

Deadly Delay: South Africa's Efforts to Prevent HIV in Survivors of Sexual Violence

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I. Summary

Sexual violence against women and girls is a problem of epidemic proportions in South Africa, including a virtually unprecedented epidemic of child rape. Because South Africa is also in the grips of an explosive HIV/AIDS epidemic, sexual violence is a potential death sentence. The most vulnerable members of society are thus doubly victimized—first suffering the trauma of sexual violence and then its potentially fatal long-term consequences. Prompt medical attention can reduce the likelihood of HIV infection for rape survivors. The South African government has adopted a policy to provide this service, but its implementation has been rocky.

In April 2002, the South African government took the important step of pledging to provide the short and affordable course of antiretroviral drugs known as post-exposure prophylaxis (PEP) to survivors of sexual violence throughout the country. Prompt PEP administration reduces the risk of HIV transmission following exposure to HIV. First developed for occupational exposures to HIV (such as when health workers are accidentally pierced by an infected syringe), PEP has been the standard of care for occupational exposures and for rape survivors in industrialized countries for several years, and for occupational exposures in South Africa since 1999.

South Africa's commitment to provide PEP to rape survivors represents a crucial step in its efforts to protect them from the consequences of sexual violence. But there remain significant obstacles to rape survivors' ability to obtain PEP. Human Rights Watch found that government failure to provide adequate information or training about PEP or clear messages in support of PEP significantly undermined access to this lifesaving service. Police, health professionals, and counselors working with rape survivors often lacked basic information about PEP, as did rape survivors themselves. As a result, many rape survivors did not get PEP simply because the various agencies charged with providing these services did not know that they existed.

The national government's opposition to providing antiretroviral drugs in the public health system, including the health ministry's highly publicized resistance to providing antiretroviral drugs for prevention of mother-to-child HIV transmission, continued even after the government said it would provide PEP. In part due to this opposition, frontline service providers who should have been offering PEP services may not have done so, even when they had information about PEP.

South African law and policy provide a framework to facilitate the prompt and integrated provision of health and other services to children and other rape survivors. Human Rights Watch found that the failure of key service providers to follow these rules undermined rape survivors' access to PEP, at the potential cost of their lives. Police failure to provide prompt assistance to rape survivors in obtaining medical treatment, and therefore PEP, completely barred some rape survivors, including children, from obtaining PEP. Medical staff refusal to treat rape survivors without police intervention also impeded access to PEP.

Children faced particular obstacles in obtaining PEP services. HIV testing is a government prerequisite for PEP, but, under South African law, children under fourteen cannot consent on their own to HIV testing or to medical procedures. This posed problems for children who attempted to get PEP unaccompanied by a parent or guardian and for children whose caretakers refused to consent to HIV testing and PEP, perhaps against the child's best interests. At the time of this writing, national government guidelines for the administration of PEP to rape survivors do not cover children under fourteen, which leaves some health care providers with insufficient guidance regarding treatment of children.

PEP was generally unavailable outside major urban centers, effectively barring PEP access for many poor, rural rape survivors. Stigma associated with both HIV/AIDS and rape also kept many rape survivors from seeking rape support services.

Because HIV/AIDS is a fatal disease that as yet has no cure, government failure to provide information about PEP and ensure effective implementation of PEP services threatens the right to life. The obligation to ensure the right to the highest attainable standard of health and to protect women and children from violence and its consequences require that South Africa address obstacles to PEP access and implement its PEP program on an urgent basis.

PEP services for rape survivors are provided in Botswana and on a very limited basis in a few other southern African countries but across most of the continent have not even been considered at the policy level. This report seeks both to highlight obstacles to effective PEP provision in South Africa and their solutions and to illustrate lessons of the South African experience that may be useful for countries that are beginning to discuss or develop PEP services.

In late 2003, the South African cabinet approved a plan to provide antiretroviral (ARV) drugs as part of a revitalized national AIDS program. The plan confirmed the

government's commitment to providing PEP and promised investment of substantial resources into upgrading the national health system, including training for health professionals on use of antiretroviral drugs. The government also committed itself to an extensive education campaign, including information about ARVs, as part of the plan. These are laudable commitments. But lessons from the PEP experience—which involves some of the same challenges as the bigger ARV roll-out, such as public education, combating stigma, a scientifically sound and constructive presentation of ARVs—must be learned and addressed. If not, the PEP experience will not bode well for the larger treatment program.

In pledging to provide PEP to rape survivors, South Africa has shown an important commitment to protecting survivors of sexual violence from HIV/AIDS. But commitment to PEP services at the policy level will continue to be compromised without measures to ensure their availability and accessibility to all sexual violence survivors, including children, on an equal basis. The government's renewed commitment to provide PEP as part of its comprehensive HIV/AIDS program presents an opportunity to strengthen support and treatment services for survivors of sexual violence. It must meet this opportunity by allocating significant resources to the task, including adequate funding to train police, health care providers and others likely to come into contact with rape survivors. To undo the damage done by their past denigration of ARVs, the president and health minister should also speak out strongly in support of PEP as a means of HIV prevention. Otherwise, the dual epidemics of rape and HIV/AIDS will continue to claim the lives of too many South Africans.

II. Recommendations

To ensure government provision of HIV post-exposure prophylaxis as part of a comprehensive package of care for sexual violence survivors, we urge that the South African government, donors, and regional and international organizations undertake the following actions:

To the Government of South Africa

Institutional and Programmatic Measures

- Launch an information campaign to educate the public about PEP and its provision as part of a comprehensive package of services for sexual violence survivors. The

president, health minister and all other Cabinet ministers should take a leadership role in this campaign and provide clear messages supporting PEP services and the use of antiretroviral drugs to prevent HIV after sexual violence. In addition, to support the implementation of the national HIV/AIDS treatment and care plan, the president, health minister and other leaders should make clear statements about the value of antiretroviral drugs for the treatment of HIV/AIDS more broadly. This is essential to overcome the confusion and lack of confidence in antiretroviral drugs caused by misinformation about them. National and provincial governments should work with the media and nongovernmental organizations to distribute materials in local languages and in a manner that is accessible to people with limited literacy skills.

- Provide PEP at all government health facilities used by the general population, including primary health care clinics. If the PEP drugs are not available at the facility where a sexual violence survivor presents, require staff at the facility to assist the survivor in obtaining them, including by steering the survivor to the nearest facility where PEP is available.
- In urban and rural areas, continue to establish and fund multidisciplinary rape service centers that provide comprehensive support and treatment, including PEP services, voluntary and confidential HIV testing, testing and treatment for other sexually transmitted diseases (STDs), legal assistance, and other appropriate counseling for survivors of sexual violence. Ensure that personnel in facilities providing these services are trained to address the particular needs of children and young adults who survive sexual violence.
- Provide training on PEP and on sexual and gender-based violence to all key service providers, including police, teachers, health care providers, and social workers handling cases of sexual and domestic violence. Ensure as a matter of priority resources to enable training to reach all frontline service providers and not be limited to high-ranking individuals. This training should include information about applicable law and policy and their implementation and include a particular focus on children. Ensure that all police officers (frontline officers, as well as station commanders and police charged with investigating cases of sexual violence) receive training on investigation of sexual violence cases.
- Staff police stations with social workers who can offer support services (including counseling and transportation to PEP services and other necessary medical treatment) to children and other sexual violence survivors.

- Ensure that PEP is covered in all public and private health insurance plans.

Legal and Policy Measures

- In accordance with current proposals to amend the Child Care Act (the Children's Bill), permit consent to HIV testing and medical treatment for children too young to consent on their own to be given by the parent, caregiver, a designated child protection organization, the head of a hospital, or a child and family court. This legislation must be passed urgently to ensure that all children have access to PEP.
- In the interim, where consent to HIV testing and medical treatment cannot be obtained due to parental absence, unreasonable refusal or incompetence, put procedures in place to obtain consent promptly from another authority.
- Enact provisions in the Criminal Procedure (Sexual Offences) Amendment Bill requiring the state to provide prophylactic treatment for HIV and sexually transmitted infections, as well as other appropriate medical and psychological treatment to survivors of sexual violence; to amend the definition of rape to make it gender-neutral and to include situations in which a perpetrator coerces another to have sex by the use or threat of force or harm to that person or to his or her property, and to criminalize oral and anal rape; to place the decision to discontinue prosecution with the National Department of Public Prosecutions rather than with the police; to abolish evidentiary rules that devalue the testimony of sexual violence survivors and children (such as corroboration and cautionary rules); and to provide protection for vulnerable witnesses.
- Clarify the responsibilities of the different departments that provide services for child survivors of sexual violence. Develop a binding mechanism to ensure effective coordination among all such departments, including implementation of sexual assault management policies, planning, monitoring and evaluation of services.

The Department of Health should:

- Draft a national protocol on PEP provision for child sexual violence survivors under fourteen and distribute this protocol to all relevant provincial departments.

- Issue policy guidance that makes clear that provision of PEP in the context of sexual violence should be regarded as an emergency and that the medical superintendent should be permitted to consent to HIV testing and PEP on behalf of children under fourteen.
- Amend national policy guidance for PEP provision for sexual violence survivors to eliminate the requirement that an HIV test be necessary to receive PEP and to ensure that in seeking consent for an HIV test, the health facility must advise the survivor of this fact and otherwise inform the survivor why the test is being offered.
- Monitor the progress made by provinces regarding implementation of PEP and provide guidance to them regarding improvements. Ensure that evaluation and monitoring of problems and progress is an integral part of national and provincial PEP programs.
- Ensure that accredited health care practitioners and other medical officers charged with forensic examination of sexual violence survivors have a reliable supply of drugs for PEP in cases of sexual violence and are trained regarding their proper use.
- Ensure that health care providers are trained on the use of antiretroviral drugs. Institutionalize this training as part of state medical school courses.
- Develop and implement binding protocols for medical practitioners and health care professionals regarding appropriate steps to be taken when sexual violence survivors present themselves for treatment. Implementation should include training on the protocols. The protocols should provide that all sexual violence survivors be examined by a health care professional immediately after reporting the incident to the police or presenting at a health care facility for care, be informed of the risk of HIV infection as a result of sexual violence and where indicated, about the availability of PEP to reduce the risk of HIV infection.
- Establish a national standard that requires that sexual violence survivors receive treatment by the same facility collecting forensic evidence and not be referred to another facility.

The Department of Safety and Security should:

- Take steps to ensure that police are trained regarding PEP and the importance of prompt access to medical care so that rape and sexual violence survivors are referred to a facility where PEP can be administered promptly.

- Together with the Department of Health, release and disseminate a clear policy statement that filing a police report is not a prerequisite to seeking PEP and other medical services following rape and sexual violence.
- Amend police instructions regarding management of sexual offences cases (*SAPS National Instruction 22/1998: Sexual Offences: Support to Victims and Crucial Aspects of the Investigation*) to mandate that police have no discretion regarding whether to accept a charge of rape or sexual violence and that sexual offence cases be immediately allocated to specially trained investigating officers who are responsible for ensuring that sexual violence survivors receive adequate medical treatment (including PEP, where indicated) and that forensic examination is completed when appropriate.

To Donors and Regional and International Organizations

- Provide financial and technical assistance to civil society organizations offering PEP and other medical and legal services to rape and sexual violence survivors, including children, and contribute to training law enforcement, judicial and health care personnel.
- Provide financial and technical assistance to strategies that facilitate rapid implementation of the government's commitment to provide PEP and related services to children and other rape and sexual violence survivors, and monitoring and evaluation of progress toward implementation.

III. Methods

This report is based on a field visit to South Africa in May and June 2003. Human Rights Watch made additional contacts with key informants both before and after this period by telephone or electronic mail from New York. In South Africa, Human Rights Watch visited KwaZulu-Natal, Gauteng and Eastern Cape provinces and also met with representatives from Limpopo province. These provinces illustrated a range of policy and program responses to sexual violence. Gauteng was important as a policy benchmark, as government provision of PEP and related services for rape survivors was relatively advanced there. KwaZulu-Natal was important because it had the country's most serious HIV/AIDS epidemic, and Eastern Cape and Limpopo because of their relative lack of resources.

During the course of Human Rights Watch's research, researchers conducted face-to-face and/or telephone interviews with over 100 people, including health care and social service workers who work with sexual violence survivors; police; prosecutors specializing in the prosecution of sexual violence cases; representatives of domestic and international NGOs and grassroots organizations working on sexual violence and on HIV/AIDS; academics; lawyers; journalists; members of South African Law Review Commission project committees; and provincial and national government officials. It was possible to get detailed information on the implementation of PEP by speaking with experienced frontline service providers working directly with rape survivors. Because of this and at the recommendation of most service providers, we chose not to extend our interviews to rape survivors. Some government employees requested that their names not be used in this report. Their reluctance to be named may reflect the sensitive nature of any discussion in South Africa regarding sexual violence, HIV/AIDS, and antiretroviral drugs.

IV. Background: HIV/AIDS and Sexual Violence in South Africa

HIV/AIDS in South Africa

An estimated 5.3 million of South Africa's 45 million people are living with HIV/AIDS, the highest officially recognized national total of people with HIV/AIDS in the world.¹ The extremely rapid increase in HIV prevalence among women attending antenatal clinics—from 0.7 percent in 1990 to 26.5 percent in 2002—is one marker of the epidemic's explosive growth. At this writing, an estimated 1,800 people are infected with HIV and 600 die from HIV/AIDS in the country each day. By 2005 it is expected that 6 million South Africans will be infected with HIV. Absent effective intervention, it is projected that women's life expectancy will drop from fifty-two years in 2001 to thirty-seven years in 2010 and men's from forty-nine years in 2001 to thirty-eight years.²

In South Africa's HIV/AIDS epidemic, like that of much of sub-Saharan Africa, a majority of persons living with HIV/AIDS are women and girls. An estimated 57 percent of all cases of HIV/AIDS among adults age fifteen to forty-nine are women. The gender imbalance is most striking among youth: nearly four times as many

¹ South African Department of Health, *National HIV and Syphilis Antenatal Sero-Prevalence Survey in South Africa: 2002*, September 9, 2003, p. 11 & Appendix 1. Compare, e.g., Government of India, National AIDS Control Organization, "HIV Estimates for Year 2001," <http://www.naco.nic.in/indianscene/esthiv.htm> (retrieved October 10, 2003) (estimating 4.58 million persons in India living with HIV/AIDS).

² South African Department of Labour, *HIV/AIDS Technical Assistance Guidelines*, May 2003, p. 4.

adolescent girls and young women age fifteen to twenty-four are HIV-positive as their male counterparts.³

Sexual Violence Against Women and Girls in South Africa

Sexual violence against women and girls is a problem of epidemic proportions in South Africa, with child rape as one of its particularly disturbing features.⁴ According to police statistics, 52,107 rapes and attempted rapes were reported to the South African Police Service (SAPS) in 2002.⁵ But this figure certainly underestimates the true extent of the problem. A Department of Health study in 1999 found that 7 percent of women age fifteen to forty-nine reported having ever been raped or coerced to have sex against their will. Only 15 percent of these women had reported such an incident to the police.⁶ A 1999 study of abuse among women eighteen to forty-nine in three South African provinces found that between 4.5 and 7.2 percent of women reported having been raped during their lifetime and that 1.3 percent of the women had been raped in the year prior to the study.⁷

According to police statistics, more than 40 percent of rape survivors who reported their case to the police between February 2002 and March 2003 were girls under eighteen, with 14 percent twelve years or younger.⁸ Experts interpret national Department of Health data to establish that most rapes are of girls age nine to eighteen. If this is accurate, preteens and teenagers are at much higher risk of rape than the population as a whole.⁹ Although reliable numbers are hard to obtain, there is evidence that child rape

³ Rob Dorrington et al., *HIV/AIDS Profile in the Provinces of South Africa*, November 2002, p. 4.

⁴ In this report, when citing South African official documents that use the term "rape," the term is used consistent with the current definition in South African law, limited to unlawful sexual intercourse by a male with a female without her consent. Otherwise, the terms "rape" and "sexual violence" are used more broadly to describe acts of coercive sexual penetration that include and go beyond the current South African legal definition of rape, including, but not limited to, oral and anal penetration. The word "child" in this report refers to anyone under the age of eighteen. The U.N. Convention on the Rights of the Child defines as a child "every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier." Convention on the Rights of the Child, adopted November 20, 1989, 1577 U.T.S. 3 (entered into force September 2, 1990), art. 1.

⁵ South African Police Service, "Crime Statistics as Released 2003-9-22," http://www.saps.gov.za/8_crimeinfo/200309/rape.htm (retrieved October 1, 2003).

⁶ Rachel Jewkes and Naeema Abrahams, "The Epidemiology of Rape and Sexual Coercion in South Africa: An Overview," *Social Science and Medicine*, vol. 55 (2002), pp. 1235-36 (analyzing results of Department of Health, *South African Demographic & Health Survey*, 1999).

⁷ Rachel Jewkes et al. " 'He Must Give Me Money, He Mustn't Beat Me:' Violence Against Women in Three South African Provinces," *Medical Research Council Technical Report*, August 1999, pp. 11-12.

⁸ South African Police Service, *Annual Report of the National Commissioner of the South African Police Service 1 April 2002 to 31 March 2003*, 2003, p. 37.

⁹ Jewkes and Abrahams, "The Epidemiology of Rape and Sexual Coercion in South Africa," p. 1234.

has become more common in recent years. In 2000 and 2001, the reported incidence of rape and attempted rape among children increased, even as the incidence among adults began to stabilize.¹⁰ Far too many girls have no safe haven from sexual violence: many girls are coerced to have sex and otherwise subjected to sexual harassment and violence by male relatives, boyfriends, schoolteachers and male classmates.¹¹

The South African Police Service has acknowledged that rape is underreported, observing that for children, this may be explained in part by the fact that many are raped by members of their family, which “tend[s] to be kept secret.”¹² Research in South Africa has shown that schoolteachers, relatives and men otherwise known to victims perpetrate a significant percentage of childhood rapes and that fear of retaliation by the perpetrator is among the barriers to reporting these crimes to police.¹³ Many women and girls do not report rape or sexual coercion by intimate partners, because they believe that a husband or boyfriend has a right to demand sex, or they have low expectations of their right to control the terms of their sexual interactions. Studies have documented a range of other obstacles to reporting, which include fear of not being believed; problems of physical access to police; and fear of legal processes involved, including poor treatment by police.¹⁴

Many rape survivors in South Africa may not go to the police because they lack confidence in the criminal justice system and believe that perpetrators will not be punished for their acts. These concerns appear justified: a 2002 government study found that only 7.7 percent of reported rape cases resulted in convictions and that a large number of cases were still being withdrawn after having been registered, despite police instructions not to do so. In many cases, rape survivors gave statements to officers untrained to deal with rape or sexual offence cases in environments that were not private. Investigating officers were not always available, and women and children rape survivors often waited hours before meeting an investigating officer.¹⁵ Police

¹⁰ Crime Information Analysis Center (CIAC), South African Police Service, “The Reported Serious Crime Situation in South Africa for the Period January - September 2001,” http://www.saps.gov.za/8_crimeinfo/200112/report.htm (retrieved October 1, 2003).

¹¹ See, e.g., Human Rights Watch, *Scared at School: Violence Against Girls in South African Schools* (New York: Human Rights Watch, 2001).

¹² CIAC, “The Reported Serious Crime Situation in South Africa for the Period January – September 2001.”

¹³ See Julia C. Kim, “Rape and HIV Post-Exposure Prophylaxis: the Relevance and Reality in South Africa,” Discussion Paper, WHO Meeting on Violence Against Women and HIV/AIDS: Setting the Research Agenda, Geneva 23-25 October, 2000, pp. 5, 6; Human Rights Watch, *Scared at School: Violence Against Girls in South African Schools* (New York: Human Rights Watch, 2001), pp. 71-87.

¹⁴ Kim, “Rape and HIV Post-Exposure Prophylaxis: the Relevance and Reality in South Africa,” p. 6.

¹⁵ Jaspreet Kindra and Ramses Gabrielse, “Most Rapists Go Unpunished, Says Report,” *Mail & Guardian*, November 15-21, p. 3. A 2003 study of cases reported to police in eight police areas in South Africa found that only 6.6 percent of rape cases resulted in convictions and that 15.8 percent were withdrawn in court. South

themselves have identified corrupt practices that undermine successful prosecution of rape cases, including acceptance of money or bribes by police, prosecutors, and other court officials to destroy a case, and dockets otherwise being lost, stolen, or destroyed.¹⁶

The Role of Gender-Specific Violence in HIV Transmission

Sexual violence may increase the risk of HIV for all survivors, male and female. Women and girls are physiologically more vulnerable than men and boys to HIV infection during unprotected heterosexual vaginal sex.¹⁷ In addition, forced or coerced sex creates a risk of trauma: when the vagina or anus is dry and force is used, genital and anal injury are more likely, increasing the risk of transmission. Forced oral sex may cause tears in the skin, also increasing the risk of HIV transmission. In cases of gang rape, exposure to multiple assailants increases the risk of transmission. The presence of other sexually transmitted diseases also heightens HIV transmission risk.¹⁸

Women and girls in abusive relationships may have limited capacity to negotiate the terms and conditions of sex, including when and whether sex takes place and whether

African Law Commission, *Conviction Rates and Other Outcomes of Crimes Reported in Eight South African Police Areas*, 2003, p. 28.

¹⁶ Neil Andersson et al., *Beyond Victims and Villains: The Culture of Sexual Violence in South Johannesburg* (Johannesburg: CIETAfrica, 2000), pp. 87-89. The gap between legal and popular definitions of rape further complicates the ability to characterize the magnitude of sexual violence. Rape is defined in current South African law to exclude nonconsensual anal and oral sex and penetration by objects other than a penis. Individual perceptions of rape may vary depending on the relationship of the victim to the perpetrator, the ages of those involved, prevalent notions of gender roles in decision-making about sex, and the conditions under which the act occurred. Many women and girls do not characterize forced sex by intimate partners as rape, which they confine to acts by a stranger or gang rape. See Jewkes and Abrahams, "The Epidemiology of Rape and Sexual Coercion in South Africa," pp. 1231-1244; see also Katherine Wood and Rachel Jewkes, "Love is a Dangerous Thing: Micro-dynamics of Violence in Sexual Relationships of Young People in Umtata," CERSA (Women's Health) Technical Report, Medical Research Council (Pretoria: 1998).

¹⁷ Factors that contribute to this increased risk include the larger surface area of the vagina and cervix, the high concentration of HIV in the semen of an infected man, and the fact that many of the other sexually transmitted diseases that increase HIV risk are often left untreated (because they are asymptomatic or because health care is inaccessible). Girls and young women face even greater risk than adult women, because the vagina and cervix of young women are less mature and are less resistant to HIV and other STIs, such as chlamydia and gonorrhea, that increase HIV vulnerability; because changes in the reproductive tract during puberty make the tissue more susceptible to penetration by HIV; and because young women produce less of the vaginal secretions that provide a barrier to HIV transmission for older women. See, e.g., Global Campaign for Microbicides, "About Microbicides: Women and HIV Risk," <http://www.global-campaign.org/womenhiv.htm> (retrieved August 28, 2003); UNAIDS, "AIDS: Five Years since ICPD—Emerging Issues and Challenges for Women, Young People, and Infants," Geneva, 1998, p. 11; The Population Information Program, Center for Communications Programs, The Johns Hopkins University, "Population Reports: Youth and HIV/AIDS," vol. 23, no. 3, Fall 2001, p. 7 (citing studies).

