Johnson, 2009), many problems such as lack of trained staff and resources in the provinces and poor integration of services resulted in poor implementation (Meyers et al., 2006). Children in rural areas were the most deprived by such conditions (Padarath, et al., 2006).

The policy announced by President Zuma (discussed above) on World AIDS Day in 2009 also increases the access to ART by all children under the age of one year to get treatment if they test positive. Before this policy, initiating treatment was determined by the level of CD cells (Zuma, 2009).

3.1.2 Infant and Young Child Feeding Policy

The National Department of Health issued the Infant and Young Child Feeding Policy in 2007 aimed at improving "the nutritional status, growth, development and health of infants and young children by protecting, promoting and supporting optimal safe infant feeding practices" (Department of Health, South Africa, 2007, p. 2) in accordance with global standards. The policy gives directives on feeding options which HIV-positive women may use in order to reduce mother-to-child HIV infection. One of the key recommendations is that "health care personnel should provide evidence - based information on HIV and Infant feeding to pregnant women and to support them in their decision with regards to infant feeding choice and continued infant and mother follow-up" (Department of Health, South Africa, 2007, p. 3). Poverty, social and cultural factors, also impact on the choice of feeding options that women make and these conditions should in addition be addressed for this policy to achieve positive results.

3.1.3 Care and Support for Orphans and Vulnerable Children (OVC)

"It is hurting when I think of my parents who are taken away from me by God – they are at peace in heaven" (- a testimony of an orphan in Northern Cape)[8]

According to the 2007 General Household Survey (GHS),[9] there were about 3.7 million orphans out of 7 million children in South Africa, 700, 000 more than there were in 2002 and the increase was attributed to the AIDS epidemic. About 79% of these orphans were of school-going age. AIDS led to the rise in child-headed households since extended families are struggling to support orphans (Meintjes and Hall, 2009). The 2007 GHS also indicated that there were 150, 000 children living in a total of 79, 000 child-headed households in South Africa and 79% of these children live in three provinces: Limpopo (38%), Eastern Cape (25%) and KwaZulu-Natal (16%). Even though other children still have one or both parents, they are exposed to various factors such as morbidity due to HIV/AIDS and poverty, which leave them vulnerable. The 2007 GHS also revealed that one in every three South African children (68%) lived in households with a per capita income below R350. Eastern Cape (78%) and Limpopo (82%) had the highest poverty rates while the Western Cape (38%) and Gauteng (48%) had the lowest. The poverty rates among children in South Africa also varied according to race. Of the total children living in poor households, 75% are African and 5% are White, 43% are coloured and 14% Indian (Statistics South Africa, 2008).

The Government has responded in various ways and has also acknowledged and adopted strategies by civil society. The Department of Social Development runs various social grants that are meant to benefit orphans and vulnerable children (see Social Assistance Act, 2004, below). The Department of Education introduced the National School Nutrition Program, targeted at schools that serve the poorest communities by providing children with at least one meal per day. In 2008, it issued a National Policy for an Equitable Provision of an Enabling School Physical Teaching and Learning Environment introduced many programmes such as the Guidance and

Counselling and Pastoral Care to offer support to learners and educators with physical and psychosocial stress due to HIV and AIDS (Department of Education, 2008). However, implementing this policy poses challenges to the system since educators are not trained to give care and counselling. Some of the policies established include the 'No-Fee Schools' policy, piloted in some provinces in 2006 and then extended nationally in 2007 to the poorest 40% of primary schools (The Presidency, The Republic of South Africa, 2009).

There is also increasing partnership between Government and civil society in order to reinforce care and support for OVC's. One example is that of "Schools as Nodes of Care and Support" initiatives. This programme is a civil society initiative which was subsequently integrated into various government policies (The Presidency, The Republic of South Africa, 2009). Oxfam Australia's Southern Africa Child Social Protection Program is also another example of collaboration between civil society and government. In this programme, Oxfam Australia works in collaboration with governments concerned (Zimbabwe and South Africa) and other organisations to reduce HIV impact on children through psycho-social support and care (Oxfam Australia, 2007). In line with this, Bradshaw et al, (2002) argue that Government should support and fund NGOs and Community Based Organisations (CBOs) that promote community based systems of OVC care and support but advise that caution should be taken to avoid undermining traditional coping mechanisms.