¹⁸ See United States Centers for Disease Control and Prevention, Fact Sheet: Prevention and Treatment of Sexually Transmitted Diseases as an HIV Prevention Strategy [online], <http://www.cdc.gov/hiv/pubs/facts/hivstd.htm> (retrieved October 27, 2003).

condoms are used.¹⁹ Violence is a concern both as a mode of transmission of HIV and as a consequence of HIV itself. HIV-positive women who disclose their status are often at risk of violence from their intimate partners, family members, or the community, which may range from emotional abuse to coerced sex and even to homicide.²⁰

Girls and young women face particular risks of contracting HIV through sexual violence.²¹ They are physiologically more vulnerable than older women.²² Some men may rape young women and girls in the belief that having sex with a virgin may cleanse a person of HIV.²³ The fear of contracting HIV also may drive some men to seek out (and sometimes rape) girls or younger women as sex partners with the idea that they are less likely than older women to be HIV-positive.²⁴ The customary practice of virginity testing may expose girls to an increased risk of sexual violence by publicly marking them as targets for men who seek out virgin girls as sex partners.²⁵ Research has documented

¹⁹ See Lisa Vetten and Khailish Bhana, "Violence, Vengeance and Gender: a Preliminary Investigation into the Links Between Violence Against Women and HIV/AIDS in South Africa," Center for the Study of Violence and Reconciliation, 2001, p.10 (citing studies reporting that many women and girls avoided discussing or requesting the use of condoms for fear of violence or rejection by their partners).

²⁰ See, e.g., Vetten and Bhana, "Violence, Vengeance and Gender," pp. 11-12, 19 (citing cases). One woman's husband burned her over a stove when she disclosed to him that she was HIV-positive; when her four-year-old son tried to stop him, he was burned as well. *Ibid.*, p. 11. More recently, on December 14, 2003, Lorna Mlosana, a 21-year-old AIDS activist, was beaten to death in the toilet of a Khayelitsha bar by several men who had raped her after she revealed to them that she was HIV-positive. Rory Carroll, "AIDS Activist Murdered in Gang Rape," *The Guardian*, December 22, 2003. This attack evokes memories of the 1998 murder of Gugu Dlamini, a South African woman who was beaten to death after openly declaring that she was HIV-positive.

²¹ A recent study of HIV/AIDS in South Africa found that 5.6 percent of children ages two to fourteen in the sample were HIV-positive and that most of this infection could not be attributed to mother-to-child transmission, and suggested sexual abuse as one of the factors that may contribute to this finding. Nelson Mandela/HSRC Study of HIV/AIDS, *South African National HIV Prevalence, Behavioural Risks and Mass Media, Household Survey*, 2002, p. 63.

²² See note 17, above.

²³ The belief that sexual intercourse with a virgin can "cleanse" a man of HIV/AIDS reportedly has wide currency in South Africa, but the extent to which it is believed, and which it has been a motivating factor in child rape, or caused an increase in it, is debated. See, e.g., Lovelife, "Hot Prospects, Cold Facts," <http://www.kff.org/content/2001/20010314/> (retrieved August 28, 2003) (25 percent of teenage South Africans surveyed did not know that sex with a virgin did not cure AIDS); Charlene Smith, "The Virgin Rape Myth - a media creation or a clash between myth and a lack of HIV treatment," presentation at IASSCS International Conference on Sex and Secrecy, June 2003; Rachel Jewkes, Lorna Martin, Loveday Penn-Kekana, "The Virgin Cleansing Myth: Cases of Child Rape Are Not Exotic," *The Lancet*, vol. 359, no. 9307 (February 23, 2002), p. 711; see also Suzanne Leclerc-Madlala, "Protecting Girlhood? Virginity Revivals in the Age of AIDS," *Agenda*, vol. 56 (2003), pp. 22-23 (citing studies of extent of belief in virgin cure).

²⁴ Kim, "Rape and HIV Post-Exposure Prophylaxis: the Relevance and Reality in South Africa," p. 5,

²⁵ Virginity testing, which involves inspection of girls' (and less often, boys') genitals to ascertain whether they have had sex, has been lauded as a way to promote sexual abstinence among young people, thereby preventing HIV/AIDS. The concern that the practice, which may include the public declaration of virginity and marking of girls' faces in distinctive ways to identify virgins, may instead increase the risk of sexual violence, and therefore HIV/AIDS has led children's rights and HIV/AIDS advocates to oppose it. See Submission by The Children's Institute, The Aids Law Project, The Alliance for Children's Entitlement to Social Security on the Child

that young men's use of violence and sexual coercion is a "normal" part of everyday life for many young women and girls in South Africa.²⁶

Preventing HIV After Sexual Violence Through HIV Post-Exposure Prophylaxis

The administration of a short and affordable course of antiretroviral drugs following a potential HIV exposure—post-exposure prophylaxis or PEP—can greatly reduce the risk that a survivor of sexual violence will contract HIV from an HIV-positive attacker. The provision of PEP, which was first developed for occupational exposures to HIV (such as when health workers are accidentally pierced by an infected syringe), has been the standard of care for high-risk occupational exposures, including in South Africa, for some years²⁷ and is emerging as the international standard of care for survivors of sexual violence. PEP provision is standard practice in many industrialized countries (including Austria, France, Germany, Italy, Luxembourg, Spain, Switzerland and Australia).²⁸ The World Health Organization is preparing policy guidance for nonoccupational PEP (including rape), expected to be released in 2004.²⁹ In the United States, the states of California, New York, Rhode Island and Massachusetts have official policies recommending PEP following sexual violence.³⁰ Botswana, South Africa's northern

Care Act Discussion Paper Endorsed By: Aids Consortium, Aids Legal Network, Children's Rights Centre, April 2002, p. 16; Suzanne Leclerc-Madlala, "Protecting Girlhood? Virginity Revivals in the Age of AIDS," *Agenda*, vol. 56 (2003), pp. 16-25; Fiona Scorgie, "Virginity Testing and the Politics of Sexual Responsibility: Implications for AIDS Intervention," *African Studies*, vol. 61, no. 1 (2002).

²⁶ Jewkes and Abrahams, "The Epidemiology of Rape and Sexual Coercion in South Africa," pp. 1231-1244; Neil Andersson, et al., "Beyond Victims and Villains: The Culture of Sexual Violence in Johannesburg," pp. 48-52.

²⁷ See South Africa Department of Health, HIV/AIDS and STD Directorate, *Management of Occupational Exposure to the Human Immunodeficiency Virus (HIV)* (1999).

²⁸ See Michelle Roland, "Prophylaxis Following Nonoccupational Exposure to HIV," <http://hivinsite.ucsf.edu/InSite.jsp?doc=kb-07-02-07> (retrieved October 5, 2003) (citing policies); D. Rey et al., "Post-exposure Prophylaxis After Occupational and Non-occupational Exposures to HIV: an Overview of Policies Implemented in 27 European Countries," *AIDS Care*, vol. 12, no. 6 (2000), pp. 695-701.

²⁹ E-mail communication with David Miller, prevention team, HIV/AIDS Department, World Health Organization, February 17, 2004. The United Nations provides PEP to its staff in case of rape, and its Inter-Agency Group on Reproductive Health in Refugee Situations has recommended that PEP be available for rape survivors in emergency and conflict situations and has requested UNFPA to include PEP drugs in the reproductive health kits used in these settings. World Health Organization, *Post-Exposure Prophylaxis*, <http://www.who.int/hiv/topics/prophylaxis/en/index.html> (retrieved June 3, 2003); e-mail communication with Wilma Doedens, technical officer, Humanitarian Response Unit, UNFPA, January 26, 2004.

³⁰ Except for Italy, California and New York, all of the PEP policies mentioned above cover other high-risk nonoccupational exposures, such as consensual sex and injection drug use. See Michelle Roland, "Prophylaxis Following Nonoccupational Exposure to HIV," (citing policies); D. Rey et al., "Post-exposure Prophylaxis After Occupational and Non-occupational Exposures to HIV: an Overview of Policies Implemented in 27 European Countries," pp. 695-701. In 2003, California enacted legislation creating a task force to create treatment guidelines for PEP for non-assault nonoccupational HIV exposure. Cal. Health & Safety Code Section 121348-121348.2 (2003).

neighbor, has provided PEP for rape survivors through the public health system since 2001.³¹

In April 2002, the South African Cabinet pledged to provide PEP to survivors of sexual violence in all of the country's nine provinces.³² A national PEP protocol was released and distributed to all provinces at the end of May 2002, requiring that PEP be offered to sexual violence survivors age fourteen and older.³³ In October 2002, the government announced that additional funds would be provided "to cover the training, drugs and HIV test requirement of the program for survivors."³⁴ In August 2003, a national

The American Academy of Pediatrics also recommends PEP for high-risk exposures (including sexual assault) with persons known to be infected with HIV. Peter L. Havens and the Committee on Pediatric AIDS, "Postexposure Prophylaxis in Children and Adolescents for Nonoccupational Exposure to Human Immunodeficiency Virus," *Pediatrics*, vol. 111, no. 6 (June 2003), pp. 1475-1489. Because obtaining the HIV status of an alleged assailant after rape or other sexual violence is highly unlikely and complicated by legal and ethical difficulties, PEP protocols in industrialized countries have developed a method of risk stratification that considers the likelihood of the assailant's risk of being HIV-positive or recommend the assailant's HIV status not be a factor in considering whether to provide PEP. See O. Lawrence, "HIV Testing, Counseling, and Prophylaxis After Sexual Assault," *JAMA*, vol. 271, no. 18 (1994), pp. 1437-44; Mitchell Katz and Julie Gerberding, "The Care of Persons with Recent Sexual Exposure to HIV," *Annals of Internal Medicine*, vol. 128 (February 15, 1998), pp. 306-311 (if HIV status of source contact unknown, treatment decisions should be based on likelihood of source contact's being HIV-positive, taking into account that person's HIV risk behaviors and the prevalence of HIV/AIDS in the community); ER Wiebe et al., "Offering HIV Prophylaxis to People Who Have Been Sexually Assaulted: 16 Months' Experience in a Sexual Assault Service," *Canadian Medical Association Journal*, vol. 162, no. 5 (2000), pp. 641-45; New York State Department of Health, "Recommendations for Post-Exposure Prophylaxis;" European Project on Non-Occupational Post Exposure Prophylaxis, *Management of Non-Occupational Post Exposure Prophylaxis to HIV (NONOPEP): Sexual, Injecting Drug User or Other Exposures* (recommending PEP in cases of rape where HIV prevalence is at least 15 percent). In South Africa, the HIV status of the perpetrator is not a consideration in the decision whether to administer PEP to rape survivors. Department of Health, "Policy Guideline for Management of Transmission of Human Immunodeficiency Virus (HIV) and Sexually Transmitted Infections in Sexual Assault," <http://www.doh.gov.za/aids/docs/rape-protocol.html> (retrieved July 28, 2003).

As of February 1, 2004, the cost of a 28 day course of AZT and 3TC tablets is 189.55 rand (U.S.\$28.43); a 28 day course of pediatric syrup sufficient for a six-year-old child is 290.78 rand (U.S.\$43.62) (using full bottles) or 264.89 rand (U.S.\$39.75) (decanted). E-mail communication with Dr. Neil McKerrow, chief specialist and head of pediatrics and child health, Pietermaritzburg Metropolitan Hospitals, Pietermaritzburg, February 12, 2004.

³¹ Human Rights Watch telephone interview with Dr. Williams Jimbo, AIDS/STD Unit, Botswana Ministry of Health, February 16, 2003; see also Botswana Ministry of Health, *Revised Guidelines for the Use and Monitoring of Antiretroviral Drugs in Botswana*, February 2002, pp. 25-26.

³² Cabinet of South Africa, "Cabinet Statement on HIV/AIDS, 17 April 2002," <http://www.gov.za/speeches/cabinetaid02.htm>.

³³ Department of Health, "Policy Guideline for Management of Transmission of Human Immunodeficiency Virus (HIV) and Sexually Transmitted Infections in Sexual Assault." As of this writing, no national policy guideline has been finalized for children less than fourteen. Several provinces, including Gauteng, KwaZulu-Natal and Eastern Cape have developed guidelines for children under fourteen.

³⁴ Cabinet of South Africa, "An Update on Cabinet's Statement of 17 April 2002 on fighting HIV/AIDS," October 9 2002, <http://www.gov.za/issues/hiv/cabinetaid02.htm>, (retrieved March 7, 2003); see also National Treasury, *Medium Term Budget Policy Statement 2002* (29 October 2002) ("Additional funds will go towards the roll-out of . . . post-exposure prophylaxis . . . in line with Cabinet's statement of 17 April 2002. A technical committee is currently reviewing options, costs and affordability to take forward the Cabinet decision."), p. 64.

government task team included PEP for survivors of sexual violence as a core prevention component of a comprehensive health sector response to HIV/AIDS, noting also that provincial and national governments should continue their efforts to secure better prices for antiretroviral drugs for PEP.³⁵

The government's April 2002 announcement marked an important shift in policy. Before then, PEP was generally unavailable through the public health system, although some service providers in the public and private sectors had offered it to survivors of sexual violence as early as 1997.³⁶

Under the national policy guidelines issued in May 2002, PEP should be offered to all male and female sexual violence survivors fourteen years and older who present to a health facility within seventy-two hours of being raped and who test negative for HIV.³⁷ Survivors who refuse to be tested for HIV cannot receive PEP.³⁸ The national guidelines also instruct that survivors should be counseled about the risks of HIV transmission after rape, told that the efficacy of the particular drugs provided (AZT and

³⁵ Summary Report of the Joint Health and Treasury Task Team Charged with Examining Treatment Options to Supplement Comprehensive Care for HIV/AIDS in the Public Health Sector, August 1, 2003.

³⁶ These initiatives include the nonprofit, community-based Greater Nelspruit Rape Intervention Program (GRIP), established in March 2000, which set up public hospital-based rape care centers that provide PEP; the Groote Schuur and G.F. Jooste public hospitals in Cape Town, which have offered PEP since 1998 and 2000, respectively; the Albertina Sisulu Rape Crisis Centre, at Sunninghill Hospital in Johannesburg, which has offered PEP since 1998; the Rainbow Clinic at Coronation Hospital and the Teddy Bear Child Abuse Clinic, which have offered PEP to child rape survivors since 1997; and Netcare Hospital Group, which has offered PEP to rape survivors since 2000. Julia C. Kim et al., "Rape and HIV Post-Exposure Prophylaxis: Addressing the Dual Epidemics in South Africa," *Reproductive Health Matters*, vol. 11, no. 22 (2003), pp. 101-112; Human Rights Watch interview with Dr. Linda Cartwright, Rainbow Clinic, Johannesburg, May 19, 2003; Human Rights Watch interview with Dr. Lorna Jacklin, Teddy Bear Child Abuse Clinic, Johannesburg, May 20, 2003; Human Rights Watch interview with Mandé Toubkin, coordinator, Netcare Sexual Assault Crisis Centre, Johannesburg, May 19, 2003; Mandé Toubkin, "Rape: A Social Responsibility Project. Can It Be Managed In The Private Health Care Environment?" Power Point Presentation, 2003. Western Cape has offered PEP to sexual violence survivors as a matter of provincial policy since 2001.

³⁷ South African Department of Health, "Policy Guideline For Management Of Transmission Of Human Immunodeficiency Virus (HIV) and Sexually Transmitted Infections In Sexual Assault." Assessing HIV status before providing PEP is a step that is not unique to PEP procedures in South Africa because the PEP course of antiretroviral drugs will obviously not be useful to prevent HIV for rape survivors who are already HIV-positive, and some experts have raised the concern that the PEP drugs may lead to the development of antiretroviral drug resistance, which would complicate longer-term treatment for someone living with AIDS. However, because PEP must be initiated promptly after rape, and because some individuals may be unwilling or unable to make a quick, informed decision about HIV testing, Human Rights Watch recommends, consistent with jurisdictions both within and outside South Africa, that PEP not be delayed due to reluctance or refusal to be tested for HIV. See, e.g., Western Cape Province Department of Health, *Provincial Policy on the Management of Survivors of Rape and Sexual Assault* (2004); Joan E. Myles and Joshua Bamberger, *Offering HIV Prophylaxis Following Sexual Assault: Recommendations for the State of California*. San Francisco: The California HIV PEP after Sexual Assault Task Force in conjunction with the California State Office of AIDS. 2001.

³⁸ *Ibid.*

3TC) in preventing HIV in cases of sexual violence is under study and still unknown, and informed of common side effects of the drugs.³⁹

Antiretroviral Drug Therapy and HIV/AIDS

PEP services are centered on the provision of antiretroviral drugs, which have been the object of an extraordinary political battle in South Africa. In wealthy countries since the mid-1990s, antiretroviral drug therapy has been crucial in improving the survival and quality of life for people living with HIV/AIDS and in containing the disease. But the prohibitive cost of antiretroviral medicines has kept them out of reach of most people living with HIV/AIDS in the developing world. In South Africa, efforts to secure these drugs to treat people living with HIV/AIDS have been impeded by international pressure to protect multinational pharmaceutical companies' patents on antiretroviral drugs as well as misguided political leadership on the national level.

In 1996 South Africa developed a national drug policy, intended to address problems with the affordability and availability of essential medicines to all citizens who needed them. The policy recommended a number of strategies to meet these objectives, including legal and regulatory mechanisms encouraging generic substitution of medicines

³⁹ Ibid. The efficacy of PEP following sexual violence is presumed based on scientific evidence of the efficacy of antiretroviral therapy (ART) in preventing HIV transmission after occupational exposure and preventing mother-to-child HIV transmission. Joan Stephenson, "PEP Talk: Treating Nonoccupational HIV Exposure," *JAMA*, vol. 289, no. 3 (January 15, 2003), pp. 287-288; see also Michelle Roland, "Prophylaxis Following Occupational Exposure to HIV," *HIV InSite Knowledge Base Chapter*, April 2003; Peter L. Havens and the Committee on Pediatric AIDS, "Postexposure Prophylaxis in Children and Adolescents for Nonoccupational Exposure to Human Immunodeficiency Virus," *Pediatrics*, vol. 111, no. 6 (June 2003), pp. 1475-1489; AIDSMap, "Treatment during Primary Infection: PEP," <http://www.aidsmap.com/treatments/ixdata/english/082ab2c6-5bcc-4ddd-ac7e-8e56c570228a.htm> (all citing studies). Animal studies initiating ART within seventy-two hours of exposure and continued for twenty-eight days support the biological plausibility of providing ART following sexual exposure. Ibid. Prospective, randomized, controlled studies to prove the efficacy of PEP are unlikely because of the ethical concerns arising from withholding PEP in the face of converging evidence in its favor, the size and cost of such studies, and the frequent inability to attribute HIV seroconversion to the perpetrator of sexual violence versus another exposure. Roland, "Prophylaxis Following Occupational Exposure to HIV."

Data from observational cohort studies of PEP administered after sexual exposure show very few cases of HIV transmission following PEP. See *ibid.* (citing studies); A. Grulich et al., "Highly targeted use of non-occupational post-exposure prophylaxis (NPEP) in Australia." In: *The 2nd IAS Conference on HIV Pathogenesis and Treatment*. Paris, France, 2003; François Bela et al., "Programme Médical de Prise en Charge des Personnes Victimes de Violence Sexuelle Brazzaville-République du Congo. Médecins Sans Frontières. March 2000-February 2002," *Centre Collaborateur de l'OMS pour la Recherche en Épidémiologie et la Réponse aux Maladies Emergentes*, May 2002. A study in South Africa showed that only one of 435 sexual violence survivors who received PEP within seventy-two hours of assault subsequently developed HIV infection. Adrienne Wulfsohn et al., "Post-Exposure Prophylaxis for HIV After Sexual Assault in South Africa," poster presentation at 10th Conference on Retroviruses and Opportunistic Infections, Boston, Massachusetts, February 10-14, 2003. These data are limited, however, by lack of information regarding who actually took PEP drugs and limited return (173 of 435) for follow-up by survivors.

not under patent, parallel importation of medicines and purchasing of generic medicines on the international market.⁴⁰ The Medicines Act of 1997 authorized compulsory licensing (whereby states authorize generic production of a patented product without the patent holder's consent)⁴¹ and parallel importation (cross-border trade in a product without permission of the patent holder)⁴² and promoted the practice of prescribing less expensive generic versions of patented drugs, including antiretroviral drugs essential in fighting HIV/AIDS.⁴³

Although the Medicines Act of 1997 was passed, it did not come into force. In February 1998, the South African Pharmaceutical Manufacturers Association and forty-one multinational drug companies filed an action in the Pretoria High Court to prevent the government from bringing into operation certain sections of the Act that would allow the government to produce or import drugs at lower cost.⁴⁴ Intense lobbying efforts by multinational pharmaceutical companies and the United States government further undermined South Africa's capacity to implement the provisions of the Act.⁴⁵

⁴⁰ South Africa Department of Health, *National Drug Policy*, 1996.

⁴¹ Compulsory licensing and parallel importation are mechanisms by which poor countries can contain the high cost of drugs and have been supported based on various public interest grounds, including public health, economic development and national defence. The World Trade Organization's Trade Related Aspects of Intellectual Property Agreement (TRIPS), to which South Africa is a party, permits countries facing a "national emergency or other circumstances of extreme urgency or for public non-commercial use" to issue compulsory licenses without first making an effort to get the patent-holder's consent, as long as such countries abide by safeguards in TRIPS, including adequate compensation to patent owners. Agreement on Trade-Related Aspects of Intellectual Property Rights, Apr. 15, 1994, Annex 1C, 33 I.L.M. 1125, 1168 (1994), arts. 31(b, h). Parallel importation is also authorized under TRIPS. See *ibid.*, art. 6.

⁴² Because patent-holders sell at different prices in different markets, parallel importation permits countries with limited resources to buy drugs at the lowest world price and then redistribute the drugs domestically.

⁴³ Medicines and Related Substances Control Amendment Act, Act No. 90 of 1997, amending the Medicines and Related Substances Control Act, No. 101 of 1965, sections 15C, 22F. See also Andy Gray et al., "Policy Change in a Context of Transition: Drug Policy in South Africa 1989-1999," Center for Health Policy, University of Witwatersrand, July 2002, pp. 25-40.

⁴⁴ The plaintiffs claimed that the Act granted unconstitutional power to revoke patent rights and did not comply with TRIPS. See *Pharmaceutical Manufacturers Association of South Africa et al. v The President of the Republic of South Africa, et al.*, Case No. 4183/98 (1998).

⁴⁵ Between 1997 and 1999, the U.S. exerted significant pressure on South Africa with respect to the Medicines Act in binational meetings and other international fora. On April 30, 1999, following intensive lobbying by the pharmaceutical industry, the U.S. government put South Africa on its "301 Watch List," initiating a special out-of-cycle review of South Africa's intellectual property policy. Among the reasons cited for this decision were that the Medicines Act "appear[ed] to grant the Health Minister ill defined authority to issue compulsory licenses, authorize parallel imports, and potentially otherwise abrogate patent rights" and that "[d]uring the past year, South African representatives have led a faction of nations in the World Health Organization (WHO) in calling for a reduction in the level of protection for pharmaceuticals in TRIPS." Office of the United States Trade Representative, "USTR Announces Results of Special 301 Annual Review," 99-41, April 30, 1999. See also James Love, director, Consumer Project on Technology, "What is the United States' Role in Combating the Global AIDS Epidemic?" *Statement before the Subcommittee on Criminal Justice, Human Resources and Drug Policy, Committee on Government Reform*, July 22, 1999 (summarizing U.S. trade policy and dispute over Medicines Act).

In 1999 the Treatment Action Campaign (TAC), a nongovernmental organization with a nationwide base, coordinated an aggressive international campaign in response urging the pharmaceutical industry to lower the prices of patented drugs and calling for the United States government to halt its efforts to roll back the Medicines Act. In September 1999, following intense activist pressure in both South Africa and the U.S., the U.S. government conceded the validity of the Medicines Act and in December 1999, removed South Africa from its list of countries identified as lacking sufficient intellectual property rights protection (the “301 Watch List”).⁴⁶

In April 2001 the Pharmaceutical Manufacturers Association withdrew its case seeking to strike down legislative provisions that would allow the government to produce or import antiretroviral drugs at low cost.⁴⁷ The South African government did not, however, take advantage of this opportunity to mount a publicly funded program to make HIV/AIDS treatment available.

South African Government Interference with Antiretroviral Drug Provision

In 1997, nongovernmental organizations began lobbying the Department of Health to develop a program to prevent mother-to-child transmission of HIV, including by providing AZT (an antiretroviral drug that reduces the risk of perinatal transmission when administered to pregnant women).⁴⁸ Initially, the health ministry supported these

⁴⁶ Office of the United States Trade Representative, “U.S.-South Africa Understanding on Intellectual Property,” 99-76, September 17, 1999; Office of the United States Trade Representative, “The Protection of Intellectual Property and Health Policy,” 99-98, December 1, 1999.