3.1.4 VCT, STI and Life Skills Implemented via Mass Media and Community Action.

Policies of Voluntary Counselling (VCT), Sexually Transmitted Infections (STI) and Life Skills, especially among older children and other youth (above 18 years old) are being implemented through community action and mass media by civil society groups in partnership with government. Initiatives such as Soul City, Love Life and Khomanani (mainly initiated and run by civil society groups but also supported by government) use mass media to popularise key concepts in AIDS and to promote prevention methods among older children or youth according to government policies. These initiatives rely on public sector HIV and AIDS services and programmes such as condom distribution, VCT, STI and Life Skills programmes. While such initiatives can help implement HIV and AIDS policies among the youth, they often lack collaboration among themselves. On the one hand, Love Life has been criticised for absorbing huge amounts of public funding without accounting for it and on the other hand, Khomanani has been inconsistent due to the regular changing of contracting agencies (after every two years) and poor service delivery (Collinge, 2005). Though this observation was made way back in 2005, the nature of challenges such as poor service delivery and lack of accountability still make the newspaper headlines on weekly basis.

3.2 Legislation

3.2.1 National Health Act (Act 61 of 2003)

Section 1 of the National Health Act of 2003 states that if a person receiving treatment is below the age of consent, a parent or guardian or another person authorised by law, can give consent on behalf of that person below the age of consent. Section 6 of the Health Act requires that the consent should be informed and this means that the person should have full knowledge of a range of issues regarding the health service sought. This includes his/her health status, available treatment options, benefits, risks and costs of the service sought. Section 8 states that the user has a right to participate in the decision affecting his/her personal health or treatment and if the user is capable of understanding, then he/she must be informed even though he/she cannot give legal consent. In this way, the Health Act obliges health care providers to explain to a child's parent, (that is, if the child is below the age of the needed consent) and to the child above the age of consent, regarding the required health service, treatment options and consequences of the decision made. Section 14 of the Act requires that any consent to disclose the health status of the user must be made in writing (Mahery, 2006).

3.2.2 The Children's Act (as amended)

The Children's Act (Act 38 of 2005) and the Children's Amendment Act 41 of 2007 are now referred to as the Children's Act (as amended). Sections 130-133 of the Act govern HIV testing of a child and the confidentiality of information related to that. The age for medical treatment, surgical operations, HIV testing and contraceptives has been lowered from 14 to 12 years. This means that a child at the age of 12 does not require the consent of parents in order to have an HIV test. A child under the age of 12 can also consent to an HIV test if the child is mature enough to understand the consequences and implications of the test. The Act also obliges the child to be of sufficient maturity and to understand the advantages, risks and other implications of the treatment, operation or the HIV test.

In view of the fact that there are many relatives, caregivers, foster parents and heads of children's homes and shelters that take care of children even though they do not have any parental rights and duties that are recognised by law, the Children's Act allows for such people to give consent for medical treatment, contraceptives and HIV testing on behalf of a child below the age of 14 (Republic of South Africa, 2005). Implementation of this Act is thwarted by critical shortage of social service practitioners such as probation

officers, development workers, child and youth care workers, social auxiliary workers and social security workers. These are expected to provide various services in accordance with the Act but on conditions that they are registered under the Service Professions Act 110 of 1978. However, the only practitioners that currently, can register are social workers and social auxiliary workers (Jamieson et al., 2009).

3.2.3 The Social Assistance Act (No. 13 of 2004)

In terms of Section 6 of the Social Assistance Act, the Child Support Grant is extended to the primary care giver of that child. Section 7 entitles a parent, primary care giver or foster parent of a child who receives permanent care due to his or her physical or mental disability to a Care Dependency Grant. A Foster Care Grant is awarded to a foster parent as long as the child is in need of care (Section 8). Sections 9-13 talk about other grants such as the Disability Grant and Older Persons Grant (Republic of South Africa, 2004).