⁴⁷ See Jean-Pierre Garnier, “We Have a Deal: A Drug Company Boss Explains the Climbdow in South Africa,” *Guardian*, April 20, 2001 (statement by GlaxoSmithKline chief executive); “Treatment Action Campaign releases statement on the Lawsuit: An Explanation of the Medicines Act and the Implications of the Court Victory,” <http://www.tac.org.za/> (retrieved October 8, 2003); “Court Case Between 39 Pharmaceutical Firms and the South African Government,” <http://www.cptech.org/ip/health/sa/pharma-v-sa.html> (retrieved October 8, 2003) (catalog of legal documents and news articles relating to the dispute).

⁴⁸ HIV can be transmitted from an HIV-infected mother to her child during pregnancy, labor and delivery, or through breastfeeding. Research first demonstrated in 1994 that the administration of the antiretroviral drug zidovudine (AZT) to HIV-infected pregnant women reduces the risk of mother-to-child HIV transmission. In 1998, a groundbreaking study showed that a short course of AZT given to the mother and the child, beginning at thirty-six weeks of pregnancy, greatly reduced mother-to-child HIV transmission. Nancy Wade et al., “Abbreviated Regimens of Zidovudine Prophylaxis and Perinatal Transmission of the Human Immuno Deficiency Virus,” *New England Journal of Medicine*, vol. 339, no. 20 (November 12, 1998), pp. 1409-14. A single dose of nevirapine given to the mother during labor, followed by a single dose to the infant shortly after birth, has also been shown to reduce this risk, as have combination regimens with AZT and lamivudine (3TC). See World Health Organization, “Prevention of Mother-to-Child Transmission of HIV: Selection and Use of Nevirapine. Technical Notes,” WHO/HIV_AIDS/2001.03, WHO/RHR/01.21 (citing studies); see also J. Brooks Jackson et al., “Intrapartum and Neonatal Single-Dose Nevirapine Compared with Zidovudine for Prevention of Mother-to-Child Transmission of HIV-1 in Kampala, Uganda: 18 Month Follow-Up of the HIVNET 012 Randomized Trial,” *The Lancet*, vol. 362, no. 9387 (September 16, 2003), pp. 859-868.

efforts.⁴⁹ But by the end of 1999, South African government officials had begun to express concerns about the safety of antiretroviral drugs. By early 2000, government officials began to question the causal link between HIV and AIDS, suggesting among other things that poverty, not HIV, was the root cause of AIDS.

In a 1999 speech, President Thabo Mbeki questioned the safety of AZT, warning that “the toxicity of this drug is such that it is in fact a danger to health.” Mbeki announced that he had “asked the Minister of Health, as a matter of urgency, to go into all these matters so that, to the extent that is possible, we ourselves, including our country's medical authorities, are certain of where the truth lies.”⁵⁰ Two weeks later, Minister of Health Manto Tshabalala-Msimang told the National Assembly that though she was aware that AZT reduced perinatal HIV transmission, “there are other scientists who say that not enough is yet known about the effects of the toxic profile of the drug, that the risks might well outweigh the benefits, and that the drug should not be used.”⁵¹ In early 2000, the Medicines Control Council issued a report concluding, consistent with international medical consensus, that the benefits of AZT use outweighed their risks, but political opposition to its use continued.⁵²

By early 2000, Mbeki had begun to solicit the opinions of AIDS “denialists” or “dissidents,” a small group of scientists and activists who believe that AIDS in Africa is not caused by HIV, but by poverty, poverty-related conditions and illnesses (such as malnutrition and tuberculosis), and drugs used to treat HIV.⁵³ AIDS denialists also claim that the AIDS epidemic is a huge medical fraud promoted by pharmaceutical companies, scientists and doctors to provide profit and job security for themselves and that AIDS treatments (such as antiretroviral drugs) are themselves poisons.⁵⁴

⁴⁹ See, e.g., Department of Health, “Discussion Document: Prevention of HIV Transmission from Mother-to-Child,” (1998) (cited in Helen Schneider, “On the Fault-Line: The Politics of AIDS in Contemporary South Africa,” *African Studies*, vol. 61, no. 1 (2002)); Joint Statement of the Minister of Health and TAC, April 30, 1999.

⁵⁰ Thabo Mbeki, “Address to the National Council of Provinces,” October 28, 1999.

⁵¹ Mark Heywood, “Preventing Mother-to-Child Transmission in South Africa: Background, Strategies and Outcomes of the Treatment Action Campaign Case Against the Minister of Health,” *South African Journal of Human Rights*, vol. 19, part 2 (2003), p. 282, n. 21 (citing Debates of the National Assembly, *Hansard*, November 16, 1999, pp. 1835-62).

⁵² See Heywood, “Preventing Mother-to-Child Transmission,” p. 283 and n. 24; see also World Health Organization, “Safety and Tolerability of Zidovudine [AZT]: a Review of the Literature,” (2000).

⁵³ See Heywood, “Preventing Mother-to-Child Transmission,” pp. 281-85 and notes 26, 28; Mark Schoofs, “Flirting with Pseudoscience,” *The Village Voice*, March 14-21; Drew Forrest, “Opinion: The Record Reveals President Thabo Mbeki's True Stance on AIDS,” *Mail & Guardian*, October 26, 2001; Michael Cherry, “Letter Fuels South Africa's AIDS Furore,” *Nature*, vol. 404 (April 27, 2000), p. 911.

⁵⁴ See www.virusmyth.net for information setting forth denialists' positions; see also U.S. National Institutes of Health, “The Evidence that HIV Causes AIDS,” <http://www.niaid.nih.gov/factsheets/evidhiv.htm> (retrieved November 23, 2003) (refuting denialists' contentions).

In May 2000, Mbeki convened a presidential AIDS advisory panel to consider both the causes of AIDS and appropriate responses to the HIV/AIDS epidemic in South Africa.⁵⁵ The panel was made up of thirty-three scientists of whom two-thirds subscribed to the orthodox scientific view that HIV causes AIDS, while the remaining one-third were AIDS dissidents.⁵⁶ Mbeki's questions about the causes of AIDS, which reflected the influence of the denialist arguments, gained currency in the African National Congress (ANC) and in the government and began to influence health policy at the national and provincial level.⁵⁷

In August 2000, a committee of the national Minister of Health and the nine provincial cabinet health ministers (the Minister and the Members of the Executive Council, or MinMEC) took the decision to provide the antiretroviral drug nevirapine at a small number of pilot sites throughout the country once it was registered with the Medicines Control Council.⁵⁸ This decision ignored the recommendation of the head of the national AIDS office for HIV/AIDS to provide nevirapine to all HIV-positive pregnant women who already knew their status as well as scientific evidence on the safety and efficacy of its use in this context.⁵⁹

In August 2001, following the withdrawal of the Pharmaceutical Manufacturers Association's case challenging the Medicines Act, a coalition including TAC sued the government to require it to provide antiretroviral drugs in the public sector to all HIV-

⁵⁵ See Schoofs, "Flirting with Pseudoscience;" see also Michael Cherry, "South Africa Turns to Research in the Hope of Settling AIDS Policy," *Nature*, vol. 404 (May 12, 2000), p. 105.

⁵⁶ See *ibid.*; Helen Schneider, "On the Fault-Line: The Politics of AIDS Policy in Contemporary South Africa," *African Studies*, vol. 61, no. 1 (2002). Mbeki's consideration of dissident positions regarding the causes of AIDS generated international concern that doubting or denying the causes of AIDS would interfere with HIV prevention efforts, including implementation of MTCT programs. To address these concerns, 5000 scientists and doctors released the "Durban Declaration," an international petition supporting the view that HIV causes AIDS, at the International AIDS Conference in Durban in July 2000. "The Durban Declaration," *Nature*, vol 406 (July 6, 2000), pp. 15-16.

⁵⁷ See Heywood, "Preventing Mother-to-Child Transmission;" Schneider, "On the Fault-Line."

⁵⁸ Nevirapine, like AZT, has been shown to reduce mother-to-child transmission even when given to the woman only a few times near the end of pregnancy. In July 1999, the results of a study finding that a single dose of nevirapine to the mother during labor and to the infant shortly after birth was, like AZT, highly effective in reducing mother-to-child HIV transmission, were released by the U.S. Department of Health and Human Services. The study showed comparable efficacy to AZT in reducing mother-to-child transmission could be achieved with a simpler and less expensive drug regimen. U.S. Department of Health and Human Services, "Researchers Identify a Simple, Affordable Drug Regimen that is Highly Effective in Preventing HIV Infection in Infants of Mothers with the Disease," July 14, 1999; Laura A. Guay et al., "Intrapartum and neonatal single-dose nevirapine compared with zidovudine for prevention of mother-to-child transmission of HIV-1 in Kampala, Uganda: HIVNET 012 randomised trial," *The Lancet*, vol. 354, no. 9181 (September 4, 1999), pp. 795-802.

⁵⁹ Heywood, "Preventing Mother-to-Child Transmission," pp. 286-87.

positive women to prevent mother-to-child HIV transmission. In December 2001, after the Pretoria High Court ruled that the government's refusal to provide antiretroviral drugs to HIV-positive pregnant women violated the constitution and ordered it to provide these medications, Tshabalala-Msimang announced that she would seek leave to appeal this decision directly to the Constitutional Court.⁶⁰ And in February 2002, Tshabalala-Msimang announced that contrary to recommendations in a Department of Health sponsored report that nevirapine "can and should be provided immediately to all pregnant women who are already known to be HIV positive," the health ministry would not make a decision on the program until May 2002, after it had been running for one year.⁶¹

Provincial Government Interference with PEP Provision Prior to April 2002

Provincial governments share responsibility with the national government for health policy and provision and are responsible for implementing national health policy.⁶² In some provinces, public health officials who provided PEP as a matter of conscience to sexual violence survivors were punished by provincial health officials blindly following a misguided and deadly national government policy opposing antiretroviral drug provision.

The eastern province of Mpumalanga is a case in point. In early 2000, the Greater Nelspruit Rape Intervention Programme (GRIP), an NGO that provides free counseling and support services for rape survivors, including PEP, opened an office in an unused room at a state hospital in Nelspruit, Mpumalanga.⁶³ GRIP had been asked to provide these services by hospital superintendent Dr. Thys von Mollendorff, who had been

⁶⁰ Ibid., p. 301.

⁶¹ Ibid, p. 303 (citing Department of Health, "Outcomes of the MinMEC Meeting of 31 January – 1 February"). In July 2002, the Constitutional Court ordered the government "without delay" to facilitate the provision of nevirapine to prevent mother-to-child HIV transmission. *Minister of Health v Treatment Access Campaign and Others*, CCT 8/02 (2002).

⁶² Constitution of the Republic of South Africa, chs. 3, 6, schedule 4. National health department responsibilities include formulation of health policy and legislation and norms and standards of care; ensuring appropriate utilization of health resources and access to cost-effective and appropriate health commodities; information coordination and monitoring of national health goals; and regulating public and private health care. Provincial departments of health responsibilities include provision of health services and ensuring that delegated functions are performed. The national department of health's plan is based on a district model that focuses on improving primary health care services. Forty-two health regions and 162 health districts have been demarcated under this plan. Government Communication and Information System, *South Africa Yearbook 2002/03*, pp. 339-40.

⁶³ GRIP supplies or funds HIV tests and PEP drugs in several government hospitals and private clinics in Mpumalanga, provides counseling, follow-up care and court assistance to sexual violence survivors, and provides community education and training to police, medical staff and other service providers about rape and HIV/AIDS prevention. E-mail communication from Barbara Kenyon, CEO, GRIP, to Human Rights Watch, October 7, 2003 and November 30, 2003; Barbara Kenyon et al., "The Greater Nelspruit Rape Intervention Program," poster presentation at 14th International AIDS Conference, Barcelona, Spain, July 2002.

unable to secure a budget or staff to improve his hospital's existing internal services for rape survivors.⁶⁴

In October 2000 provincial health minister Sibongile Manana criticized GRIP for providing antiretroviral drugs to rape survivors, reportedly accusing GRIP and von Mollendorff of trying to poison black people and undermining national government policy by doing so.⁶⁵ She ordered GRIP out of the public hospitals, fired the district health manager for failing to get written permission for the group to use its premises, and charged von Mollendorff and several other top hospital administrators with gross misconduct for their tacit support of GRIP's work.⁶⁶

Manana eventually withdrew these charges, but in November 2001, she suspended von Mollendorff, charging him with gross insubordination for allowing GRIP to dispense drugs in a manner the provincial Department of Health considered a violation of national and provincial policy forbidding the use of antiretroviral drugs in public hospitals.⁶⁷ The Department settled its case with von Mollendorff in March 2003, agreeing to compensate him financially and pay his court costs.⁶⁸ Manana has gone to court to evict GRIP from the public hospitals on at least two other occasions, in May 2001 and January 2003.⁶⁹

Mpumalanga's conflicts with GRIP contributed to misinformation about antiretroviral drugs. At one point, the African National Congress (ANC) Women's League reportedly approached GRIP's black female counselors, promising them jobs with the provincial

⁶⁴ Sizwe samaYende and Justin Arenstein, "Sacked—for Putting Patients' Interests First," *Focus* 25, vol. 25, March 2002, <http://www.hsf.org.za/focus25/focus25mollen.html> (retrieved October 31, 2003).

⁶⁵ Nashira Davids, "Now Rest Your Case, Miss Manana. Mpumalanga Health MEC Wastes Taxpayers' Money by Trying to Evict—Again—a Group that Dispenses AIDS Drugs at Provincial Hospitals," *Sunday Times*, February 2, 2003; Sizwe samaYende and Justin Arenstein, "Sacked—for Putting Patients' Interests First."

⁶⁶ *Ibid.*; see also Amnesty International, "HIV/AIDS in South Africa. Support Rape Survivors' Right to Treatment. Defend Doctors' Right to Provide Best Available Standard of Care," http://www.amnestyusa.org/nwsa/about_aids_southafrica.html (retrieved August 4, 2003).

⁶⁷ Von Mollendorff was formally charged with insubordination on February 22, 2002. Following the national government's April 2002 announcement supporting the provision of antiretroviral drugs for sexual violence survivors, the Mpumalanga Health Department denied that the provision of drugs was the reason for von Mollendorff's dismissal. Von Mollendorff has contradicted this position in a written account of his dismissal. Amnesty International, "HIV/AIDS in South Africa. Support Rape Survivors' Right to Treatment. Defend Doctors' Right to Provide Best Available Standard of Care."

⁶⁸ In January 2003, Manana dropped a court case to evict GRIP, and was ordered to pay legal costs, the second time in two years that Manana (and therefore the provincial government) was ordered to foot the bill for her attempts to evict GRIP. Mariana Balt, "Thys von Mollendorff," *Lowvelder*, March 13, 2003.

⁶⁹ Nashira Davids, "Now Rest Your Case, Miss Manana. Mpumalanga Health MEC Wastes Taxpayers' Money by Trying to Evict—Again—a Group that Dispenses AIDS Drugs at Provincial Hospitals," *Sunday Times*, February 2, 2003.

government if they signed a petition denouncing GRIP.⁷⁰ The petition stated: “[A]s card-carrying members of the ANC and the ANC W/L [Women’s League], we distance and dissociate ourselves from all activities of GRIP. As members of the ANC, we cannot defy our government and its policies. We cannot defy our President Thabo Mbeki in his call against the use of AZT. We cannot defy our national MEC Manto [T]shabalala. We cannot defy our provincial MEC Sibongile Manana.”⁷¹ The petition referred to GRIP as “those who buy AZT to poison and kill our people” and compared GRIP and its supply of antiretrovirals to the work of Wouter Basson, the apartheid-era scientist who was tried for murdering black people during drug experiments.⁷²

In Northern Cape province, a doctor in Kimberley in November 2001 provided PEP to a nine-month-old rape survivor, apparently pursuant to a 1997 provincial policy that the doctor’s discretion should be used regarding the administration of PEP in rape cases.⁷³ Following news reports that the child had been treated with AZT, a high-level health official in Northern Cape chastised the hospital chief executive officer for having permitted this, cross-examining him on why the child had been given antiretroviral drugs. The official also demanded to know whether the practice had been widespread. The hospital subsequently issued a circular making clear that doctors were barred by National Department of Health HIV/AIDS policy from administering antiretroviral drugs to rape survivors.⁷⁴

Recent Mixed Messages on Antiretroviral Drug Provision in the Public Health System

In April 2002 the South African Cabinet issued a policy statement on HIV/AIDS that the “government’s starting point is based on the premise that HIV causes AIDS,” and made a commitment to provide antiretroviral drugs to prevent mother-to-child-transmission of HIV and to prevent HIV transmission due to sexual violence.⁷⁵ While this statement signaled a change in the government’s position, in fact the government

⁷⁰ Chris McGreal, “HIV Prevention has South African Health Minister Outraged,” *Guardian Unlimited*, July 23, 2001.

⁷¹ Rape Defusers Memorandum to Temba Hospital, November 3, 2000.

⁷² *Ibid.* Basson, an apartheid-era head of South Africa’s chemical and biological warfare program, was acquitted of these charges in April 2002. See Center for Conflict Resolution, “The South African Chemical and Biological Warfare Programme. Trial Report: Sixty-Three – Report on the Judgment in The State vs. Wouter Basson Delivered on 11 April 2002,” <http://ccrweb.ccr.uct.ac.za/cbw/63.html> (retrieved October 27, 2003).

⁷³ Khadija Magardie and Nawaal Deane, “State Fury Over AIDS Drug for Raped Baby,” *Mail & Guardian*, January 11, 2002.

⁷⁴ *Ibid.* According to one Kimberley doctor, doctors in the province had been prescribing antiretroviral drugs to rape survivors at their discretion for some time. *Ibid.*

⁷⁵ Cabinet of South Africa, “Cabinet Statement on HIV/AIDS, 17 April 2002,” <http://www.gov.za/speeches/cabinet/aid02.htm>.

continued to send mixed signals in its response to the epidemic. The government was still engaged in a court battle contesting High Court orders requiring the government to provide the antiretroviral drug nevirapine to prevent mother-to-child transmission.⁷⁶ And the government continued to include prominent AIDS denialists at high-level government meetings and as members of the President's AIDS Advisory Panel.⁷⁷

In August 2003 the South African government stated that HIV causes AIDS and that antiretroviral drugs can mitigate the impact of the disease, and directed the Department of Health "as a matter of urgency" to develop a detailed operational plan for a nationwide antiretroviral treatment program.⁷⁸ On November 19, 2003, the Cabinet approved a plan to provide comprehensive HIV/AIDS care and treatment throughout South Africa, stating its intention to provide antiretroviral drugs as part of a comprehensive approach to the treatment of people living with HIV/AIDS. The plan confirmed the government's prior commitment to providing PEP and committed it to investing substantial resources to upgrade the national health system, including by implementing a training program for health professionals regarding use of antiretroviral drugs. It also committed itself to an extensive education campaign as part of the plan.⁷⁹ It remains to be seen whether, and with what speed, the health minister and the government will act to implement this plan.

Meanwhile, just as Mbeki's Cabinet declared itself ready to authorize the use of antiretroviral drugs in government health services, other parts of the government were taking steps to make it more difficult to get such drugs. On the eve of the Cabinet's August 2003 announcement, the South African Medicines Control Council questioned the use of nevirapine, threatening to revoke its approval unless its manufacturer

⁷⁶ The government appealed these orders to the Constitutional Court, which issued a decision on July 5, 2002 ordering the government "without delay" to facilitate the provision of nevirapine to prevent mother-to-child HIV transmission. *Minister of Health v Treatment Access Campaign and Others*, CCT 8/02 (2002). See also Heywood, "Preventing Mother-to-Child Transmission in South Africa," pp. 299-312 (discussing litigation).

⁷⁷ In January 2003, Minister of Health Manto Tshabalala-Msimang invited Robert Giraldo, a prominent AIDS denialist, to address the meeting of the Southern Africa Development Community's ministerial health committee, which she chaired. "Giraldo, unsurprisingly, informed the meeting that 'the transmission of AIDS from person to person is a myth,' and that the 'homosexual transmission of the epidemic in Western countries, as well as the heterosexual transmission in Africa, is an assumption made without any scientific validation.'" Justice Edwin Cameron, "The Dead Hand of Denialism," *Mail & Guardian*, April 17, 2003.

⁷⁸ *Statement on Special Cabinet Meeting: Enhanced Programme Against HIV and AIDS*, August 8, 2003, <http://www.gov.za/speeches/8aug03.htm> (retrieved August 29, 2003). This announcement followed a report by the Ministries of Health and Finance that shows that the South Africa could afford to make the drugs available and that up to 1.7 million lives could be prolonged by the treatment. A special task team presented South Africa's health minister with a draft plan of the program on September 30. Elliott Sylvester, "AIDS Drugs Distribution Plan Presented," *Associated Press*, September 30, 2003.

⁷⁹ *Executive Summary: Operational Plan for Comprehensive HIV and AIDS Care and Treatment for South Africa*, November 19, 2003, <http://www.gov.za/speeches/8aug03.htm> (retrieved November 20, 2003).

provided new evidence of the drug's safety within ninety days.⁸⁰ In July 2003 the requirement that government provide antiretroviral drugs and other medical treatment to survivors of rape and other sexual offences was deleted from a parliamentary bill.⁸¹ According to the State Law Advisors, the committee considering the bill was concerned about the cost of providing treatment to all sexual offence survivors and the system's capacity to handle this service.⁸² In January 2004, the chair of the committee reviewing the bill announced that it would include a clause making clear that rape survivors would be entitled to receive PEP services from designated government clinics.⁸³

Health and Social Service Provision

Resource constraints compound barriers posed by government failure to provide clear messages in support of PEP. A lack of sufficient financial and human resources poses considerable obstacles to health and social service provision in South Africa, particularly in areas historically disadvantaged under apartheid, such as former "homeland" areas and townships and shanty towns—known as squatter camps—in urban areas.⁸⁴ South Africa has taken significant steps to redistribute health sector services to historically disadvantaged areas, making access to primary health care in rural areas a priority.⁸⁵ But many South Africans still have significant problems obtaining adequate—or any—health care. Unequal resource allocation, scarcity of clinics to cover rural areas, and difficulty in

⁸⁰ Reuters, "South Africa Still Doubts Value of AIDS Drug," *New York Times*, August 1, 2003. This announcement came just days after the World Health Organization had reconfirmed its recommendation that nevirapine should be included in the minimum standard package of care for HIV-positive women and their children. "South Africa Anti-AIDS Shock," *BBC Online*, July 31, 2003.

⁸¹ Charlene Smith, "Rape Survivors Must Fend for Themselves," *The Sunday Independent*, August 3, 2003. South Africa's draft law on sexual offences (the Criminal Procedure (Sexual Offences) Amendment Bill), which, as of this writing, has been scheduled to be reviewed by a parliamentary committee next term (after the April 2004 elections), had included a clause requiring the state to provide and bear the cost of the care and medical treatment and counseling for survivors of sexual violence who may have sustained injuries, psychological harm or been exposed to the risk of sexually transmitted infections as the result of a sexual offence.

⁸² Comments of Advocate Johan de Lange at hearings on Sexual Offences bill before the Joint Monitoring Committee on Improvement of Quality of Life and Status of Women, November 14, 2003.

⁸³ Comments of Advocate Johan de Lange at deliberations on Sexual Offences bill before the Justice and Constitutional Development Portfolio Committee, January 29, 2004.

⁸⁴ As originally conceived, the apartheid system aimed to deprive all black Africans of South African citizenship, making them citizens of "independent" homelands. Ten homelands were created, four of which (Transkei, Bophuthatswana, Venda and Ciskei) became nominally independent. Six others (KwaZulu, Gazankulu, KaNgwane, Lebowa, QwaQwa and KwaNdebele) had a lesser degree of autonomy and were self-governing. The homelands were integrated into nine provinces formed in 1994. Under apartheid, health services were systematically underfunded in the former "homeland" areas relative to the former provinces.

⁸⁵ See Jane Doherty, et al., "Health Care Financing and Expenditure," *South African Health Review 2002* (Durban, South Africa: Health Systems Trust, 2003); Stephen Thomas et al., "Financing and Need across Districting Municipalities," *South African Health Review 2002*, pp. 67-82.

retaining medical staff within the public health sector and within South Africa all contribute to these problems.⁸⁶

Health services, social services and specialized police services that provide the structures and personnel for making PEP provision work are severely understaffed and underfunded in many parts of South Africa. Police officers who are meant to transport sexual violence survivors to health facilities may find themselves without enough working vehicles to provide this important service. Many have caseloads so high that they lack time to conduct proper investigations.⁸⁷ Specialized police charged with handling crimes related to family violence, rape and other sexual offences are not posted in many rural police stations.⁸⁸

Many health care practitioners lack sufficient training and expertise regarding the examination and treatment of rape survivors. Until recently, district surgeons—medical doctors appointed by government to perform clinical medico-legal examinations—or physicians in private practice performed forensic examinations on sexual violence victims.⁸⁹ In 1999 the Minister of Health announced that district surgeons would be phased out and replaced by “accredited health care practitioners,” who would be physicians or nurses that had completed specialized training and were registered with the South African Health Professions Council or Nursing Council.⁹⁰ Consolidating medical services in one location would improve the chances that sexual violence survivors would

⁸⁶ See *ibid.* In May 2002, Gauteng, an historically advantaged province, announced its intention to provide PEP to sexual violence survivors by the end of the year. At the same time, eight state-funded tuberculosis hospitals in Eastern Cape Province temporarily shut down, due to reports that the provincial province was behind in its subsidy payments. Eastern Cape, a province with an unemployment rate of 70 percent, is largely composed of rural areas that were the economically neglected Bantustan homelands under the apartheid regime. Zachary Wales, “Analysis; South Africa Acknowledges AIDS,” *UPI*, May 22, 2002.

⁸⁷ A 2003 investigation by the Democratic Alliance of specialized police units charged with handling sexual violence crimes reported that nationwide, a substantial percentage of such units were understaffed and under-resourced; officers’ caseloads were so high that they lacked time to conduct proper investigations; and that they lacked specialized training in child protection. Mike Waters, *South Africa’s Betrayed Children. Government’s Broken Promises. Report on Conditions & Activities of Child Protection Units*, February 2003.

⁸⁸ See Human Rights Watch, *Unequal Protection: The State Response to Violent Crime on South African Farms* (New York: Human Rights Watch, 2001), pp. 197-201.

⁸⁹ District surgeons were doctors appointed by the state, usually on a contractual basis, to perform clinical medico-legal procedures, including examination of sexual violence survivors, drunken drivers, prisoners, and applicants for disability and military pensions. Lorna J. Martin, *Forensic Examination Model in South Africa* (Geneva: World Health Organization, 2001), p. 8; see also Human Rights Watch, “South Africa: Violence Against Women and the Medico-Legal System,” *A Human Rights Watch Report*, vol. 9, no. 4, August 1997.

⁹⁰ See Martin, *Forensic Examination Model*. An “accredited health care practitioner” is a medical officer, specialist, or specially trained nurse who has “proved to have the necessary skills and knowledge by means of formal and/or informal training and experience” and who has been appointed by the Department of Health to conduct forensic medical examinations for victims of sexual offences. Department of Health, *Uniform National Health Guidelines for Dealing with Survivors of Rape and Other Sexual Offences* (2000).

both undergo forensic examination and get medical treatment for the assault.⁹¹ In practice, however, as district surgeons have been phased out, insufficient training has been provided to medical practitioners who were to replace them to ensure that the district surgeons' expertise in performing clinical forensic examinations remained in the health service.⁹²

Many sexual violence survivors' first contact with the health system is with the casualty (accident and emergency) department at a hospital, where treating physicians and nurses are often overworked, inexperienced, and untrained to do clinical forensic exams or manage rape cases.⁹³ In early 2003 the national Department of Health announced its decision to train forensic nurses throughout the health system to assume some of these responsibilities.⁹⁴

Notwithstanding these resource problems, South Africa has the capacity to provide PEP in more areas than it is doing so. Financial resources for HIV/AIDS increased substantially in 2003/2004: the national government allocated more than 2 billion rand (U.S.\$300,000,000)⁹⁵ (8.6 percent of the overall social services budget) to fighting HIV/AIDS, a greater than 75 percent increase from the amount set aside in the budget the previous financial year.⁹⁶ In February 2004 finance minister Trevor Manuel

⁹¹ See Martin, *Forensic Examination Model*.

⁹² See Ibid. "Policy makers also mistakenly assumed that every medical practitioner performing clinical district health services would be taught by existing full-time expert District Surgeons to perform sophisticated clinical forensic examinations (rape, child abuse, drunken driving). These assumptions however have not materialised and unfortunately, due to the lack of manpower and training, the necessary expertise required for examining rape survivors is not available at most primary health care clinics." Ibid.

⁹³ Medical students in South Africa are given minimal training in handling sexual offences. Health Minister Manto Tshabalala-Msimang reported that she had been told that medical students were given forty-five minutes' training in the handling of sexual offences: "Imagine a doctor with a 45-minute exposure to the issue of sexual offences examining a victim or survivor of a brutal, intimate and potentially soul-destroying crime like rape . . . For me, the thought is unbearable." Kerry Cullinan, "Forensic Nurses," *Health-e Online Health News Services*, March 27, 2000.

⁹⁴ The national Department of Health has announced plans to train forensic nurses throughout the country to improve the treatment of sexual violence survivors and to ensure that sound medical forensic evidence is collected. Kerry Cullinan, "Forensic Nurses," *Health-e Online Health News Services*, March 27, 2000. The first group of forensic nurses completed their training in Gauteng in November 2003. Gauteng Department of Health, "Fight Against Sexual Offences Gets a Boost," November 21, 2003, <http://www.gpg.gov.za/frames/pr1121a-f.html> (retrieved December 7, 2003).

⁹⁵ As of this writing, one 1 South African rand is worth approximately 0.15 U.S. dollars.

⁹⁶ The government initially allocated 1.952 billion rand (U.S.\$292,800,000) to combat HIV/AIDS, including funds for an antiretroviral drug program and for strengthening health services to better deal with the epidemic. Alison Hickey and Nhlanhla Ndlovu, "What Does Budget 2003/4 Allocate for HIV/AIDS?" *IDASA-Budget Information Service*, Budget Brief No. 127, March 25, 2003. An additional allocation of 90 million rand (U.S.\$13,500,000) was later approved for the Department of Health to begin implementation of the national antiretroviral treatment program. National Treasury, "Adjusted Estimates of National Expenditure," *Medium Term Budget Policy Statement 2003*, p. 72.

announced South Africa's plans to allocate an additional 2.1 billion rand (U.S.\$315,000,000) to HIV/AIDS, boosting the government commitment to fight HIV/AIDS over the next three years to more than 12 billion rand (1,800,000,000).⁹⁷

And PEP can—and should—be integrated into existing health care services that the government has promised. Many of the services required as part of prevention of mother-to-child HIV transmission programs (which the health ministry has been establishing since 2001), as well as for the treatment plan to which the government committed itself in November 2003, overlap with those required for PEP provision. HIV testing and counseling, effective drug procurement systems, and staff trained regarding HIV/AIDS and antiretroviral drugs are part of all of these programs. These currently exist at some level throughout the country. South Africa's recent commitment to a comprehensive HIV/AIDS care and treatment plan, which includes upgrading the national healthcare system, extensive training of health care workers, and massive education campaigns on prevention and treatment of HIV/AIDS, should greatly enhance the provision of PEP services.⁹⁸

V. PEP Implementation: Human Rights Watch Findings

Outside of Western Cape, PEP was not generally provided to rape survivors by the public health system prior to April 2002.⁹⁹ National and provincial policies and programs to provide PEP through the public health system mark important progress, but problems in gaining access to PEP and related services remain, especially for children.

Human Rights Watch identified several impediments to PEP services. Government failure to provide adequate information or training about PEP left rape survivors and key service providers with little or no knowledge about PEP. Government failure to provide clear messages in support of ARVs compounded this problem. In the face of its

⁹⁷ Minister of Finance Trevor Manuel, "2004 Budget Speech," February 18, 2004. In his Medium Term Budget Policy Statement, Manuel announced that total government expenditure to combat HIV/AIDS would exceed 3 billion rand (U.S.\$450,000,000) by 2004, 4 billion rand (U.S.\$600,000,000) in 2005/2006 and 4.8 billion rand (U.S.\$720,000,000) in 2006/2007. Minister of Finance Trevor Manuel, "Address to the National Assembly on the Tabling of the Medium Term Budget Policy Statement and the Adjustments Appropriation Bill, 2003," November 12, 2003.

⁹⁸ Cabinet of South Africa, *Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa*, November 19, 2003, p. 24.

⁹⁹ Prior to April 2002, a few service providers, including the NGO GRIP in Mpumalanga, and a few public and private hospitals in Gauteng, also provided PEP to rape survivors. See note 36, above.

history of pronouncements against ARV drugs, even those who had information about PEP were confused about whether it was government policy to provide it.

Inadequate police response to sexual violence complaints coupled with arbitrary requirements imposed by health professionals has also posed barriers to PEP. Problems obtaining consent to PEP services and lack of guidance for providers regarding PEP administration were additional concerns for children under fourteen. Other barriers to PEP services include stigma and discrimination of rape survivors and people with HIV, unequal access to poor and rural dwellers, inattention to social factors that inhibit completion of medications, and inadequate coordination among service providers. These are considered below.

Lack of Information about PEP

There are good policies in this country. . . a good constitution, human rights provisions. But [the] numerous guidelines that have been produced by the government, they're not disseminated. That's because there's poor administration on behalf of the health department. People in charge most probably have no clue how to operationalize the strategic plan.

- Dr. Kas Kasongo, pathologist, Port Elizabeth, May 30, 2003

The national government announced its intention to roll out PEP services in April 2002 as part of a “comprehensive package of support” for sexual violence survivors without launching an information campaign to educate the general public and relevant service providers about PEP or providing training on its administration. Provincial governments, for the most part, neglected this task as well. As a result, rape survivors often did not know about the health risks of rape or about PEP and other treatment and services available to them. Some of the agencies charged with providing services to rape survivors likewise did not know that the government has committed itself to providing PEP, nor what it is, where to get it, or how to administer it.

In light of the government’s attacks on the use of antiretroviral drugs for treatment of people living with HIV/AIDS, the government has a particularly weighty obligation to insure that members of the public as well as service providers have complete and accurate information about PEP to prevent HIV after rape. Human Rights Watch’s investigation suggests that they failed to meet this obligation. Many rape survivors had not received PEP services simply because neither they nor the various agencies charged with providing services to them had any idea that they existed. Health care providers,

police, rape crisis center staff, and others who interact with sexual violence survivors were inadequately informed about this service. Since PEP must be administered within seventy-two hours of rape, this lack of information may have been deadly for many sexual violence survivors.

Provincial Efforts to Disseminate Information about PEP

Gauteng started its PEP program in June 2002, two months after the national policy was announced.¹⁰⁰ Between June and December 2002, the Gauteng Department of Health conducted four training sessions for medical staff and social workers on PEP.¹⁰¹ During the initial rollout of the program, the department did not publicize the program widely, out of concern with making sure that it would be ready to deal with the influx of people who needed drugs. According to Mohau Mokhasane, deputy director of medico-legal services in the Gauteng Health Department: “We entered into the program cautiously because we didn’t want to get everyone to come into clinics without having the correct information out there.”¹⁰²

In KwaZulu-Natal, provincial health authorities informed hospital directors by electronic mail and follow-up fax that the protocol for the management of rape survivors had been amended to include PEP at end-September 2002 and relied on hospital directors to inform relevant health care workers of these changes.¹⁰³ However, no systematic efforts were made to ensure that clinicians in each institution were aware of the procedures. There were few efforts to train clinicians regarding administration of the drugs; monitoring or evaluation procedures were not put in place to see that the programs were properly implemented.¹⁰⁴ Nor were there corresponding efforts to train police or other frontline workers who interact with survivors of sexual violence, or an information campaign put in place to educate the general public.

¹⁰⁰ Gauteng Health Department completed its PEP protocol in June 2002 and thereafter disseminated it to regional management and to health centers that were to implement the program. The South African Police Services were informed of the policy at provincial level meetings attended by representatives of the departments of health, social welfare and safety and security. Human Rights Watch telephone interview with Mohau Mokhasane, deputy director, medico-legal services, Gauteng Department of Health, August 25, 2003.

¹⁰¹ These trainings, which focused on voluntary testing and counseling for HIV/AIDS, included a one-day continuing medical education course targeted at doctors, which was held in August 2002, a three-day voluntary testing and counseling training in June 2002, and three ten-day training sessions in July, August, and November/December. Ibid.

¹⁰² Human Rights Watch interview with Mohau Mokhasane, deputy director, medico-legal services, Gauteng, June 2, 2003.

¹⁰³ Circular Minute No. G 47/2002 from Prof. R.W. Green-Thompson, superintendent-general, Department of Health, KwaZulu-Natal (September 25, 2002) (including protocols for PEP administration to adults and to children under fourteen); Human Rights Watch interview with Dr. Neil McKerrow, chief specialist and head of pediatrics and child health, Pietermaritzburg Metropolitan Hospitals, Pietermaritzburg, May 13, 2003.

¹⁰⁴ Ibid.

Kas Kasongo, a physician who had conducted PEP training for health care providers in Eastern Cape on behalf of the provincial health department noted similar problems. People who attended the trainings on PEP services for rape survivors were hospital superintendents and matrons,¹⁰⁵ not frontline health care workers who received rape survivors and dealt with their issues on a daily basis.¹⁰⁶ Dr. Kasongo told Human Rights Watch that he was not aware of any campaign to disseminate information about PEP and that generally speaking, many people were unaware of their rights to PEP and other services after rape.¹⁰⁷

Following Eastern Cape's January 2003 announcement that the province would provide PEP, a journalist, posing as a rape survivor, attempted to get the drugs at four of the nine hospitals designated as PEP providers. The journalist found that these drugs were not available at two hospitals and that some medical staff at these hospitals did not know what antiretroviral drugs were. Medical staff at a third hospital confirmed that the drugs were available for rape survivors, provided they had been examined by the district surgeon and opened a case with the police—neither of which conditions were required by government protocols.¹⁰⁸ Eastern Cape Health MEC Bovan Goqwana reportedly denied that the drugs were unavailable but conceded that hospital staff were not always aware of government policies.¹⁰⁹ In fact, as of the end of May 2003, antiretroviral syrup for child rape survivors was not available at all institutions designated to provide PEP, apparently due in part to misinformation about its availability.¹¹⁰

¹⁰⁵ Matrons are senior nurses who have supervisory responsibilities.

¹⁰⁶ Human Rights Watch interview with Dr. Kas Kasongo, Port Elizabeth, May 30, 2003.

¹⁰⁷ Ibid.

¹⁰⁸ Michelle Pughe-Parry, "Bisho Pledge to Rape Victims," *Weekend Post*, January 11, 2003.

¹⁰⁹ Ibid. An MEC, or Member of the Executive Council, is a member of cabinet in the provincial government.

¹¹⁰ AZT and 3TC are produced in syrup as well as tablet form. Syrups may be preferred for children because they are easier to ingest and because the dose can be more easily adjusted to the child's size than tablets. See Peter Havens et al., "Postexposure Prophylaxis in Children and Adolescents for Nonoccupational Exposure to Human Immunodeficiency Virus," *Pediatrics*, vol. 111, no. 6 (June 2003), pp. 1475-1489; Human Rights Watch telephone interview with Dr. Neil McKerrow, chief specialist and head of pediatrics and child health, Pietermaritzburg Metropolitan Hospitals, Pietermaritzburg, March 31, 2003.

In February 2003, in response to reports by rape crisis counselors that liquid antiretroviral drugs were not available for children, Eastern Cape Health MEC Bevan Goqwana replied that the liquid had been difficult to obtain because it had not been put on national tender for provinces to buy in bulk, but that depots had it in stock for hospitals and clinics to order. Michelle Pughe-Parry, "Child Victims Given AIDS Drug Pledge," *Weekend Post*, February 8, 2003. Pediatric antiretroviral syrup was not available at Umtata General Hospital until the end of May 2003, apparently because the hospital believed it was not available in the province. Human Rights Watch interview, Umtata, May 26, 2003. As a result during the first six months of 2003, several children under fourteen who came to the hospital for treatment within seventy-two hours of rape did not receive PEP. Ibid.

Lack of Information about PEP among Service Providers

Institutions that work with children and with sexual violence survivors, including health care facilities, police stations and schools each may be the first point of contact for rape survivors. It is therefore essential that they all have information about PEP. Human Rights Watch found, in each of the provinces we visited, that many key service providers lacked even basic information about PEP.

Medical Staff

A pharmacist at an Eastern Cape public hospital designated to provide PEP told Human Rights Watch that doctors working in his hospital did not know about PEP. “In February and March, we had PEP going and I still found doctors not knowing about it. I sent out circulars [about PEP], but some doctors still didn’t know . . . Doctors rotate. They might have [previously] been in a rural hospital with no PEP.”¹¹¹ The pharmacist also said that lack of information about how PEP works may explain, in part, why compliance with the PEP regimen was poor. His hospital’s policy was to issue a three-to seven-day supply of antiretrovirals and then to issue the remainder of the drugs when the survivor returned for her HIV test results. But after receiving the initial supply, “a lot of patients don’t return” for the remaining supply of drugs. The pharmacist suggested that the lack of information among both patients and service providers contributed to the failure of so many patients to follow up on PEP services.¹¹²

Police

Specialized police units in main population centers known as “Child Protection Units” or “CPUs” are charged with handling crimes against children related to family violence, rape and other sexual offences. In areas where there is no CPU present, child abuse cases are supposed to be handled by specialized police officers attached to the detective unit.¹¹³

¹¹¹ Human Rights Watch interview, East London, May 28, 2003.

¹¹² *Ibid.*

¹¹³ Child Protection Units (CPUs) were established in 1995, in response to the increase in criminal complaints related to child abuse. In 1996, the South African Police began to restructure the CPUs to extend their services to include investigation of family violence and all sexual offences. See South African Police Services, “Family Violence, Child Protection and Sexual Offences Unit,” http://www.saps.org.za/7_crimeprev/7_childunit.htm (retrieved August 7, 2003). There were forty-five specialized units countrywide as of the end of 2002, of which thirty-three were CPUs and twelve were Family Violence, Child Protection and Sexual Offences units. South African Police Service, *Annual Report 2001/2002*, 2002, p. 47. In 156 towns, specialized police attached to the detective service had been assigned to handle crimes against women and children. In this report, we refer to all such units as CPUs, the name by which they are commonly known.

High-ranking officials with CPUs in Durban, KwaZulu-Natal, and Umtata, Eastern Cape shared with Human Rights Watch comprehensive written protocols for handling rape cases, which acknowledged the importance of collecting forensic evidence but did not incorporate information about PEP.¹¹⁴ A senior officer with the Durban CPU told Human Rights Watch that he had learned about the availability of PEP over a year after the national government's announcement of the program. He had heard a report "as I was driving, I heard it on the radio Until now there has been no government [support for services]. . . . We got no notification [of the medical protocol]. I speak to doctors, so I know about it."¹¹⁵

A senior officer with the CPU in Umtata, Eastern Cape reported that he had had no training about PEP, antiretroviral drugs, or how to prevent HIV after rape. He told Human Rights Watch that he had learned about PEP from a pharmacist at Umtata General Hospital who said that the PEP drugs, like all medications provided to rape survivors, were free. The pharmacist said that for the drugs to be helpful, they must be provided to the victim immediately.¹¹⁶ The officer also told Human Rights Watch that if a person were raped in the middle of the night, he or she would get the drugs the following day.¹¹⁷

There were two health care facilities that offered comprehensive care for rape survivors in the area covered by the Umtata CPU: one in Umtata, and a second in Limbode, about thirty minutes from Umtata by car. CPU police took rape survivors to the closer of the two facilities for care. As of May 2003, PEP was available only in Umtata. Perhaps if the CPU had been properly informed about PEP, they might have been able to facilitate the distribution of these drugs to rape survivors who were picked up closer to the Limbode facility by bringing them to the Umtata facility.

Not only children and young people are affected by lack of information about PEP among police. In April 2003, a woman in her sixties was brought to Sinawe Rape Crisis Centre in Umtata, which administered PEP as part of its affiliation with Umtata General Hospital. The woman was taken to the police two days after having been raped, but the police had no vehicle to take her to the hospital. She was brought to Sinawe the fourth day after the rape, by which time it was too late for her to get PEP according to the

¹¹⁴ Human Rights Watch interview, Durban, May 15, 2003; Human Rights Watch interview, Umtata, May 27, 2003.

¹¹⁵ Human Rights Watch interview, Durban, May 15, 2003.

¹¹⁶ Human Rights Watch interview, Umtata, May 27, 2003.

¹¹⁷ *Ibid.*

official protocol. According to a nurse at Sinawe, “the police knew to take the woman to Sinawe [instead of the local clinic], but didn’t know anything about PEP.”¹¹⁸

Lack of Information among Sexual Violence Survivors

Many sexual violence survivors lacked information about PEP. In the context of the highly publicized controversy regarding the links between HIV and AIDS and on the provision of antiretroviral drugs, their need for information about PEP is particularly acute. Failure to take action on the part of health care providers (which may be related to inadequate information about PEP) only makes this problem worse. As a result, rape survivors who present promptly for care may not get PEP, or may not seek post-rape care promptly because they do not understand the importance of doing so. These problems are compounded for children, who must often rely on others for assistance in obtaining services.

Arthur Jokweni, national youth coordinator for the Treatment Action Campaign (TAC) in Durban, told Human Rights Watch of an incident from April 2003 that illustrates how rape survivors’ lack of information impeded access to PEP services. In April 2003, a Durban pharmacist phoned Jokweni asking for TAC’s help with a woman who had been raped but had not been prescribed PEP. Jokweni went to the pharmacy and met with the rape survivor, who told him that she had been raped early the previous morning. She had reported this to the police and been taken to a hospital in Durban. She was told that the doctor was not there and was then taken to a hospital in Umlazi (about a half hour away), where she was asked for her consent to take a blood test. The doctor did not explain to her why she needed to take blood or otherwise explain PEP. The woman refused to allow her blood to be tested and was given a prescription for antibiotics and an appointment for a follow-up visit.

After Jokweni told the rape survivor about PEP, including the requirement that she test negative for HIV to obtain it, she told him that she wanted PEP. Jokweni accompanied the woman to the Durban hospital where she had gone the day before. After several hours, and with Jokweni’s assistance in struggling with the hospital bureaucracy, the woman ultimately got a blood test and a prescription for PEP drugs. The lack of urgency with which the hospital administration and the social worker treated this case suggests that they also may not have understood the importance of prompt provision of PEP services.

¹¹⁸ Human Rights Watch interview, Umtata, May 28, 2003.

Lack of Information about PEP in Rural Areas

Problems regarding lack of information about PEP may be more acute for South Africans living in rural areas. Rural South Africans generally have worse access to complete, up-to-date HIV prevention information and fewer opportunities for HIV education than their urban counterparts. As a result, they may have suffered the greatest harms due to misinformation about HIV, AIDS and antiretroviral drugs.

Nomakuze Solwande, director of a women's support center in Butterworth, rural Eastern Cape, devoted much of her time to assisting rape survivors in pursuing medical and legal assistance and advocating on their behalf before local and provincial governmental bodies. Solwande told Human Rights Watch that she had never heard of PEP. "It's not happening in my area. Even now, there is no nevirapine in my area. . . . All rape victims get is some kind of antibiotics."¹¹⁹ Solwande has years of experience working with rural sexual violence survivors, and has contacts with women's groups and government officials extending to major urban areas in Eastern Cape. If she did not know about PEP, it is all the less likely that other members of her community did.