The Child Support Grant has been recently revised but challenges in the system persist. In July 2008, about 8 million children between the ages of 0-13 were in receipt of grants. Initially the grant was allocated for children between 0-6 years; the age has now increased to 15 years. Children's Rights organisations are now lobbying government to extend the child care grants to children up to the age of 18 years (The Presidency, The Republic of South Africa, 2009). Since April 2009, the value was increased from R180 to R240 per month per child. Eligibility was based on the primary care giver's monthly income set at R2, 400 for a single caregiver and R4, 800 per month for the joint income of the caregiver and married spouse (Hall, K., 2009). However, children without necessary documents such as birth registrations cannot access the grant and it is usually such children who are most vulnerable. At the end of 2008, there was a backlog of 157, 000 applications for the Foster Care Grant and there was a chronic and severe shortage of social workers to process these, monitor foster care and respond to a wide range of other child care and protection needs (AIDS Foundation, 2010).

4 MEN

There may be few HIV/AIDS policies specifically designed for men but several innovative programmes have been developed in an effort to implement the already existing HIV and AIDS prevention, treatment and research policies and some of these initiatives may, in the long term, develop into policies.

4.1 Policies

There are several but pocket initiatives for stopping the spread of HIV and AIDS that specifically target men such as Men in partnership against AIDS (MIPAA), which promote men to actively participate in fighting AIDS through campaigns, workshops and many other methods involve active participation (Department of Health, 2002). The recent PMTCT policy document emphasises support of families, extending VCT services to men as well (National Department of Health, 2008).

There are also initiatives that promote HIV and AIDS awareness, prevention and treatment among men whose work, lifestyle or situation puts them at high risk of HIV infection. Some of these include long distant truck drivers, men who have sex with other men and men in prisons. Research-based intervention suggestions include condom distribution at truck stops and toll plazas and provision of treatment and VCT at strategic points such as along major trucking routes and shebeens (Chopra et al., 2008, Friedman et al., 2006).

4.1.1 Circumcision

The overwhelming scientific evidence that men circumcision helps to prevent HIV and the high prevalence of the epidemic in South Africa calls for an urgent formulation of this practice as national policy (Setswe, 2009). Three trials on male circumcision held, first in South Africa and then in two other African countries (Kenya and Uganda) all showed that: "circumcision performed by well-trained medical professionals was safe and reduced the risk of acquiring HIV infection by approximately 60%. Circumcision should now be recognised as an efficacious intervention for HIV prevention and promoting circumcision should be recognised as an additional, important strategy for the prevention of heterosexually acquired HIV infection in men". (WHO/UNAIDS, 2007).

In 2008, Botswana, Uganda and Zambia introduced circumcision as part of their HIV and AIDS strategies. In its National Strategic Plan 2007-2011, SANAC (2007) recommended the Department of Health to introduce a male circumcision policy. There is no national policy yet on circumcision. In 2009, (August), Bophelo Pele Male Circumcision Centre in the township of Orange Farm near Johannesburg was the only place offering free male circumcision (*IRIN PlusNews* 9 August 2009). Debate still exists regarding how circumcision should be introduced. In KwaZulu-Natal Province, a group of South African bioethicists complained about a proposed mass male circumcision. They were concerned that men might not be given adequate information to make informed decision regarding circumcision. The group was also concerned that the initiative had potential for increasing powerlessness of women to negotiate condom usage, which offered 80-90% protection against the virus (*Daily News*, Thursday April 15, 2010). When introduced, however, the national policy should recognise and caution

men and women about the shortcomings of male circumcision since it does not provide 100% effective protection against HIV infection. The policy should also recognise existing HIV/AIDS policy and legislation, guarding against discrimination of uncircumcised men and ensuring that no one is forced to be circumcised (Setswe, 2009).