Inge Human, program manager of a victim support center based in Port Elizabeth, Eastern Cape, worked in Eliot, Fort Beaufort and Lungisi (rural areas outside of Port Elizabeth) to establish victim support centers. None of the hospitals in these areas had the PEP protocol until Human's agency provided it to them; nor did they stock antiretroviral drugs for sexual violence survivors.¹²⁰ According to Human, another problem in rural communities like these was that "there's a lot of ignorance among the role-players about what should happen and how the process should work. . . . Sometimes the victim goes to hospital and the doctor is not there and the victim is told to come back the next day. If you have to administer PEP, you can't let the victim go home."¹²¹

Government Opposition to Antiretroviral Drugs as an Obstacle to PEP Services

President Mbeki's and Minister of Health Tshabalala-Msimang's highly publicized opposition to providing antiretroviral drugs to treat HIV/AIDS through the public

¹¹⁹ Human Rights Watch interview with Nomakuze Solwande, director, Masonwabisane Women's Support Center, East London, May 27, 2003.

¹²⁰ Human Rights Watch interview with Inge Human, program manager for community victim support, NICRO, Port Elizabeth, May 30, 2003. These hospitals were not included among the nine hospitals initially designated to provide PEP in Eastern Cape.

¹²¹ Human Rights Watch interview with Inge Human, Port Elizabeth, May 30, 2003.

health system and their engagement of denialists as high-level AIDS advisors continued even after the 2002 PEP announcement. In the face of its history of opposition to antiretroviral drugs, government failure to provide clear messages supporting PEP services undermined access to these services. Police and medical staff who should have been on the frontlines of providing PEP may not have done so, even when they knew about PEP, because of misinformation from the highest levels of government.

Dr. Kasongo, from Eastern Cape, told Human Rights Watch in May 2003 that many physicians and other health care workers in Eastern Cape did not know about PEP. He blamed the widespread lack of information about PEP on the government's more general reluctance to provide antiretroviral drugs.

A year ago, the national department of health, the government, had made it official and legal that antiretrovirals could be given to rape survivors. But one cannot take the provision of ART [antiretroviral therapy] in isolation. There's a lot of controversy related to the provision of antiretrovirals in general, universal access to antiretrovirals. It's still a very debated issue. Because the government is still reluctant to provide antiretrovirals in general, there's been very little done in terms of educating health care workers about how to use antiretrovirals. Health care workers should be trained with respect to the use of antiretrovirals, but this hasn't been happening.¹²²

St. Elizabeth Hospital in Lusikisiki, northern Eastern Cape, a hospital designated in January 2003 to provide PEP, did not provide the drugs until the following month, after an NGO worker explained that doing so was part of provincial government policy. Said the NGO project manager: "The hospital superintendent was scared to give the antiretrovirals because he thought it was against government policy. He got a protocol, but he had no drive from the government to help staff the program. I had to convince the hospital superintendent to start providing PEP."¹²³

A senior officer with the Durban CPU told Human Rights Watch that "When the KwaZulu-Natal [PEP] policy was made, it was in conflict with the national government's

¹²² Human Rights Watch interview with Dr. Kas Kasongo, Port Elizabeth, May 30, 2003.

¹²³ Human Rights Watch telephone interview with Dr. Herman Reuter, project manager, Médecins Sans Frontières mission in Lusikisiki, May 14, 2003.

standpoint on the issue. The national government says we're not sure that this works. Now the announcement was made, but I'm not sure the access is really there."¹²⁴

Childline is an NGO that provides a twenty-four-hour child abuse telephone help-line and community education on child abuse prevention and on services for rape survivors, including PEP. Joan van Niekerk, national coordinator, Childline-South Africa, told Human Rights Watch that government opposition to antiretroviral drugs had created confusion about whether PEP was beneficial or harmful, even among experienced Childline workers. In June 2003, a longtime Childline volunteer told van Niekerk, then director of Childline-KwaZulu-Natal, "that he had been asked by someone in government to spearhead a campaign against ARVs . . . He claimed that he had been approached by someone in government to lead a campaign in his community against the call for PEP because of the belief that PEP in itself caused death and severe illness."¹²⁵ He also told van Niekerk that he was confused about the information that he had been given by Childline regarding the benefits of PEP.¹²⁶ Van Niekerk was extremely concerned about this report: "If he was confused, as a trained volunteer, then what about people in the community?"¹²⁷

Dr. Michelle Roland, professor of medicine at the University of California-San Francisco Positive Health Program, trains physicians on PEP in the United States and South Africa. In mid-2003, an experienced physician who had provided PEP to hundreds of rape survivors in Western Cape expressed his confusion to Roland about the utility of antiretroviral drugs to treat HIV, in light of past government statements that these drugs were toxic and of no probable value to treat HIV. "After working in an HIV clinic in San Francisco and reading the literature, this doctor is now a strong supporter of ARV therapy. But if an experienced sexual assault health care provider, who routinely provides PEP, was confused about the utility of ARVs to treat HIV, how will providers with no PEP experience respond to PEP policy? This is likely to be a confusing transition period relative to ARV therapy and PEP in the professional domain."¹²⁸

¹²⁴ Human Rights Watch interview, Durban, May 15, 2003.

¹²⁵ Human Rights Watch telephone interview with Joan van Niekerk, national director, Childline-South Africa, December 12, 2003.

¹²⁶ *Ibid.*

¹²⁷ *Ibid.*

¹²⁸ Human Rights Watch e-mail communication with Michelle Roland, professor of medicine, University of California-San Francisco Positive Health Program, December 11, 2003.

Lack of Guidance Regarding PEP for Children Under Fourteen

As of this writing, the South African government had not finalized guidelines for PEP for children under fourteen, leaving many health care providers without basic information on PEP services for younger children. Eastern Cape's PEP protocol includes guidance on PEP for children under fourteen but these guidelines were not provided to all health care providers handling child rape cases. Nurses who worked with children at rape crisis centers in Umtata and Uitenhage, Eastern Cape—which both had significant problems with sexual violence—had copies of the national guidelines (which lacked instruction for children under fourteen) on file, and were surprised to learn of the existence of the provincial guidelines.

Gauteng's policy guideline for management of sexual violence cases included brief information on dosage of pediatric antiretroviral syrup for children.¹²⁹ The guideline did not define who is a child for the purposes of PEP provision. This may have been a source of confusion for practitioners, given that the age of majority varies widely among South African laws dealing with children.¹³⁰

Consent to HIV Testing and to Medical Treatment for Children Under Fourteen

National and provincial PEP guidelines require that a rape survivor test negative for HIV in order to qualify to receive PEP drugs.¹³¹ Children under fourteen cannot, however, consent on their own either to HIV testing or to medical treatment.¹³² There

¹²⁹ See Gauteng Health Department, *Revised Policy Guideline for Management of Victims of Sexual Assault Cases*, June 2002, p. 17.

¹³⁰ The Gauteng policy guideline itself notes these differences. See *ibid.*, annexure A, "Legal Aspects and Acts-Sexual Offences. The Different Ages of Majority in the Different Acts" comparing, among others, Criminal Procedure Act, Act 51 of 1977, Child Care Act of 1983, Constitution of the Republic of South Africa, Section 28(1) ("child" defined as a person under eighteen years) with Age of Majority Act 57 of 1972 (children attain age of majority at twenty-one years old); Sexual Offences Act 23 of 1957, sec. 14 (criminalizing male attempt to have unlawful intercourse with a girl female under sixteen and female attempt to have unlawful intercourse with male under sixteen).

¹³¹ See South African Department of Health, "Policy Guideline For Management Of Transmission Of Human Immunodeficiency Virus (HIV) and Sexually Transmitted Infections In Sexual Assault." Provincial guidelines in KwaZulu-Natal, Gauteng and Eastern Cape, modeled on the national guidelines, also require rape survivors to submit to HIV tests before receiving PEP.

¹³² Under the Child Care Act, children under fourteen cannot receive medical treatment without the consent of a parent or guardian, or, where the child is in the custody of a person other than her parent or guardian, or certain state institutions, the consent of the head of the institution or the person in whose custody the child has been placed. Child Care Act, Sections 4(b); 53(1). Problems obtaining consent are of particular concern for children in communities very hard hit by HIV/AIDS, where children are often cared for outside of their biological families or have no adult caretaker and locating a legal guardian promptly (or at all) is difficult. In December 2003, the Johannesburg High Court ruled that consent for HIV care and treatment could be given by caretakers of children living with HIV/AIDS who are orphans or whose parents or guardians cannot be readily located. The decision is limited to a group of pediatricians providing HIV care and treatment at three Johannesburg hospitals.

are provisions to obtain consent in cases where no parent or guardian can be reached and in urgent cases, but many medical staff and counselors charged with treating child sexual violence survivors either do not know or do not follow them. As a result, some children are barred from treatment altogether, at the potential cost of their lives.

Procedures to Bypass Consent

If parental or guardian consent cannot be obtained, a medical practitioner may apply to the Minister of Social Development to obtain permission for HIV testing or medical treatment.¹³³ This requirement has been criticized as impractical.¹³⁴ And where time is of the essence—as is the case of PEP—it may be too time-consuming an option to pursue.

In an emergency, the medical superintendent of a hospital where a child is being treated may consent to medical treatment on behalf of a child under fourteen, provided the treatment is “necessary to preserve the life of a child or to save him or her from serious and lasting physical injury or disability and that the need for the operation or medical treatment is so urgent that it ought not to be deferred for the purpose of consulting the person who is legally competent to consent to the operation or medical treatment.”¹³⁵

KwaZulu-Natal’s PEP protocol considers HIV testing and PEP to be necessary lifesaving treatment for rape survivors, permitting the medical superintendent to consent to HIV testing and PEP for children who have no parent or guardian to consent on their behalf.¹³⁶ Other protocols offer no similar guidance, however.

“South Africa: Court Ruling Favors Children Orphaned by AIDS,” *PlusNews*, December 8, 2003; see also Notice of Motion in the Application of Meyers et al. in the High Court of South Africa (Witwatersrand Local Division), Case No. 03/29172, November 28, 2003.

¹³³ The law provides that where a parent or guardian refuses to consent, cannot be found, or cannot consent because he or she is mentally ill or deceased, “the practitioner shall report the matter to the Minister, who may, if satisfied that the operation or treatment is necessary, consent thereto in lieu of the parent or guardian of the child.” Child Care Act, Act No. 74 of 1983, Section 39(1).

¹³⁴ See, e.g., South African Law Commission, *Report on the Child Care Act*, December 2002, p. 140.

¹³⁵ Child Care Act, Act No. 74 of 1983, Section 39(2).

¹³⁶ See KwaZulu-Natal Child Sexual Assault Algorithm. Dr. Neil McKerrow, chief specialist and head of pediatrics and child health, Pietermaritzburg Metropolitan Hospitals, explained that “our protocol suggests that in the absence of a parent or guardian to provide consent commissioner’s consent is used as we consider this to be a life-threatening situation. Commissioner’s consent can be provided by the head of a hospital.” E-mail communication with McKerrow, April 1 and August 20, 2003. An HIV test has been interpreted to constitute “treatment” within the meaning of Section 39 by the State Law Advisers. Human Rights Watch telephone interview with Liesl Gerntholtz, head of legal unit, AIDS Law Project, January 9, 2004. See also Liesl Gerntholtz, “HIV Testing and Treatment, Informed Consent and AIDS Orphans,” *ESR Review*, vol. 4, no. 3, September 2003 (HIV testing should be considered urgent medical treatment in context of PEP).

Parental/Guardian Refusal to Provide Consent

Medical staff and counselors working with child rape survivors reported differing interpretations about what they were permitted to do when a parent or guardian refused consent to HIV testing or PEP.

Inge Human, program manager of a victim support center based in Port Elizabeth, told Human Rights Watch about a case in which an eleven-year-old rape survivor was denied treatment when her mother refused to consent to her daughter's HIV test. Both the doctor and the rape crisis counselor tried to educate the mother about the test and about PEP, but since the mother refused to let her child be tested, the child did not get PEP. In the counselor's understanding, even though the child had presented for treatment within seventy-two hours: "If a parent refuses [to consent for a child's HIV test], there is nothing you can do."¹³⁷ V.B. Mohammed, a physician who treated child sexual violence survivors, likewise told Human Rights Watch that if the family opposed HIV testing (thereby blocking PEP), she could not compel them to consent, as she had no right to do so.¹³⁸

Lorna Jacklin, a physician specializing in the treatment of child sexual abuse survivors, explained that the South African constitution required that every decision be made in the "best interests of the child." Accordingly, in situations where a child's parent or guardian refused testing or treatment, the hospital superintendent could provide consent on the child's behalf if refusal to consent would be against the child's "best interests."¹³⁹ Hangwi Manavhela, executive officer at a rape crisis center in Sibasa, Limpopo, told Human Rights Watch that in cases where guardians refused to consent to HIV testing, her organization likewise sought assistance from the hospital superintendent.¹⁴⁰

Unaccompanied Children

Human Rights Watch's research suggests that there is a dangerous lack of clarity regarding how to obtain consent for unaccompanied children. Some medical staff and

¹³⁷ Human Rights Watch interview with Inge Human, program manager for community victim support, NICRO, Port Elizabeth, May 30, 2003. A nurse at Sinawe Referral Center, a rape crisis center in Umtata, Eastern Cape, likewise reported that if a parent refused an HIV test for her child, they wouldn't do it, and the child consequently could not get PEP. Human Rights Watch interview, Umtata, May 26, 2003.

¹³⁸ Human Rights Watch interview with Dr. V.B. Mohammed, Umlazi, May 15, 2003.

¹³⁹ Human Rights Watch interview with Dr. Lorna Jacklin, Teddy Bear Child Abuse Clinic, Johannesburg, May 20, 2003.

¹⁴⁰ Presentation by Hangwi Manavhela, executive officer, Thohoyandou Victim Empowerment Programme, at workshop on PEP implementation convened by the Center for the Study of Violence and Reconciliation and the AIDS Law Project, Johannesburg, May 21, 2003.

counselors working with child rape survivors told Human Rights Watch that consent for testing and treatment of unaccompanied children under fourteen could be obtained from the medical superintendent or from the police, while others reported that unaccompanied children went untreated. Rape crisis counselors in Eastern Cape identified problems obtaining consent as one of the barriers impeding unaccompanied children's access to PEP. In one case, a twelve-year-old rape survivor who came to the hospital alone was told by the doctor who saw her that no one could consent for her to have an HIV test. As a result, she was not prescribed PEP.¹⁴¹ Physicians who treated sexual violence survivors in KwaZulu-Natal and Gauteng told Human Rights Watch that consent to HIV testing and PEP could be obtained from the hospital for street children or unaccompanied children.¹⁴²

Physicians and rape crisis counselors also reported that in situations where parental or guardian consent was unavailable, they or the treating physician sought consent for HIV testing on behalf of the child from the police.¹⁴³ While police may provide proxy consent for children to undergo forensic examinations in certain situations,¹⁴⁴ they do not otherwise have capacity to consent to HIV testing and PEP on behalf of children under fourteen, which are not part of forensic examinations. And, filing a charge—that is, dealing with the police at all—is not a prerequisite to PEP and may in fact itself interfere with prompt receipt of PEP and related medical services.

Recommendations to Facilitate Obtaining Consent

The Child Care Act amendments (Children's Bill) propose changes regarding consent that would facilitate access to treatment for children under fourteen whose parents cannot or will not consent to HIV testing and PEP services on their behalf.¹⁴⁵ The bill

¹⁴¹ Human Rights Watch interview rape with crisis counselor, Rape Crisis-Port Elizabeth, Port Elizabeth, Eastern Cape, May 29, 2003.

¹⁴² Human Rights Watch interview with Dr. Lorna Jacklin, Teddy Bear Child Abuse Clinic, Johannesburg, May 20, 2003; Human Rights Watch interview with Dr. V. B. Mohammed, Umlazi, May 15, 2003.

¹⁴³ Human Rights Watch interview with Dr. Lorna Jacklin, Teddy Bear Child Abuse Clinic, Johannesburg, May 20, 2003; Human Rights Watch interview with Dr. Linda Cartwright, Rainbow Child Abuse Clinic, Coronation Hospital, Johannesburg, May 19, 2003; Human Rights Watch interview, Port Elizabeth, May 29, 2003.

¹⁴⁴ In cases of child sexual violence where a charge has been laid, the police may consent to a medical examination. See Criminal Procedure Act, Act No. 51 of 1977, as amended by Criminal Law Amendment Act, Act No. 4 of 1992 (providing that in investigating cases of indecent assault or acts of violence against a minor, a magistrate, commissioned police officer, or the police official in charge of a local station may grant consent to medical examination by a district surgeon or registered medical practitioner in situations where the child's parent or guardian cannot be traced within a reasonable time, cannot grant consent in time, is a suspect in the offence, unreasonably refuses to give consent, is incompetent to consent, or is deceased).

¹⁴⁵ The Children's Bill, drafted by the South African Law Commission, aims to consolidate laws relating to child welfare and protection in one comprehensive statute. South African Law Commission, *Report on the Review of the Child Care Act*, December 2002, pp. 1-8. The bill initially submitted to parliament has been split into two

recognizes that the HIV/AIDS pandemic has dramatically altered the world in which South African children live. It recommends that the age of consent to medical treatment be lowered to twelve for children sufficiently mature to understand the “benefits, risks, social and other implications of the treatment.” For children under twelve or otherwise incapable of consent, it recommends consent be given by the child’s parent, primary caregiver or relative caring for a child.¹⁴⁶ The bill also expands the options for consent to medical treatment where a parent or primary caregiver unreasonably refuses to give consent or is unavailable.¹⁴⁷ Under the bill’s provisions, a hospital superintendent may consent to medical treatment in certain emergency situations and on behalf of a street child or a child in a child-headed household.¹⁴⁸

The bill’s provisions specifically address HIV testing. They state that consent to an HIV test may be given by a child over twelve and by a child under twelve if the child is of “sufficient maturity to understand the benefits, risks and social implications of the test,” the child’s parents, caregivers, or a designated child protection agency arranging placement of the child or a hospital superintendent in certain defined circumstances.¹⁴⁹ A child and family court also can give permission for an HIV test if the consent is being unreasonably withheld or the child’s parent or caregiver is incapable of giving consent.¹⁵⁰

As of this writing, there is no indication when the Children’s Bill might be enacted. In the interim, Human Rights Watch recommends that the provisions of the bill pertaining to consent be enacted to ensure that all children have access to PEP. Until such legislation is passed, we recommend that where parental or guardian consent cannot be obtained, expedited procedures be put in place to get consent to facilitate prompt administration of PEP services for sexual violence survivors.

sections: a “section 75” bill that covers areas of national legislative competence and a “section 76” bill that applies to areas of provincial legislative competence. Republic of South Africa, *Memorandum on the Objects of the Children’s Bill, 2003*, addendum to Children’s Bill introduced in National Assembly August 13, 2003, p. 84. The bill has been withdrawn from parliament and as of this writing there is no indication when it will be rescheduled for consideration. See Progress Report on Bills Before National Assembly Committees, February 5, 2004; see also “Setback for Child Rights Law,” *Mail & Guardian*, February 6, 2004.

¹⁴⁶ Children’s Bill, Sections 135(3), 207(1)(b), (3).

¹⁴⁷ A person who cares for a child, but is does not have parental rights and responsibilities for that child (such as an unrelated, voluntary caregiver) and a child and family court may consent to medical treatment of that child if such consent cannot be reasonably obtained from the child’s parent or primary caregiver. *Ibid.*, Sections 44(2), 135(5). A child and family court may consent to medical treatment if the parent or primary caregiver is physically or mentally incapable of consenting on the child’s behalf, is deceased, or cannot readily be traced. *Ibid.*, Section 135(5).

¹⁴⁸ *Ibid.*, Sections 135(4), 237.

¹⁴⁹ *Ibid.*, Sections 136(2)(a-d).

¹⁵⁰ *Ibid.*, Section 136(2)(e).

Refusal to be tested for HIV or to consent to HIV testing on behalf of a child rape survivor should not bar the survivor from receiving lifesaving PEP drugs.¹⁵¹ Human Rights Watch recommends that the national policy guidance for PEP provision to sexual violence survivors be amended to eliminate the requirement conditioning PEP on a negative HIV test.¹⁵² Until such change is made, we recommend that the Department of Health issue policy guidance that makes clear that provision of HIV post-exposure prophylaxis following sexual violence be regarded as an emergency situation and the medical superintendent be permitted to consent to HIV testing and PEP on behalf of children under fourteen.

Police Interference with Access to PEP and Related Services

Police are often the first point of contact for rape survivors and their gateway to PEP and other post-rape services. This first interaction with government officials after being the survivor of a crime of sexual violence often sets the tone of her or his treatment from the criminal justice and health care systems. It is impossible to overstate how important it is that police officers be trained to work with survivors of sexual violence, be aware of the time constraints around administration of PEP, and be committed to ensuring that every survivor receive timely and appropriate medical treatment. In South Africa, the police response fails to meet these criteria.

Children are more likely to be dependent on police and other adults for assistance in obtaining PEP and other post-rape services and more likely to be intimidated than adults by police. Police interference with access to PEP services may therefore pose a more serious obstacle to children than to adult rape survivors.

National policy guidelines set out clear instructions for police investigation of domestic violence and sexual offences cases.¹⁵³ These guidelines mandate that police must accept

¹⁵¹ This is consistent with guidelines for PEP following rape in jurisdictions both within and outside South Africa. See, e.g., Western Cape Province Department of Health, *Provincial Policy on the Management of Survivors of Rape and Sexual Assault*, (2004); New York State Department of Health AIDS Institute, "Recommendations for Postexposure Prophylaxis."

¹⁵² Rape survivors or their parents or guardians may refuse to be tested for HIV for many reasons, including stigma associated with HIV and lack of treatment for people living with HIV. Lifesaving PEP should not be withheld because of refusal to be tested for HIV, especially where children cannot make this decision on their own. In a related context, it has been recommended that women living in high HIV-prevalence areas who are unable or unwilling to be tested for HIV be provided with antiretroviral drugs to prevent mother-to-child HIV transmission. Jeffrey S.A. Stringer et al., "Nevirapine to Prevent Mother-to-Child Transmission of HIV-1 Among Women of Unknown Serostatus," *The Lancet*, vol. 362 (November 29, 2003), pp. 1850-1853.

¹⁵³ See Domestic Violence Act, Act No. 116 of 1998 and SAPS *National Instruction 7/1999 on Domestic Violence*; South African Police Service, *National Policy Guidelines for Victims of Sexual Offences-South African Police Service*, <http://www.doj.gov.za/info/sex-guide-01.html> (retrieved August 1, 2003). Failure to comply with

and investigate all charges of domestic violence and not turn away any sexual violence survivors.¹⁵⁴ They require that sexual violence survivors be interviewed by police in a private room or quiet area away from the main desk and that reports of sexual offences be given immediate attention. They permit a survivor to report a case by appearing in person to a police station outside of the jurisdiction of her home or where the offence occurred, or by telephone.¹⁵⁵ The police must establish whether the survivor is in need of medical attention and, if so, arrange for it immediately.¹⁵⁶ The guidelines also instruct that the medical examination “must be conducted as soon as possible,” and that the investigating officer make the necessary arrangements for it, including escorting a survivor. Even where sexual violence was not reported in a prompt fashion (within seventy-two hours), a forensic exam should still be conducted, since “[e]ven if the victim has washed” the “possibility of obtaining evidence cannot be discounted.”¹⁵⁷

Human Rights Watch documented several accounts of police actions contrary to these requirements.¹⁵⁸ Heidi Allison, administrator at a crisis center in Pinetown, KwaZulu-

obligations imposed under the Domestic Violence Act or national instructions issued thereunder constitutes misconduct that must be reported to the Independent Complaints Directorate (ICD), an independent body charged with investigating complaints of misconduct by members of the South African Police Service. Domestic Violence Act, Section 18(b)(4). Failure to comply with the police section of the National Policy Guidelines, which have been issued as national instructions (*SAPS National Instruction 22/1998: Sexual Offences: Support to Victims and Crucial Aspects of the Investigation*) could give rise to internal police sanctions or be the source of an investigation by the ICD. See *SAPS National Instruction 22/1998: Sexual Offences: Support to Victims and Crucial Aspects of the Investigation*; South African Police Service Act, Act No. 68 of 1995, Section 53(2).

¹⁵⁴ Police instructions issued under the Domestic Violence Law require that where a criminal charge is laid by the complainant, the police must open a docket and have it registered for investigation. South African Police Service, *SAPS National Instruction 7/1999 on Domestic Violence*, paragraph 7(1). Police must also fully document their responses to every incident of domestic violence on a specific form, regardless of whether or not a criminal offence has occurred. *Ibid.*, paragraph 12(2). The Domestic Violence Law’s broad coverage extends to sexual violence committed against children by parents and others who have or have had a parental relationship with a child, other family members, intimate partners and past or current co-residents. *Ibid.*, Section (1)(vii).

SAPS national instructions on sexual offences direct the first officer receiving a report of sexual violence to open a docket and notify an investigating officer immediately, and instruct that no survivor be turned away from laying a charge. *SAPS National Instruction 22/1998: Sexual Offences*, paragraphs 3, 4.

¹⁵⁵ South African Police Service, *SAPS National Instruction 22/1998: Sexual Offences*, paragraphs 3, 4; *SAPS National Instruction 7/1999 on Domestic Violence*, paragraphs 4, 5.

¹⁵⁶ *SAPS National Instruction 22/1998: Sexual Offences*, paragraphs 3, 4, 7; Domestic Violence Law, Section 2(a) and *SAPS National Instruction 7/1999 on Domestic Violence*, paragraph (9) (requiring police to provide necessary assistance to victims in obtaining medical treatment).

¹⁵⁷ *SAPS National Instruction 22/1998: Sexual Offences*, paragraph 7.

¹⁵⁸ A 2002 investigation by the South African Human Rights Commission similarly found that police response to sexual violence against children was poor. Among other things, the commission found that the police failed to comply with national and local policy guidelines regarding management of sexual abuse, and that their knowledge of them was limited and that “contrary to policy, statements made are taken by inexperienced police officers as opposed to CPU members who specialize in child abuse . . . [which] negatively impacts on the investigation and ultimately on the outcome of the cases.” South African Human Rights Commission, *Report on Sexual Offences Against Children. Does the Criminal Justice System Protect Children?* April 2002, pp. 56-58.

Natal, reported that in February 2003, police repeatedly refused to open a case for a fifteen-year-old girl who had been gang-raped. The girl was taken to the police station, where the policeman on duty told the child that he could not deal with children's issues and turned her away. The child returned the next day and the day after that but was not able to get help. Ultimately, the crisis center intervened to assist the child with opening a case and pursuing medical treatment.¹⁵⁹ The police's refusal to open a case promptly may cost this girl her life and certainly undermined her ability to prove her case.

National policy guidelines require police to escort sexual violence survivors to the hospital or other place where a medical examination can be done, but in some locations police routinely refuse to do so.¹⁶⁰ According to Heidi Allison, "police are supposed to accompany the victim to hospital but sometimes they just give forms to the clients, and tell them, 'take this form J88 and go to RK Khan [Hospital].'"¹⁶¹

Rape survivors who attempt to report their cases promptly to the police may nonetheless present too late for PEP and forensic examination because their cases are not prioritized or because the police lack resources to transport them to a health care facility. A social worker who works with child rape and abuse survivors in Kwamashu, a township outside of Durban, told Human Rights Watch that if a rape survivor came to the police station at 10 a.m., the police might keep her waiting the entire day before taking her to the hospital.¹⁶² The police's reliance on the Child Protection Unit—which was outside Kwamashu—to transport child rape survivors to the hospital would contribute to any delay.¹⁶³

Dr. V.B. Mohammed of Prince Mshyeni Hospital in Umlazi told Human Rights Watch that police frequently discouraged children from filing complaints and sometimes told them that they had to pay to open a case and for transport to the hospital.¹⁶⁴ Delphine Serumaga, executive director of People Opposing Women Abuse, told Human Rights Watch that "lost files" was a common problem interfering with rape cases. She said that a rape survivor would open a case, be told to return and upon returning be told that the file had been lost. According to Serumaga, the statement that the "file is lost" was a

¹⁵⁹ Human Rights Watch interview with Heidi Allison, Open Door Crisis Care Centre, Pinetown, May 16, 2003.

¹⁶⁰ *SAPS National Instruction 22/1998: Sexual Offences*, paragraph 7; see also South African Police Service, *SAPS National Instruction 7/1999 on Domestic Violence*, paragraph 9 (mandating police assist domestic violence complainant in obtaining medical treatment).

¹⁶¹ Human Rights Watch interview with Heidi Allison, Open Door Crisis Care Centre, Pinetown, May 16, 2003.

¹⁶² Human Rights Watch interview, Durban, May 14, 2003.

¹⁶³ *Ibid.*

¹⁶⁴ Human Rights Watch interview with Dr. V.B. Mohammed, Umlazi, May 15, 2003.

euphemism that meant that someone had come to take the file to block the case or that the police were asking the survivor for a bribe for the case to proceed.¹⁶⁵

Although national policy mandates that police must accept cases where the offence is reported, in practice, police did not always do so. Dr. Mohammed told Human Rights Watch: “I recently had a child that had come to me from the Stanger area. She just pitched up here and said, ‘Doctor, I’m pregnant; what can I do?’” A decision was made to terminate the pregnancy; because the pregnancy was the result of incest, Dr. Mohammed phoned the police station to report the case and to arrange for the police to collect evidence from the termination of the girl’s pregnancy. Dr. Mohammed spoke with the inspector in charge, who told her it was “not possible” to report the case by phone, but that the girl had to return to Stanger. Eventually, Dr. Mohammed managed to get the captain on the phone and got a case number, and arranged for the CPU in Pietermaritzburg (which covers the Stanger area and is over an hour by car from Umlazi) to collect the forensic evidence.¹⁶⁶

NGOs working with child rape survivors told of cases where police refused to open cases for sexual violence survivors who reported more than seventy-two hours after the incident, telling the survivors that they could not investigate the case because there was no evidence.¹⁶⁷ Local police procedure provided similar instruction. Durban’s CPU protocol classified rape survivors who present after seventy-two hours as “non-urgent” cases and advised that in such cases, “immediate medical [is] attention not necessary unless: 1) [the] child is victim of traumatic rape, such as when there is active bleeding, 2) [the] investigator deems it necessary after consultation with the medical registrar.”¹⁶⁸ A senior Umtata CPU official told Human Rights Watch that if more than seventy-two hours had passed since the incident, forensic evidence could not be collected. “After seventy-two hours, we still take the victim to hospital, but we don’t take a crime kit because we can’t get forensic exhibits.”¹⁶⁹

Child rape survivors who do manage to register cases with the police may nonetheless have problems pursuing them because of the poor quality of statements taken by police. Val Melis, a prosecutor with expertise in prosecuting child sexual offences cases, told

¹⁶⁵ Human Rights Watch interview with Delphine Serumaga, Johannesburg, May 19, 2003.

¹⁶⁶ Human Rights Watch interview with Dr. V.B. Mohammed, Umlazi, May 15, 2003.

¹⁶⁷ Human Rights Watch interview with Heidi Allison, Open Door Crisis Care Centre, Pinetown, May 16, 2003. See also Game Hosken, “ ‘ Cops ignored by raped child:’ Woman tells of verbal abuse while reporting ordeal,” *Daily News (Durban)*, February 13, 2003.

¹⁶⁸ Durban protocol for management of child rape and abuse cases.

¹⁶⁹ Human Rights Watch interview, Umtata, May 27, 2003.

Human Rights Watch: “[O]ne of the biggest problems that we have with the police has been when the first statement is taken poorly, we spend the rest of the time standing around and trying to repair the damage.”¹⁷⁰ According to Melis, one problem is that police have a “standard formula” that they use when taking rape survivors’ statements: “It starts off, ‘I was accosted by an unknown black male. . . He grabbed me from behind, unknown, stood there, got on top of me, and I gave no one permission to do this to me.’”¹⁷¹ In some cases, the formulaic statement contradicts the facts reported by the rape survivor, undermining the survivor’s credibility.

Melis told Human Rights Watch about a May 2003 case in which a ten-year-old child rape survivor was “very very clear now when we interviewed her about what happened. Very clear about the fact that she knew the perpetrator and she knew he visited her home on previous occasions.” The statement taken by the police was not so clear, however:

In this instance [the statement] was true to formula: ‘he grabbed me from behind, unknown, stood there, got on top of me, and I gave no one permission to do this to me.’ I said to the prosecutor, ‘Look at the second to last paragraph, she’ll identify him there.’ Second to the last paragraph [of the statement read], ‘I know the man who did this to me, he lives near me, he comes to my house often.’ Now, the first thing the defense are going to say is ‘when you went to the police you knew who this was. Why did you say in the second paragraph [he] was unknown?’ ‘The policeman put that on.’ ‘Well, did you read the statement.’ I said to the prosecutor, she’s only ten years old. She’s not going to challenge the police captain and say ‘Hold on. I didn’t say he was unknown.’ She’s just going to quietly sign her name and hope that it’s all over. That kind of thing is a big problem because once it’s committed to paper, you cannot do away with it. It’s there.”¹⁷²

Arbitrary Denial of PEP Services

Administrative requirements imposed by health care providers significantly interfere with access to PEP and other services for child rape survivors. Most strikingly, and in violation of national policy, the requirement that sexual violence survivors file a police

¹⁷⁰ Human Rights Watch interview with Val Melis, senior public prosecutor, Durban Magistrate’s Court, May 16, 2003.

¹⁷¹ *Ibid.*

¹⁷² *Ibid.*

report before receiving medical services posed significant barriers to access to PEP. In addition, labyrinthine administrative procedures regarding drug procurement discourage effective implementation and undermine the message that PEP must be given in a timely matter and that its administration is a matter of life and death urgency.

Sexual violence survivors were required to file a complaint with the police before they could be examined or receive medical treatment, according to service providers in all of the provinces that Human Rights Watch visited. But this requirement is not part of Department of Health policy.¹⁷³ And the fact that some rape survivors may not report their cases to the police, as well as the time involved in reporting, may effectively bar some survivors from receiving PEP within the necessary seventy-two hours. Requiring a police report to receive medical treatment also may prevent a rape survivor from obtaining medical evidence that could be crucial for successful prosecution of a case.

Nonhlananhla Magwanyana, a social worker at Childline-KwaZulu-Natal, told Human Rights Watch that “almost all the time police refuse to open a case” for child rape survivors. Doctors, in turn, often refused to examine children who had not reported their rape to the police. In one case, an eight-year-old girl was raped by a stranger and then returned to her house, bleeding heavily. The girl’s mother tried to report the rape, but the police refused to open a case because the child could not identify the perpetrator or his car.¹⁷⁴ In another case, a sixteen-year-old girl went to the hospital after having been raped, but the doctor refused to examine or treat her because she had not reported the case to the police and referred her back to the police. The girl did not want to file a report with the police; as a result, she received no medical treatment and a forensic medical exam was not done.¹⁷⁵

¹⁷³ Department of Health guidelines recognize that sexual violence survivors may come to a health facility without having laid a charge, and instruct that “[i]n such cases, wherever possible, the medical examination and the health examination should be provided at the point of entry into the system,” and further, that following examination, “[i]f the victim arrived without referral by the SAPS but now indicates that she wishes to lay charges, the police should be called to the health centre.” Department of Health, *Uniform National Health Guidelines for Dealing with Survivors of Rape and Other Sexual Offences*, http://www.doj.gov.za/policy/guide_sexoff/sex-guide02.html#1 (retrieved August 1, 2003), pp. 1-2 (issued as part of *National Policy Guidelines for Victims of Sexual Offences*, which set out procedural standards for police, health care practitioners, welfare and correctional service personnel who handle rape and other sexual offences cases). The national policy guidance for PEP does not require a police report as a condition of receiving PEP. See Department of Health, “Policy Guideline for Management of Transmission of Human Immunodeficiency Virus (HIV) and Sexually Transmitted Infections in Sexual Assault,” <http://www.doh.gov.za/aids/docs/rape-protocol.html> (retrieved July 28, 2003).

¹⁷⁴ Human Rights Watch interviews with Nonhlananhla Magwanyana, social worker, Childline-KwaZulu-Natal, Durban, May 14 and 16, 2003.

¹⁷⁵ *Ibid.*

Magwanyana observed that it was not right to require a case number before receiving treatment because “medical services obviously come first. With the case number being the first priority, this hinders everything else.”¹⁷⁶ She and her colleagues have pointed this out to the doctors who treat rape survivors, “but what they normally say is that they get the crime kit from the police,” and that they need to get a case number to get the crime kit.¹⁷⁷

Heidi Allison, administrator at a crisis center in Pinetown, KwaZulu-Natal, explained that if a rape survivor came to the crisis center where she worked before having seen the police, “we take them to the police because for them to get examined by a doctor, they need to go to the police and get a J88 form first.”¹⁷⁸ A case needs to be opened because RK Khan [hospital] requires it.” Allison acknowledged that requiring rape survivors to report the incident to the police posed a serious barrier to prompt PEP services, because a survivor “may have to wait some time” for the police to take her statement.¹⁷⁹

Rape crisis counselors in Port Elizabeth, Eastern Cape also reported that doctors had refused to examine sexual violence survivors without case numbers.¹⁸⁰ Zoleka Nqonqoza, at Rape Crisis-Port Elizabeth, told Human Rights Watch that in April 2003,

¹⁷⁶ Ibid. Busi Biyela, Magwanyana’s colleague at Childline-KwaZulu-Natal, told Human Rights Watch about another sixteen-year-old rape survivor who had a similar experience. After having been raped, the girl came to Childline-KwaZulu-Natal, and Biyela took her straight to the doctor. The doctor said that she had to open a case before she could examine the girl. Biyela sat with the doctor, who called several police stations until they were able to open a case over the phone, at which point the doctor proceeded with her medico-legal examination. Human Rights Watch interview with Busi Biyela, Durban, May 14, 2003.

¹⁷⁷ Ibid. The sexual assault evidence collection kit (“crime kit”) contains test tubes, slides and other equipment for taking such biological samples as may be necessary. Crime kits are kept by the police unless a special dispensation is made for them to be held elsewhere. Human Rights Watch interview with Thoko Majokweni, director, Sexual Offences and Community Affairs Unit, National Prosecuting Authority, Pretoria, June 4, 2003. The police provide the crime kit to the health care professional conducting the forensic examination and are responsible for collecting the sealed crime kit when the examination has been completed.

¹⁷⁸ The police issue two forms to rape and sexual assault survivors (forms J88 and SAPS 308) and a crime kit. The purpose of the form 308 is to establish the survivor’s informed consent to be examined by a medical officer and to disclose otherwise confidential medical evidence to the police for the purpose of criminal proceedings. The J88 is used by health care professional conducting the forensic examination to record medical evidence. The crime kit contains equipment for taking necessary biological samples. The investigating officer is responsible for collecting the J88 form and sealed crime kits from the examining health care practitioner.

¹⁷⁹ Human Rights Watch interview with Heidi Allison, Open Door Crisis Care Centre, Pinetown, May 16, 2003. A senior CPU official in Durban told Human Rights Watch that doctors in his jurisdiction would not see a rape victim without a case number from the police. “Without the case number, the doctors don’t want to treat the child. It’s their protocol.” Human Rights Watch interview, Durban, May 15, 2003. Dr. V.B. Mohammed, explained that “the reason that I ask for a case number is because I want the person responsible to be taken to task. What is happening is that in cases that you don’t have a case number, you find that the rape continues.” But “if a victim refuses to open a police case, I still document my findings.” Human Rights Watch interview, Umlazi, May 15, 2003.

¹⁸⁰ Human Rights Watch interviews with Zoleka Nqonqoza, assistant director, and Viki Proudlock, volunteer, Rape Crisis-Port Elizabeth, Port Elizabeth, May 29, 2003.

for example, a rape survivor went to the hospital for treatment on Saturday night and was turned away and told that she would be examined only if she came back with the police.¹⁸¹ Rape Crisis-Port Elizabeth therefore counseled rape survivors that they should first go to the police station to get a case number, not to the hospital, because the doctors would not examine them without a case number.¹⁸²

Gauteng's written policy indicated that PEP could be delayed until a sexual violence survivor had reported the case to the police.¹⁸³ A clinic supervisor in Johannesburg explained in a January 2003 radio interview that "one of the criteria [for receiving PEP] is that the person must report the case to police."¹⁸⁴

During the initial implementation of the PEP program in KwaZulu-Natal, Dr. Neil McKerrow, head of children's health services for the western region of KwaZulu-Natal, was informed that some KwaZulu-Natal hospitals and crisis centers would issue PEP only on production of a police case number by the rape survivor and that administrative problems (such as doctors' poor understanding of the ordering mechanism for the drugs and reluctance to complete paperwork) also discouraged medical staff from offering antiretroviral drugs to sexual violence survivors.¹⁸⁵ In March 2003, McKerrow wrote to Prof. R.W. Green-Thompson, superintendent-general of the KwaZulu-Natal Department of Health, to alert him to these problems and to request that training be

¹⁸¹ Human Rights Watch interview with Zoleka Nqonqoza, May 29, 2003.

¹⁸² Ibid.

¹⁸³ Gauteng's written policy instructed that "if a victim presents to a health care center without reporting a case, where possible, the police should be called to the health center to take a statement. . . . Once the victim has informed the authority that they have been raped/sexually abused, they should be forwarded to the front of a health queue, or given priority status." Gauteng Health Department, *Revised Policy Guideline for Management of Victims of Sexual Assault Cases* (June 2002), p. 7. Free State's provincial protocol requires rape survivors to report the rape to the police as a condition of receiving PEP. Free State Provincial Government, "Rape and HIV Post Exposure Prophylaxis: Protocol, Policy and Procedures," Health Support Circular No. 9 of 2002, July 2, 2002, p. 28.

¹⁸⁴ Khopotso Bodibe, "PEP for Survivors of Rape – What is it?" Health-e News Service, January 31, 2003 (available at <http://www.health-e.org.za/view.php3?id=20030114>) (quoting Beverley Pepper). At the time of the interview, Pepper was the supervisor of a clinic at the Hillbrow Community Health Center, Johannesburg. Ibid. She has since been appointed the PEP coordinator at the Gauteng Department of Health. Human Rights Watch telephone interview with Mohau Makhosane, August 25, 2003.

¹⁸⁵ Human Rights Watch interview with Dr. Neil McKerrow, chief specialist and head of pediatrics and child health, Pietermaritzburg Metropolitan Hospitals, Pietermaritzburg, May 13, 2003. In November 2002, Dr. Ames Dhai conducted a workshop on PEP in Durban, at which she was told by the district surgeon at a major Durban hospital that the hospital would not treat rape survivors who presented without a case number. Dr. Dhai explained to the district surgeon that requiring a case number was not in keeping with the provincial protocol and notified Dr. Shireen Akojee, the director of forensic services in the KwaZulu-Natal Department of Health, asking whether she was aware that there were district surgeons who were not treating rape survivors unless they had a case report number, and stating that this situation needed to be clarified. In March 2003, Dhai learned that district surgeons in Durban had not changed this practice. Human Rights Watch interview with Dr. Ames Dhai, Johannesburg, May 21, 2003.

done regarding implementation of PEP.¹⁸⁶ In response to these concerns, the provincial health department requested that McKerrow run a series of workshops on sexual violence and PEP in each of the health districts in KwaZulu-Natal.¹⁸⁷

Sexual Violence Against Boys and Men

PEP may be a greater issue for men and boys than is appreciated and their needs should be taken into consideration as the government implements its commitment to provide PEP to sexual violence survivors.

There is little information regarding rape committed against men and boys, perhaps due to stigma. As a senior officer with the SAPS Child Protection Unit in Durban said: “To be honest, we rarely get cases where boys report sexual assault. They don’t want to be seen as sissies—it’s the mindset here; the mentality hasn’t changed. The boys may go to the social workers but not us.”¹⁸⁸ Nonhlanhla Magwanyana, a social worker with Childline, a national NGO that provides physical and emotional support for child survivors of abuse and rape, told Human Rights Watch that police treated boys differently from girls. “If a boy presents with a case of abuse, police would laugh.”¹⁸⁹

Health care and social service providers who worked with child rape and sexual abuse survivors consistently told Human Rights Watch that boys comprised only a small percentage of their caseload. The number of boys who presented for care was “minimal,” according to Mandé Toubkin, the coordinator of Netcare Sexual Assault Crisis Centre’s programs.¹⁹⁰ Between September 2000 and April 2003, Netcare treated 1465 sexual violence survivors. Sixty-seven of these patients (4.5 percent) were male.¹⁹¹

¹⁸⁶ Human Rights Watch interview with Dr. Neil McKerrow, Pietermaritzburg, May 13, 2003; letter from Dr. McKerrow to Prof. Green-Thompson, 25 March 2003.

¹⁸⁷ Human Rights Watch interview with McKerrow, Pietermaritzburg, May 13, 2003; E-mail communication with McKerrow, August 19, 2003. The trainings were scheduled to take place in February and March of 2004. Human Rights Watch e-mail communication with McKerrow, December 4, 2003.

¹⁸⁸ Human Rights Watch interview, Durban, May 15, 2003.

¹⁸⁹ Human Rights Watch interview, Durban, May 14, 2003.

¹⁹⁰ Netcare Hospital Group operates sexual violence care centers providing PEP, forensic examination and counseling for rape survivors in eight of forty-four private hospitals and specialized medical facilities that it owns and manages. Email from Mandé Toubkin, coordinator, Netcare Sexual Assault Crisis Centre, to Human Rights Watch, July 23, 2003; Human Rights Watch interview with Mandé Toubkin, Johannesburg, May 19, 2003.

¹⁹¹ Human Rights Watch interview with Mandé Toubkin, Johannesburg, May 19, 2003; Mandé Toubkin, “Rape: A Social Responsibility Project. Can It Be Managed In The Private Health Care Environment?” Power Point Presentation, 2003.

Other clinics reported similar statistics. Five of 106 patients treated for sexual violence at Sinawe Referral Centre in Umtata January-May 2003 were male, three of them boys under 18.¹⁹² Dr. V.B. Mohammed, a physician who treated child sexual violence survivors, estimated that 90 percent of 376 cases treated in recent months were children less than fifteen, but that very few of these cases were boys.¹⁹³ Research on child sexual abuse suggests the actual incidence of sexual violence among boys is higher than these clinics report. A recent study of child sexual abuse in Eastern Cape conducted by the Medical Research Council found that 17.7 percent of teenage boys interviewed had been forced to have sex against their wishes, and that 16.3 percent of the boys (as compared to 28.9 percent of teenage girls) had been forced to have sex by a person at least five years older than they were.¹⁹⁴

Stigma and Discrimination Interfering with PEP Services

As of this writing, government protocols require that sexual violence survivors test negative for HIV to be eligible for PEP.¹⁹⁵ Human Rights Watch's research suggests that this requirement may have barred many rape survivors from receiving PEP altogether. According to service providers, because of the stigma and fear attached to HIV/AIDS and attendant discrimination against people living with the disease and their families, many sexual violence survivors and their parents or guardians refused HIV testing and were therefore denied PEP.

The stigma of rape and the shame associated with the sexual abuse of children also interfered with access to PEP services by discouraging rape survivors and their guardians from disclosing abuses and seeking care for them. Counselors and advocates reported that parents and guardians were afraid to disclose a child's rape because they do not want it known that their child had lost her virginity through rape and because of the shame that child rape brought to the family.¹⁹⁶ As Ntombi Rekwena, a social worker who worked with rape survivors explained, some survivors did not want to open a case

¹⁹² Human Rights Watch interview with nurses at Sinawe Referral Centre, Umtata, May 26, 2003, and statistics provided by Sinawe Referral Centre nurses. Sinawe Referral Centre is a trauma clinic affiliated with Umtata General Hospital.

¹⁹³ Human Rights Watch interview with Dr. V.B. Mohammed, Umlazi, May 15, 2003 and statistics provided by Dr. Mohammed.

¹⁹⁴ Rachel Jewkes, "Child Sexual Abuse in the Eastern Cape," presentation at the Second South African Conference on Gender Based Violence and Health, May 7, 2003.

¹⁹⁵ See note 37 and accompanying text.