4.2 Legislation

The Westville prison antiretroviral access case is a recent example of jurisprudence which ensured the constitutional right to access to health care for men in prison. A total of 15 inmates at Westville Prison in KwaZulu-Natal were helped by the Aids law Project to access the necessary antiretroviral treatment through a court order in 2006. The Aids law Project requested the removal of restrictions that stopped prisoners from accessing the treatment and the court ruled in its favour. This case serves as a good example of civil society making use of legislation to ensure the right to access to health care by every South African. The Aids law Project successfully managed, through the Durban High Court, to ensure that the prisoners had access to health care services in the form of ART. The Department of Correction Services had intended to delay implementing the court order which instructed it to provide an action programme of how it was going to provide ART to the prisoners by applying for leave in order to make an appeal against the judgement but the judge quoted Judge Yacoob in the Grootboom case:

> "The formulation of a programme is only the first stage in meeting the State's obligation. The programme must also be reasonably implemented. An otherwise reasonable programme that is not implemented reasonably will not constitute compliance with the State's obligations". (Government of the Republic of South Africa and Others v Grootboom and Others, 2000).

This was Judge Yacoob's interpretation of Section 27 of the Constitution which states the following regarding health care, food, water and social security:

> (1) Everyone has the right to have access to (a) health care services, including reproductive health care; (b) sufficient food and water; and (c) social security, including, if they are unable to support themselves and their dependants, appropriate social assistance. (2) The State must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights. (3) No one may be refused emergency medical treatment, (Republic of South Africa, 1996).

The Durban High Court rejected the appeal and not only ordered the Department of Correctional Services to immediately provide antiretroviral treatment to the prisoners in need at Westville Prison, but also interpreted the delay by Government to submit a plan of action as a disturbing contempt of court. The Department of Correctional Services complied.

5 CHALLENGES AND PROSPECTS

The main challenge that stands out in this discussion is that of implementation. Legislation is not an end in itself, but one of the means to facilitate policy implementation through the training of stakeholders, acquiring the necessary resources and through monitoring and evaluation. It is at this level of implementation that the South African HIV and AIDS policies fall short due to several challenges discussed above. The PMTCT rollout faces challenges of shortage of staff and drugs. As a result, women in need of VCT and ART are deprived of these services and those in rural areas are affected most. Even though the policy on infant feeding and nutrition is very informative the majority of mothers that live in poor conditions, without access to clean water and food basics they find it difficult to avoid the dangers of their babies contracting the virus. Rape survivors (mostly women and girls) stand the high risk of contracting HIV. However, most of the cases go unreported and the perpetrators are not incriminated and if arrested, most of them walk free. There is little awareness regarding TOP and this means that most women cannot access its services. Large numbers of orphans and vulnerable children do not have relevant identity documents to access social grants and there are few social workers to ensure that children have access to these grants as provided by the Social Assistance Act (Act 13 of 2004).

However, the fact that South Africa has implemented several policies and legislative instruments designed to respond to the HIV and AIDS epidemic demonstrates how great an opportunity it has to fight the epidemic. These developments are a result of a strong resolute Government to reduce the spread of HIV and AIDS. The general collaboration between civil society groups and Government indicates that the fight against HIV and AIDS is a shared responsibility. Most of the policies and legislative provisions target women and children, the most vulnerable groups affected by HIV and AIDS and they have been formulated in the spirit of increasing access to health care services by the people. This is more evident when one considers the 2008 PMTCT update, the new policy on HIV and AIDS by President Jacob Zuma as well as the proposed National Health insurance.

6 CONCLUSION

This paper has argued that while South Africa's recent policy and legislation regarding HIV and AIDS show great willpower by Government, implementation challenges stand in the way of achieving the dream of reversing the epidemic. The fight against HIV and AIDS in the early years of attaining of independence by South Africa was not coordinated as Government paid very little attention to input from civil society. In recent years, however, this has since changed. Through collaboration with civil society, Government has come up with sound policies and laws to fight HIV and AIDS. The policies pay special attention to the most vulnerable groups in the society, namely women and children. Nevertheless, the main challenge remains that of implementation due to various setbacks, some of which include ignorance of the established policies and laws, lack of proper documents such as birth certificates to access social grants and at times, lack of personnel and drugs, especially in poor communities.

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