¹⁹⁶ Human Rights Watch interview, Eastern Cape, May 26, 2003; Human Rights Watch interview with Nomakuze Solwande, director, Masonwabisane Women's Support Center, East London, May 27, 2003.

because of the stigma associated with rape, and "most people don't want to get tested because of the stigma of having HIV."¹⁹⁷

Human Rights Watch documented several cases in which adult and child sexual violence survivors who reported for medical treatment within seventy-two hours—in time to receive PEP—refused HIV tests and therefore were denied PEP. A nurse who worked at a rape crisis center in Johannesburg commented that parents or guardians of sexually abused children may refuse to be tested or to consent to testing for children in their care because they were not informed or did not properly understand that the test was a prerequisite to potentially lifesaving treatment that could prevent HIV altogether.¹⁹⁸ Absent this information, given the stigma associated with HIV/AIDS and discrimination practiced against people living with HIV/AIDS and their families, there was no incentive to be tested, particularly since HIV/AIDS treatment is inaccessible for most South Africans. As one person told Human Rights Watch in discussing people's reluctance to test for HIV: "People think it's better not to take the test. Everyone is negative until they take the test."¹⁹⁹

Stigma associated with rape and HIV may undermine PEP services even for those who receive an initial course of PEP. Zoleka Nqonqoza, assistant director of a rape crisis center in Eastern Cape, told Human Rights Watch that for children and married women who had not disclosed to their parents, boyfriends or husbands that they had been raped, "coming home with the cocktail [antiretroviral drugs] might be a problem." In her experience, women who were reluctant to disclose rape to their husbands or partners were more likely to default on their drug regimen.²⁰⁰ A Johannesburg rape crisis center nurse commented that sexual violence survivors had provided false addresses or telephone numbers to her center. She suggested that they did so because they not want a health care provider to be able to follow up with them, perhaps because they had not disclosed the rape to their family.²⁰¹

¹⁹⁷ Human Rights Watch interview with Ntombi Rekwena, social worker, People Opposing Women Abuse, Soweto, May 24, 2003.

¹⁹⁸ Comment at workshop on PEP implementation convened by the Center for the Study of Violence and Reconciliation and the AIDS Law Project, Johannesburg, May 21, 2003.

¹⁹⁹ Human Rights Watch interview, Johannesburg, June 3, 2003.

²⁰⁰ Human Rights Watch interview, Port Elizabeth, May 29, 2003.

²⁰¹ Workshop on PEP implementation convened by the Center for the Study of Violence and Reconciliation and the AIDS Law Project, Johannesburg, May 21, 2003.

Services for Low-Income Survivors and Rural Dwellers

PEP services are provided free of charge to sexual violence survivors. However, as of this writing, they remain generally unavailable through the public health system outside of most major urban centers. As a result, sexual violence survivors who lack resources to travel to a facility where PEP services are available are often denied them altogether. Even if they are able to receive an initial dose of PEP medicines, the unavailability of PEP at the local level impedes their ability to complete the treatment. These problems are particularly acute in areas historically disadvantaged under apartheid (former “homeland” areas and townships in urban areas).

A nurse who worked at a trauma center affiliated with Umtata General Hospital told Human Rights Watch of two rape survivors living in rural areas who each sought health care at local clinics within seventy-two hours of having been raped. In both cases, the clinic referred the woman to Umtata General Hospital for specialized care. Neither of the women could afford the cost of transportation to Umtata, which they ultimately borrowed from the clinic nurses. By the time these women arrived at the trauma center, more than seventy-two hours had elapsed and they therefore were ineligible to receive PEP. As the nurse pointed out, had the clinics had PEP, both of these women could have benefited from the treatment.²⁰²

In some cases, rape survivors living in townships or villages that lack PEP services may make it to a health facility in time to receive an initial course of PEP drugs but be unable to get transportation to return for follow-up treatment. Although the national policy guidelines recommend that the entire course of PEP drugs be provided to rape survivors who cannot return “for logistical or economic reasons,” in practice, health care providers often prescribed three or seven days of PEP medicines, which meant that rape survivors who could not return for follow-up did not receive the full benefit of the treatment.

Inge Human, program manager of a victim support center based in Port Elizabeth, recounted a case in which a thirteen-year-old girl was raped and taken to the local hospital the following day, after her mother learned of the rape. At the hospital, the girl was instructed to go home and return the next day because the doctor had gone home. Fortunately, a church leader insisted on driving the child to Port Elizabeth where she was seen at a rape crisis center and given an initial course of PEP medicines. But once she returned home—ninety miles from Port Elizabeth—it was difficult for her to return for follow-up treatment. In this case, Human’s agency assumed the responsibility to take

²⁰² Human Rights Watch interview, Umtata, May 26, 2003.

the medications to the child so that she could complete the PEP regimen. Absent this intervention, she might not have been able to do so.

Providing PEP and related services to rural sexual violence survivors may be difficult, but some community-based groups as well as health care providers who work in under-resourced areas have demonstrated its feasibility and offered models for successful implementation. For example, Thohoyandou Victim Empowerment Programme (TVEP), based in Sibasa, a poverty stricken area in Limpopo Province, worked with sexual violence and abuse survivors as part of the Thohoyandou Trauma Centre, a one-stop trauma center at Tshildzini Hospital. As of this writing, the Thohoyandou Trauma Centre sees about forty rape survivors a month, most of them children less than sixteen years old. From the end of October 2002, when the Trauma Centre began offering PEP to sexual violence survivors, through March 2003, eighty-three rape survivors were offered PEP.²⁰³

To facilitate sexual violence survivors' compliance with the PEP regimen, TVEP provides bus tickets for their follow-up visits to the Trauma Centre. The program obtains permission from survivors to visit them at their homes. TVEP informs survivors that if they have any problems with the PEP medication, they should contact TVEP, which can organize a home visit in urgent cases. Midway through the twenty-eight day course of treatment, field workers go to sexual violence survivors' homes, including those of children, to see if they are taking their medications. This intensive involvement yields results: of the eighty-three rape survivors who received PEP between October 2002 and March 2003, all but two completed their course of treatment.²⁰⁴

Additional Challenges to PEP Implementation

Problems with Ensuring Completion of PEP Regimen

National policy guidelines instruct that sexual violence survivors be given a one-week supply of antiretroviral drugs, and return one week later for further assessment, at which time the remainder of the drugs should be provided.²⁰⁵ Those who cannot return for

²⁰³ Presentation by Hangwi Manavhela, executive officer, Thohoyandou Victim Empowerment Programme, at workshop on PEP implementation convened by the Center for the Study of Violence and Reconciliation and the AIDS Law Project, Johannesburg, May 21, 2003.

²⁰⁴ Ibid.

²⁰⁵ The Department of Health policy instructs that rape and sexual assault survivors fourteen and over be provided with a combination of AZT and 3TC. Department of Health, "Policy Guideline for Management of Transmission of Human Immunodeficiency Virus (HIV) and Sexually Transmitted Infections in Sexual Assault,"

logistical or economic reasons should be given the complete twenty-eight-day course of the drugs. All survivors receiving these drugs should be counseled regarding the importance of compliance with the PEP regimen.²⁰⁶

Provincial department of health representatives, medical staff, and rape crisis counselors reported that many sexual violence survivors failed to return for follow-up medication, thus defaulting on their treatment. A 2003 study conducted by Gauteng Health Department suggested that only 16.2 percent of sexual violence survivors in Gauteng who had received an initial course of PEP completed the treatment.²⁰⁷

Medical staff and rape crisis counselors identified several factors likely contributing to default, including lack of transportation to return for treatment; inadequate information regarding the PEP regimen; and possible side effects from the treatment.²⁰⁸ As described above, providing transportation assistance and other ongoing support to survivors can greatly increase adherence to the PEP regimen.²⁰⁹

Problems with Coordination Among Service Providers

The coordination of police, the health care sector and the criminal justice system is essential to protect child sexual violence survivors, ensure their access to lifesaving PEP, and bring to justice the perpetrators of these crimes. The prosecution's role in handling cases of child sexual violence is intertwined with that of the police and the health care system, and its success is dependent on their performance. Police and health care providers collect and maintain evidence important for prosecution, establish contacts with sexual violence survivors and witnesses, and may also testify at trial. Forensic medical evidence collected by health care practitioners and preserved by police is important in sexual offences cases to establish that the alleged act did occur, to support

<http://www.doh.gov.za/aids/docs/rape-protocol.html> (retrieved July 28, 2003). Gauteng, KwaZulu-Natal and Eastern Cape provincial guidelines instruct that children under twelve be provided these drugs in syrup form.

²⁰⁶ Ibid. Gauteng and KwaZulu-Natal provincial guidelines provide likewise, while Eastern Cape's protocol instructs that rape survivors who cannot return at weekly intervals be given a three-week supply of drugs at the first weekly follow-up visit.

²⁰⁷ Presentation by Mohau Makhosane, deputy director of medico-legal services, Gauteng Health Department, at workshop on PEP implementation convened by the Center for the Study of Violence and Reconciliation and the AIDS Law Project, Johannesburg, May 21, 2003.

²⁰⁸ Human Rights Watch interview with Saliswa Ngqangweni, nurse, Thuthuzela Centre, Mdantsane, Eastern Cape, May 29, 2003.

²⁰⁹ See discussion of Thohoyandou Victim Empowerment Programme, above. In order to promote compliance with PEP, the Thuthuzela Centre in Mdantsane, Eastern Cape, tried to identify potential problems from the outset and provided ongoing support, and, where possible, transportation assistance to rape survivors for follow-up treatment. Human Rights Watch interview with Saliswa Ngqangweni, nurse, Thuthuzela Centre, Mdantsane, Eastern Cape, May 29, 2003.

allegations that the perpetrator used force, and to address the identity of the perpetrator. As Val Melis, a prosecutor with expertise in prosecuting child sexual offences, told Human Rights Watch, “the evidence of the doctor or forensic nurse is a crucial element of any rape case, especially a child rape case. . . especially when you have a situation where there’s minimal penetration and you need the doctor to explain the sort of things like vulval intercourse that still constitute rape.”²¹⁰

South African law and policy provide a framework to facilitate the integrated provision of services among police, health care and prosecutors. The Domestic Violence Act of 1998, which covers sexual and other forms of abuse by parents, guardians, other family members and those who are or have been co-residents with the victim, requires police to provide necessary assistance, including arrangements for medical treatment, to victims of domestic violence, as well as information about their rights, and provides sanctions for noncompliance with these duties.²¹¹ The 1998 National Policy Guidelines for Victims of Sexual Offences set out procedural standards for police, prosecution services, medical personnel, welfare and correctional services for handling cases of rape and sexual offences.²¹²

Human Rights Watch’s investigation found that while there were many distinct and very committed actors providing services to sexual violence survivors, there were problems with coordination of their respective activities. Since sexual violence survivors may present themselves for services to a number of agencies (for example, to health clinics, counselors or police), such coordination is essential to ensure appropriate care.

Medical staff and counselors working with sexual violence survivors told Human Rights Watch that police specializing in sexual violence cases sometimes failed to make prompt or appropriate referrals to health care providers who, in turn, failed to provide complete and accurate forensic evidence and information to prosecutors. In some cases, district surgeons confined their role to forensic examination, failing to provide medical treatment. And, overall, medical, legal, and agency staff (including NGOs) were often

²¹⁰ Human Rights Watch interview with Val Melis, senior public prosecutor, Durban Magistrate’s Court, Durban, May 16, 2003.

²¹¹ Domestic Violence Act, Act No. 116 of 1998, Sections 3, 18(2, 4); South African Police Service, *Domestic Violence National Instruction 7/1999*, Sections 7-10, 13.

²¹² National Policy Guidelines for Victims of Sexual Offences, www.doj.gov.za/info/policy_guidelines1998.htm (retrieved August 1, 2003). The guidelines for police have been issued as *SAPS National Instruction 22/1998: Sexual Offences: Support to Victims and Crucial Aspects of the Investigation*. Provincial governments have also developed guidelines for intersectoral cooperation in managing cases of child survivors of sexual violence. See, e.g., *Gauteng Multi-Disciplinary Child Protection and Treatment Protocol*; KwaZulu-Natal Department of Health, *The Management of Survivors of Child Survivors of Violence*, <http://www.kznhealth.gov.za/protocol2htm> (retrieved August 14, 2003).

unaware of the complex of services available to survivors and of the ways in which these services were linked. Human Rights Watch's findings are consistent with those of recent South African investigations of service provision for child sexual violence survivors, which have found that in failing to implement an effective, coordinated strategy to prevent children from sexual violence and its consequences, the government was failing to meet its obligations under the Constitution and international law.²¹³

VI. Law and Policy Efforts to Improve Services for Rape Survivors

The South African government has recognized that there are problems with the criminal justice system's handling of sexual violence cases and has undertaken important efforts to address them. These include initiatives to improve the prosecution of sexual offences cases; establishment of specialized police units; and enactment of legislation to broaden legal protections for sexual violence survivors.

Prosecution of Sexual Offence Cases

The criminal justice system plays a crucial role in the care and support of rape survivors. Police, the first point of contact for many rape survivors, may be their connection to PEP and other rape services. But many rape survivors do not report the assault to the police because they do not believe that doing so will lead to punishment for the perpetrator. Improving prosecution of sexual violence cases may improve access to PEP services, by motivating rape survivors to seek prompt police assistance following rape.

South Africa has established specialized sexual offences courts to improve the prosecution of sexual offences.²¹⁴ These courts aim to reduce the trauma experienced by sexual violence complainants during the investigations and prosecution; to improve coordination among criminal justice agencies; and to increase the reporting, prosecution and conviction rate for sexual offences. To this end, staff training is provided, and

²¹³ See South African Human Rights Commission, *Report on Sexual Offences Against Children: Does the Criminal Justice System Protect Children?*, April 2002, p. 57; *Report of the Parliamentary Task Group on the Sexual Abuse of Children*, 2002, p. 106.

²¹⁴ The Wynberg Sexual Offences Court, the first such court in South Africa, was established in 1993, in response to advocacy on the part of women's organizations to improve the treatment of rape victims in the criminal justice system. The Wynberg Sexual Offences Court is described in the Human Rights Watch report, *Violence Against Women in South Africa*, pp. 118-121. The Durban Magistrate's Court established a specialized sexual offences court in 1994. Human Rights Watch interview with Val Melis, Durban, May 16, 2003.

courts are equipped with special facilities to minimize contact between survivors and perpetrators (such as closed-circuit television, two-way mirrors and separate waiting and interview rooms). Cases are managed by specially trained prosecutors who handle lighter caseloads to allow them more time for case preparation. To date, the National Prosecuting Authority has established forty-three sexual offences courts while continuing to monitor the courts' performance and provide staff training.²¹⁵

In 1999, the Sexual Offences and Community Affairs (SOCA) unit was created within the National Prosecuting Authority to improve the handling of sexual offences cases against women and children. The unit's priorities include the establishment throughout South Africa of sexual offences courts and multidisciplinary care centers for survivors of sexual and domestic violence. SOCA, together with the Department of Health and the South African Police Service, has established several multidisciplinary centers for survivors of sexual offences and domestic violence at hospitals in Eastern Cape, Western Cape and Gauteng.²¹⁶ These centers are staffed by health care professionals, counselors, police and prosecutors who work together as a team, enabling rape survivors to receive medical treatment and counseling and to report an offence to police at one site.²¹⁷ In 2000, the SOCA Unit, together with the Departments of Safety and Security, Social Development, and Health established an Interdepartmental Management Team that, as of this writing, is working to develop a comprehensive anti-rape strategy.

Law Reform

The government of South Africa has enacted pioneering legislation on domestic violence. At the time of this writing, it was also considering legislation on sexual offences and children's issues that would broaden protections for child sexual violence survivors.

²¹⁵ The National Prosecuting Authority hoped to have 60 such courts by end-2004. Human Rights Watch interview with Thoko Majokweni, director, Sexual Offences and Community Affairs Unit, New York, October 2, 2003.

²¹⁶ The Thuthuzela Multi-disciplinary Care Centre at G.F. Jooste Hospital in Cape Town was launched in July 2000. Similar centers have since been opened in Limbode and Mdantsane, Eastern Cape and in Soweto, Gauteng. The National Prosecuting Authority plans to open up ten such centers by the end of 2004. Presentation by Anton du Plessis, head of the Crime and Justice Programme, Institute for Security Studies, Pretoria, South Africa, Second South African Gender Based Violence and Health Conference, Johannesburg, May 7, 2003.

²¹⁷ There is evidence that such on-site coordination improves rape conviction rates. A prosecutor with the Western Cape Thuthuzela Center reported that between August 2002 and August 2003, he tried eighty-nine rape cases, sixty-five of which resulted in convictions. Human Rights Watch interview with Mark Kenny, prosecutor, Thuthuzela-Cape Town, New York City, October 2, 2003.

The Domestic Violence Act, enacted in 1998, extends broad protections to child survivors of sexual violence and other forms of abuse. The act covers violence in both marital and nonmarital relationships (including same-sex partnerships), as well as by parents, guardians, family members, and anyone who is co-resident with the survivor.²¹⁸ It imposes duties on the police to provide necessary assistance, including arrangements for suitable shelter and medical treatment, to survivors of domestic violence, as well as information about their rights.²¹⁹ There are sanctions for noncompliance with these duties.²²⁰ A 2001 evaluation found, however, that the failure to allocate sufficient resources to police, courts and other support services undermined the implementation of the act.²²¹

South Africa's new draft law on sexual offences (the Criminal Procedure (Sexual Offences) Amendment Bill), scheduled to be considered by a parliamentary committee next term, proposes important changes to broaden legal protection of rape survivors and to facilitate prosecution of sexual offences. These include expanding the definition of rape to make it gender-neutral and to include anal as well as vaginal penetration; establishing procedures such as testimony by closed-circuit television for children and other "vulnerable witnesses;" and changing common law rules that allow courts inappropriately to devalue the testimony of child survivors.²²²

The draft of the bill that is under consideration as of this writing fails to include an earlier provision obliging the state to provide medical care and counseling for survivors of sexual violence who have sustained injuries or psychological harm or have been exposed to sexually transmitted infections. The deletion of this provision was apparently due to concerns about cost and system capacity to undertake this service.²²³ In January 2004, the chair of the committee reviewing the bill announced that the bill would include a clause making clear that rape survivors would be entitled to receive PEP services from designated government clinics.²²⁴ This is a welcome development. As advocates for the retention of this provision have noted inscribing obligations to provide

²¹⁸ Domestic Violence Act, Act No. 116 of 1998, Section(1)(viii).

²¹⁹ Ibid., Section 2; South African Police Service, *Domestic Violence National Instruction 7/1999*, Sections 7-10.

²²⁰ Domestic Violence Act, Sections 18(b)(2, 4); South African Police Service, *Domestic Violence National Instruction 7/1999*, Section 13.

²²¹ Penny Parenzee, "While Women Wait . . . Monitoring the Domestic Violence Act," *Nedbank ISS Crime Index*, vol. 5, no. 3, May-June 2001.

²²² Criminal Law (Sexual Offences) Amendment Bill, 2003, Sections 2-4, 14, 15, 18, 24.

²²³ Comments of Advocate Johan de Lange at hearings on Sexual Offences bill before the Joint Monitoring Committee on Improvement of Quality of Life and Status of Women, November 14, 2003.

²²⁴ Comments of Advocate Johan de Lange at deliberations on Sexual Offences bill before the Justice and Constitutional Development Portfolio Committee, January 29, 2004. The Department of Health has been charged with drafting this provision. Ibid.

PEP and other post-rape services into law is essential to ensure accountability of the government in meeting its commitment to provide PEP and other services to rape survivors.²²⁵ In view of earlier experiences, including with the Domestic Violence Act, they have urged that sufficient resources be allocated to ensure meaningful implementation and enforcement of the new law.²²⁶

As discussed above, the Child Care Act amendments (Children's Bill) propose changes regarding consent that should facilitate access to treatment for children under fourteen whose parents cannot or will not consent to HIV testing and PEP services on their behalf.²²⁷

VII. South Africa's Obligations Under International and National Law

International Law

International human rights law establishes that every person, including every child, has the right to the highest attainable standard of health, the right to life, the right to seek, receive and impart information of all kinds, the right to nondiscrimination and equal protection of the law, and the right to be protected from violence. International human rights law also requires states to address persistent violations of human rights and take measures to prevent their occurrence. With respect to violations of bodily integrity, states have a duty to prosecute abuse, whether an agent of the state or a private citizen commits the violation.

These rights are enshrined in important international and regional treaties to which South Africa is a party and which South Africa has incorporated into its domestic law. These include the Convention on the Rights of the Child (CRC), the International Covenant on Civil and Political Rights (ICCPR), the U.N. Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), and the African Charter on the Rights and Welfare of the Child.²²⁸ South Africa is also a

²²⁵ See, e.g., Rape Crisis Cape Town Trust and IDASA, *Submission to the Sexual Offences Bill to the Committee on Justice and Constitutional Development*, September 2003; Women's Legal Centre, *Submission to the Justice and Constitutional Development Committee in Response to the Criminal Law (Sexual Offences) Amendment Bill Published in Government Gazette No. 25282 Dated 30 July 2003*, September 15, 2003.

²²⁶ *Ibid.*

²²⁷ See Section VI, above.

²²⁸ CRC, G.A. res. 44/25, annex, 44 U.S. GAOR Supp. (No. 49) at 167, U.N. Doc. A/44/49 (1989), entered into force September 2, 1990 and acceded to by South Africa on July 16, 1995; ICCPR, 999 U.N.T.S. 171, entered into force March 23, 1976 and acceded to by South Africa on March 10, 1999; CEDAW, G.A. Res. 34/180, U.N.

signatory to the International Covenant on Economic, Social and Cultural Rights (ICESCR), obliging it to refrain from actions that would defeat that treaty's object and purpose.²²⁹

The Right to the Highest Attainable Standard of Health

All individuals have the right to enjoy the highest attainable standard of health, a right guaranteed by the ICESCR,²³⁰ the CRC,²³¹ and CEDAW,²³² by the South African Constitution,²³³ and by regional treaties.²³⁴ This right imposes an obligation on states to take steps necessary for the prevention, treatment and control of epidemic and other diseases, which include “the establishment of prevention and education programmes for behaviour-related health concerns such as sexually-transmitted diseases, in particular HIV/AIDS.”²³⁵ In meeting this obligation, states “should ensure that appropriate goods, services and information for the prevention and treatment of STDs, including HIV/AIDS, are available and accessible.”²³⁶

The right to the highest attainable standard of health outlined in the ICESCR is subject to “progressive realization,” under which states parties have a “specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization of [the right].”²³⁷ States must guarantee certain core obligations as part of the

Doc. A/34/46, entered into force September 3, 1981 and acceded to by South Africa on January 9, 1999; African Charter on the Rights and Welfare of the Child, OAU Doc. CAB/LEG/24.9/49 (1990), entered into force Nov. 29, 1999 and acceded to by South Africa on January 7, 2000; African [Banjul] Charter on Human and Peoples' Rights, adopted June 27, 1981, OAU Doc. CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982), entered into force Oct. 21, 1986 and acceded to by South Africa on July 9, 1996.

²²⁹See Vienna Convention on the Law of Treaties, art. 18, concluded May 23, 1969, 1155 U.N.T.S. 331, entered into force January 27, 1980.

²³⁰ ICESCR, art. 12.

²³¹ CRC, art. 24.

²³² CEDAW, art. 12.

²³³ Constitution of the Republic of South Africa, arts. 27, 28(c).

²³⁴ African Charter on the Rights and Welfare of the Child, art. 14; African Charter on Human and Peoples' Rights, art. 16.

²³⁵ Committee on Economic, Social and Cultural Rights, “General Comment 14, The Right to the Highest Attainable Standard of Health,” November 8, 2000, para. 8. The Committee on Economic, Social and Cultural Rights is the U.N. body responsible for monitoring compliance with the ICESCR. See also Committee on the Rights of the Child, “General Comment No. 3: HIV/AIDS and the Rights of the Child,” March 17, 2003, paras. 15-29. The Committee on the Rights of the Child is the U.N. body responsible for monitoring compliance with the CRC.

²³⁶ Committee on the Rights of the Child, “General Comment no. 4: “Adolescent Health and Development in the Context of the Convention on the Rights of the Child,” July 1, 2003, para. 30; see also Committee on the Rights of the Child, “General Comment No. 3: HIV/AIDS and the Rights of the Child,” March 17, 2003, paras. 20, 21.

²³⁷ Committee on Economic, Social and Cultural Rights. “General Comment no. 14. The Right to the Highest Attainable Standard of Health,” November 8, 2000, paras. 30, 31.

right to health. These include ensuring nondiscriminatory access to health facilities, especially for vulnerable or marginalized groups; providing essential drugs; ensuring equitable distribution of all health facilities, goods and services; adopting and implementing a national public health strategy and plan of action with clear benchmarks and deadlines; ensuring reproductive, maternal and child care; taking measures to prevent, treat and control epidemic and endemic diseases; and providing education and access to information for important health problems.²³⁸ According to the ICESCR Committee, to justify the failure to meet at least minimum core obligations as based on a lack of available resources, a state party “must demonstrate that every effort has been made to use all resources that are at its disposition in an effort to satisfy, as a matter of priority, those minimum obligations.”²³⁹

Realization of the right to health requires that the state ensure equality of access to a system of health care and provide health services without discrimination. Accessibility, in turn, has four overlapping dimensions: nondiscrimination, physical accessibility, economic accessibility (affordability) and information accessibility.²⁴⁰

In establishing one-stop service centers to treat sexual violence survivors, South Africa has taken an important step toward ensuring physical accessibility of health services. It should also take measures to ensure access to adequate and efficient referral services, transportation facilities and translation assistance.

South Africa has adopted a number of laws and policies that aim to improve access to health care to all and that should facilitate economic access to PEP. In 1997, for example, the Health Department outlined its plan to restructure the health system to enhance its capacity to deliver affordable health care, including by improving the affordability of drugs.²⁴¹ The Medical Schemes Amendment Act requires that medical schemes (health care plans) provide those services available at public health facilities and to which public hospital patients are entitled.²⁴² As such, PEP services should be

²³⁸ General Comment no. 14, paras. 43 and 44; see also *ibid.*, para. 12.

²³⁹ Committee on Economic, Social and Cultural Rights, “General Comment no. 3. The Nature of States Parties Obligations (Art. 2)(1),” UN Doc. E/1991/23., para. 10.

²⁴⁰ Committee on Economic, Social and Cultural Rights. “General Comment no. 14. The Right to the Highest Attainable Standard of Health,” November 8, 2000, para. 12.

²⁴¹ Department of Health. *White Paper for the Transformation of the Health System in South Africa*. Government Gazette No. 17910, April 16, 1997.

²⁴² Medical Schemes Act No. 131 of 1998, section 29(p) (“No limitation shall apply to the reimbursement of any relevant health service obtained by a member from a public hospital where this service complies with the general scope and level as contemplated in paragraph (o) and may not be different from the entitlement in terms of a service available to a public hospital patient”). Medical schemes, the main type of private insurance, receive monthly premiums from households and employers. Health insurance is offered by life and short-term

covered by medical schemes.²⁴³ The Patents Act permits the government to override patent protections in limited situations by issuing compulsory licenses to market competitors to produce and market medicines still under patent.²⁴⁴

The Medicines and Related Substances Control Amendment Act (Medicines Act), passed in 1997, identifies specific measures that the state may undertake to ensure the supply of more affordable medicines. The Act provides for the generic substitution of medicines no longer under patent, parallel importation of patented medicines and establishes a pricing committee to set up transparent pricing mechanisms.²⁴⁵ As described above, the Act's implementation was delayed for years due to extended litigation and lobbying by domestic pharmaceutical manufacturers and opposition by the U.S. government.²⁴⁶ In April 2001, pharmaceutical manufacturers withdrew their legal challenge to the Act, providing an opportunity for the government to facilitate the access to cheaper medicines and otherwise mount a publicly funded program to make HIV/AIDS treatment available. The government should take advantage of the mechanisms established under these laws and policies to facilitate access to less expensive antiretroviral drugs used in PEP.

The Right to Information

Everyone, including children, has the right to “seek, receive and impart information of all kinds.”²⁴⁷ Access to information also is essential to secure the right to the highest attainable standard of health.²⁴⁸

insurance companies and bought by households, some of which may also belong to medical schemes. Jane Doherty et al., “Health Care Financing and Expenditure,” *South African Health Review 2002* (Durban, South Africa: Health Systems Trust, 2003).

²⁴³A 2002 survey covering an estimated 80 percent of all medical schemes found that 96 percent of beneficiaries surveyed had access to antiretroviral therapy in case of sexual violence and 94 percent had such access in case of occupational exposure. Andrew Stein, Heather McLeod, Zackie Achmat, *The Cover Provided for HIV/AIDS Benefits in Medical Schemes in 2002*, Centre for Actuarial Research and Treatment Action Campaign, July 2002, pp. 5, 23-24.

²⁴⁴ Compulsory licenses are licenses granted by a government that permit a competitor to override patents or other intellectual property protections to produce and market goods protected by patent or copyright. The Patents Act, Act No. 57 of 1978, permits the South African government to issue compulsory licenses in certain limited situations. See *ibid.*, Sections 4 and 56(a).

²⁴⁵ Medicines and Related Substances Control Amendment Act, Act No. 90 of 1997, sections 15C, 22F, 22G.

²⁴⁶ See discussion in Section IV, above.

²⁴⁷ See ICCPR, art. 19, CRC, art. 13.

²⁴⁸ See Committee on the Rights of the Child, “General Comment no. 4. Adolescent health and development in the context of the Convention on the Rights of the Child,” para. 12 and note 8; Committee on the Rights of the Child, “General Comment No. 3. HIV/AIDS and the rights of the Child,” paras. 16 and 17; Committee on Economic, Social and Cultural Rights. “General Comment no. 14. The Right to the Highest Attainable Standard of Health,” November 8, 2000, para. 12(b).

In pledging to provide PEP to sexual violence survivors, South Africa has taken an important step towards ensuring the right to health. But a commitment to PEP on the policy level remains compromised absent measures to ensure its availability and accessibility to all sexual violence survivors on a nondiscriminatory basis. Sexual violence survivors cannot exercise their right to PEP if they are not informed of this option and are barred by third parties or by lack of means to access it. The right to PEP is likewise impaired if the state fails to provide appropriate training for key PEP service delivery institutions and personnel. South Africa's obligation to secure the right to health includes providing adequate information to sexual violence survivors to enable them to make a meaningful choice about PEP (including the risk of HIV infection post-assault and the benefits of PEP, where and how to obtain it) and training health care providers regarding its use.

The Right to Life

All persons enjoy an inherent right to life, which is guaranteed in article 6 of the ICCPR. Noting that the right to life “should not be interpreted narrowly,”²⁴⁹ the Human Rights Committee, which monitors compliance with the ICCPR, has observed:

The expression “inherent right to life” cannot properly be understood in a restrictive manner and the protection of this right requires that States adopt positive measures. In this connection, the Committee considers that it would be desirable for States parties to take all possible measures to reduce infant mortality and to increase life expectancy, especially in adopting measures to eliminate malnutrition and epidemics.²⁵⁰

In the face of its dual epidemics of sexual violence and HIV/AIDS, South Africa's obligations to protect the right to life extend to the provision of HIV post-exposure prophylaxis for survivors of sexual violence and provision of information on PEP services.

The Right to Measures of Protection

Article 24 of the ICCPR guarantees the right of the child to “such measures of protection as are required by his status as a minor.” The ICCPR also prohibits cruel,

²⁴⁹ Human Rights Committee, “General Comment 6” (16th sess., 1982), para. 1.

²⁵⁰ *Ibid.*, para. 5.

inhuman or degrading treatment.²⁵¹ Under article 19 of the Convention on the Rights of the Child, children have the right to protection from “all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation including sexual abuse, while in the care of parent(s), legal guardian(s), or any other person who has the care of the child.”²⁵² These protections apply to private acts of violence and harassment as well as acts committed by state agents.²⁵³

States must take all appropriate measures to protect children from sexual violence and abuse and to promote physical and psychological recovery and social integration of a child survivor of any form of neglect, exploitation, or abuse in a setting that “fosters the health, peer-respect, and dignity of the child.”²⁵⁴ These measures include providing medical treatment for child survivors of sexual violence, as well as effective mechanisms for identification, referral, investigation and follow-up of their cases.²⁵⁵

Protection from violence and its consequences is also an essential component in securing other human rights. Sexual violence puts individuals at risk of HIV/AIDS, thereby threatening the right to life. It also violates the right to bodily integrity and, by posing serious threats to physical and psychological health, infringes on the right to the highest attainable standard of health. Sexual violence in schools may deprive children of their right to an education on equal terms with their peers. Children who leave school as a consequence of sexual violence confront additional threats to their rights to life, bodily integrity and health.²⁵⁶

The obligation to take measures to protect children from violence and its consequences, as delineated in articles 19 and 39 of the Convention on the Rights of the Child, is one aspect of the “measures of protection . . . required by [one’s] status as a minor” to which children are entitled under article 24 of the ICCPR. This view is consistent with the

²⁵¹ CRC, art. 7.

²⁵² CRC, arts. 3 and 19; see also African Charter on the Rights and Welfare of the Child, arts. 4, 16.

²⁵³ CRC art. 19; see also See Rachel Hodgkin and Peter Newell, *Implementation Handbook for the Convention on the Rights of the Child* (New York: UNICEF, 1998), p. 246; CEDAW Committee, “General Recommendation No. 19: Violence Against Women.” 11th sess., U.N. Doc. CEDAW/C/1992/L.1/Add.15 (1992) (interpreting a similar provision of CEDAW to extend to “all kinds of violence” against women, including private violence); Gender and Development: A Declaration by Heads of State or Government of the Southern African Development Community,” para. H(ix), September 8, 1997 (pledge to “take urgent measures to prevent and deal with the increasing levels of violence against women and children”).

²⁵⁴ CRC., arts. 19, 24, 34, 39; African Charter on the Rights and Welfare of the Child, art. 16.

²⁵⁵ CRC art. 19(2); African Charter on the Rights and Welfare of the Child, art. 16(1).

²⁵⁶ See The World Bank, *Education and HIV/AIDS: A Window of Hope*, 2002, p. 4 (noting that education was a proven means of protection against HIV infection, and “among the most powerful tools for reducing girls’ vulnerability” to HIV/AIDS).

Human Rights Committee's general comment on the scope of article 24, which notes that "every possible economic and social measure should be taken . . . to prevent [children] from being subjected to acts of violence and cruel and inhuman treatment."²⁵⁷ In keeping with these principles, the state's obligation to take measures to protect extends to the obligation to provide PEP to survivors of sexual violence.

Sexual violence can be a form of gender discrimination, and South Africa is obligated to take all appropriate measures to eliminate violence against girls and against women more generally, and to ensure their access to health and social services without discrimination. The obligations enumerated by the CEDAW Committee extend beyond the justice system and encompass preventive and protective measures, including counseling and support services.²⁵⁸ This includes provision of medical and psychological assistance to girls who are survivors of violence. Also in accord with these principles is the provision of medical assistance to survivors of sexual violence consistent with the prevailing best practice on HIV post-exposure prophylaxis to decrease the likelihood of contracting the virus.

National Law

The South African Constitution guarantees the right to physical and psychological integrity, the right to life, the right to access to health care, and recognizes the inherent dignity of all human beings and the right to have that dignity respected and protected.²⁵⁹ The constitution prohibits unfair discrimination against anyone directly or indirectly on the basis of sex, gender or pregnancy.²⁶⁰ It grants specific recognition to the rights of children, who enjoy more broad-based rights protections than adults. Children's rights include the right to basic health care and social services and the right to be protected from maltreatment, neglect, abuse or degradation.²⁶¹ The constitution further provides that "[a] child's best interests are of paramount importance in every matter concerning the child."²⁶²

²⁵⁷ Human Rights Committee, "General Comment 17, Rights of the Child (Art. 24)," 35th sess. 1989, para. 3.

²⁵⁸ See Committee on the Elimination of All Forms of Violence Against Women, "Violence Against Women," General Recommendation no. 19 (eleventh session, 1992), U.N. Document CEDAW/C/1992/L.1/Add.15.

²⁵⁹ Constitution of the Republic of South Africa, Sections 10, 11, 12(2), 27(1).

²⁶⁰ *Ibid.*, Section 9.

²⁶¹ *Ibid.*, Section 29(1)(c,d).

²⁶² *Ibid.*, Section 29(2).

The constitution provides that international law must be considered in the interpretation of the bill of rights and “any legislation.”²⁶³ It further provides that international agreements become legally enforceable when enacted into law by national legislation, or, in the case of a self-executing provision, on approval by Parliament.²⁶⁴

The South African Constitution provides that “[n]o one may be refused emergency medical treatment.”²⁶⁵ According to South Africa’s Constitutional Court, the purpose of this right is “to ensure that treatment be given in an emergency, and is not frustrated by reason of bureaucratic requirements or other formalities. A person who suffers a sudden catastrophe which calls for immediate medical attention . . . should not be refused ambulance or other emergency services which are available and should not be turned away from a hospital which is able to provide the necessary treatment. What the section requires is that remedial treatment that is necessary and available be given immediately to avert that harm.”²⁶⁶

Sexual violence is a “sudden catastrophe” that exposes its survivors to a lethal disease that can be averted through immediate medical treatment. The state’s obligation to provide emergency treatment to prevent HIV/AIDS requires that it provide PEP to survivors of sexual violence on an urgent basis. The court is specific that bureaucratic or other formalities should not delay the provision of such treatment.²⁶⁷

The right of access to nonemergency health care services is provided for in two places in the South African Constitution. The constitution provides that everyone has the right to access to health care services and must take reasonable legislative and other measures, subject to available resources, to achieve the progressive realization of this right.²⁶⁸ Children’s rights to basic health care are not similarly qualified.²⁶⁹ Children’s right to basic health care, read together with the right to be protected from maltreatment, neglect and abuse, imposes on the state a heightened duty to protect children from sexual violence and its consequences.

²⁶³ *Ibid.*, Sections 39(b)(1) and 233; see also *S. v. Makwanyane and another* 1995(3) SA391 (CC), paras. 34-35.

²⁶⁴ Constitution of the Republic of South Africa, Section 231(4).

²⁶⁵ *Ibid.*, Section 27(3).

²⁶⁶ *Soobramoney v. Department of Health, KwaZulu-Natal* 1998 (1) SA 765 CC 774, para. 20.

²⁶⁷ The obligation to provide PEP on an urgent basis imposes a duty on police to facilitate access to prompt treatment and on hospitals to provide treatment on an urgent basis. See David McQuoid-Mason, Ames Dhai and Jack Moodley, “Rape Survivors and the Right to Emergency Medical Treatment in Order to Prevent HIV Infection,” *South African Medical Journal*, vol. 93, no. 1 (January 2003), pp. 41-44.

²⁶⁸ Constitution of the Republic of South Africa, Section 27 (1, 2).

²⁶⁹ See *ibid.*, Section 28(1)(c).

South Africa's obligation under the right to health requires that it establish a coherent program directed toward the progressive realization of the right to health, which should clearly allocate responsibilities and tasks to different spheres of government and to ensure that appropriate financial and human resources are available to carry out these tasks.²⁷⁰ Health policies should articulate clear timeframes to ensure eventual access to everyone.²⁷¹

To comply with its obligations with respect to the right to health, South Africa must articulate a comprehensive national program to provide PEP to all sexual violence survivors and must do so "with due regard to the urgency of the situations it is intended to redress."²⁷² To ensure effective implementation, the program must be afforded adequate budgetary support and incorporate monitoring and evaluation mechanisms, so as to ensure that the maximum number of people can receive lifesaving PEP services.²⁷³ This program must include instruction on administration of PEP to all key service providers, including police, teachers, health care providers, and social workers handling cases of sexual abuse and domestic violence, as well as directives to facilitate urgent access to PEP services. The program should also include an information campaign to advise sexual violence survivors of their right to these services and how to get access to them, as well as training for all key service providers.²⁷⁴

The South African Constitution imposes positive duties on the state "to take preventive operational measures to protect an individual whose life is at risk from the criminal acts of another individual. . . . In addressing these obligations in relation to dignity and the freedom and security of the person, few things can be more important to women than

²⁷⁰ See *Government of the Republic of South Africa and others v. Grootboom and others*, CCT 11/00 (2000).

²⁷¹ See *Minister of Health v. Treatment Access Campaign and Others*, CCT 8/02 (2002).

²⁷² *Government of the Republic of South Africa and others v. Grootboom and others*, CCT 11/00 (2000), para. 67; see also *ibid.*, para. 44 ("[t]o be reasonable, measures [to realize the progressive realization of a right] cannot leave out of account the degree and extent of the denial of the right they endeavour to realise. Those whose needs are most urgent and whose ability to enjoy all rights therefore is most in peril, must not be ignored by the measures aimed at achieving realisation of the right.").

²⁷³ See *ibid.*

²⁷⁴ See *Minister of Health v. Treatment Access Campaign and Others*, CCT 8/02 (2002), para. 123:

The magnitude of the HIV/AIDS challenge facing the country calls for a concerted, co-ordinated and co-operative national effort in which government in each of its three spheres and the panoply of resources and skills of civil society are marshalled, inspired and led. This can be achieved only if there is proper communication, especially by government. In order for it to be implemented optimally, a public health programme must be made known effectively to all concerned, down to the district nurse and patients. Indeed, for a public programme such as this to meet the constitutional requirement of reasonableness, its contents must be made known appropriately.

freedom from the threat of sexual violence.”²⁷⁵ The Constitutional Court has recognized that “[s]exual violence and the threat of sexual violence goes [sic] to the core of women’s subordination in society. It is the single greatest threat to the self-determination of South African women.”²⁷⁶ The state’s obligation to protect women and children from violence and its consequences should extend to its obligation to provide PEP to sexual violence survivors to protect them from HIV/AIDS.²⁷⁷

National law and policies provide an enabling legal environment for the protection of children against sexual violence.²⁷⁸ The Domestic Violence Act, which requires that police officers “render such assistance to the [domestic violence survivor] as may be required in the circumstances,” including assistance with obtaining medical treatment,²⁷⁹ imposes a duty on police officers to facilitate access to PEP.

A South African parliamentary committee has indicated that draft sexual offences legislation under consideration would be amended to include a clause making clear that rape survivors would be entitled to receive PEP services from designated government clinics. Implementing the government’s commitment to provide PEP to sexual violence survivors through national legislation is essential to secure the right to such treatment.

VIII. Conclusion

South Africa should be commended for making a commitment to provide HIV post-exposure prophylaxis for sexual violence survivors through its public health system. But for PEP services to succeed, South Africa must strive to ensure that all sexual violence survivors who need the drugs can get them—promptly and with sufficient guidance and support to ensure that they will complete the course of treatment that could save their lives.

²⁷⁵ *Carmichele v. Minister of Safety and Security, Case CCT 48/00.*, paras. 45, 62; see also *ibid.*, para. 42.

²⁷⁶ *Ibid.*, para. 62.

²⁷⁷ See *ibid.*; see also Helène Combrinck, “Positive Duties to Protect Women from Violence: Recent South African Developments,” *Human Rights Quarterly*, vol. 20 (1998), pp. 666-690; Helène Combrinck and Raygaanah Barday, “Beyond Carmichele: developing the right to freedom from violence,” *GenderNews*, vol. 6, no. 1, September 2002.

²⁷⁸ These include the Child Care Act, No. 84 of 1983 (as amended), Domestic Violence Act, No. 116 of 1998, Criminal Procedure Act, No. 51 of 1977, National Policy Guidelines for Sexual Offences.

²⁷⁹ *Ibid.*, section 2; *Domestic Violence National Instruction 7/1999*, Section 9.

Particular attention needs to be placed on children and young women and poor and rural sexual violence survivors. The government must immediately provide clear guidance regarding PEP provision for children under fourteen, including expanded provisions for consent to PEP. With respect to poor and rural women and children, it should make a serious resource commitment to rural leadership, including rural women and NGOs who work with survivors of domestic and sexual violence, whose experience and knowledge of local conditions can facilitate the implementation of PEP services in underserved areas.

The silence around HIV/AIDS “is as serious a killer as the virus itself,” as former South African president Nelson Mandela has warned. South Africa’s political leadership must break the silence around HIV/AIDS and address the deep stigma attached to the disease if rape survivors are to be able to come forward and seek PEP services in a prompt manner. Sexual violence survivors must surmount the double stigma of being HIV-positive (presumed or in reality) and being survivors of sexual violence. The deep shame associated with child rape compounds these obstacles, leaving many child sexual violence survivors to suffer in silence. As a result, government must work especially hard to reach them. Government leaders also must make serious efforts to build public confidence in the efficacy and safety of antiretroviral therapy.

South Africa’s efforts to implement PEP services illustrate the importance of integrating work around sexual violence and HIV/AIDS. To implement PEP successfully, including for children, South Africa must strengthen the skills and coordination of all those likely to be important contact points for sexual violence survivors, including health care providers, police, social workers and teachers. It must also disseminate information about PEP services—including what they are, why they are important and where to get them—to all of these contact points as well as in the general community.

South Africa has considerable financial resources, well-trained, capable service providers, and an active civil society supporting PEP provision and other services for sexual violence survivors. This would suggest that South Africa would represent a model for implementation of PEP services for other countries in the region. However, South Africa must overcome practical and political obstacles to implementation. It still struggles to address serious problems in health and social service provision rooted in apartheid-era inequalities, where services in former homelands and in townships in urban areas were practically nonexistent prior to 1994. And its history of political opposition to providing antiretroviral drugs at the highest level of government—including engaging AIDS denialists as high-level AIDS advisors—has impeded effective access to PEP. Learning from the South African experience highlights the challenges that other countries may face, and illustrates that even in countries that lack South

Africa's resources, a critical determinant of successful PEP service provision will be the depth and scope of political commitment to the provision of those services.

Other countries should assist South Africa by working to promote and establish fairer terms for South Africa to acquire and produce PEP drugs that are affordable, so that they may be available on a more equitable basis to all sexual violence survivors who need them. And all of these things need to be done right away.

By beginning programs to provide PEP services to sexual violence survivors, South Africa has made the crucial leap in thinking and policy to link sexual violence and HIV/AIDS. But only when lifesaving services like PEP are available for all who need them will South Africa truly shatter the silence that the onslaught of HIV/AIDS and sexual violence have caused in combination. South Africa will then have taken a major step towards becoming the sign of hope and progress in public health that it is for many with regard to its victory over apartheid.

As Stephen Lewis, U.N. special envoy for HIV/AIDS in Africa, once passionately observed:

[W]hen people are dying. . . [s]peed and action become the *sine qua non*. And when the action finally happens, there will be an outpouring of relief and exhilaration throughout Africa, akin, for many, to the emotional catharsis which accompanied the end of apartheid. South Africa is one of the leaders on this continent. If there is a breakthrough here, every country will feel similarly encouraged. And . . . I genuinely believe that resources will flow to sustain whatever South Africa undertakes. The world, overwhelmingly, wants South Africa to defeat the pandemic.

Acknowledgments

This report was written by Rebecca Schleifer, based on research conducted by Rebecca Schleifer and Joanne Csete of the HIV/AIDS and Human Rights Program at Human Rights Watch. It was reviewed by Joanne Csete, director of the HIV/AIDS Program; Lois Whitman, director, Children's Rights Division; LaShawn Jefferson, director, Women's Rights Division; Bronwen Manby and Nobuntu Mbelle, researchers, Africa Division; Jonathan Cohen, researcher, HIV/AIDS Program; James Ross, senior legal advisor; and Widney Brown, deputy program director of Human Rights Watch. Production assistance was provided by Andrea Holley, Jennifer Nagle, Veronica Matushaj, Rafael Jimenez and Fitzroy Hepkins.

Human Rights Watch would like to thank all the individuals and organizations who provided information, advice, and assistance during the research and preparation of this report. While they are too numerous to list by name, we extend special thanks to Joan van Niekerk, Liesl Gertholtz and Viki Proudlock for their generous assistance in facilitating this work. We also gratefully acknowledge the Ford Foundation for supporting Human Rights Watch's work in South Africa.