

**MINUTES OF THE WORKSHOP ENTITLED:  
*‘HIV/AIDS AND THE RIGHT TO BASIC  
NUTRITION’***

**BREAKWATER LODGE, WATERFRONT,  
CAPE TOWN**

**15 OCTOBER 2002**

**SOCIO-ECONOMIC RIGHTS PROJECT,  
COMMUNITY LAW CENTRE (UNIVERSITY  
OF THE WESTERN CAPE)**

**Compiled by Lynn Boesak**

**Edited by Sibonile Khoza**

This workshop was hosted with the financial assistance of the Foundation for Human Rights in South Africa (FHR). The FHR is funded by the European Union under the European Programme for Reconstruction and Development. The Ford Foundation provides supplementary funding to the Socio-Economic Rights Project. The views expressed herein do not necessarily represent the official view of the FHR or the Ford Foundation.

## **MINUTES OF PROCEEDINGS**

In attendance

See attached list of participants, marked 'A'.

### **1. Introduction**

#### **Mr Sibonile Khoza**

Sibonile welcomed all participants to the workshop. He introduced Project members and acknowledged the presence representatives from the Foundation for Human Rights of South Africa, which funds the Project.

Sibonile then proceeded to outline the background of the workshop. He said that the workshop is an event organised in pursuit of the Project's research and advocacy focus area on the intersection between the rights of access to health care, to adequate food and to basic nutrition in the context of HIV/Aids epidemic. This focus was informed by the fact that much of the current interventions around the rights of HIV infected persons are focused on medical treatment and health care services. Research reveals that food and nutrition are important to the reduction of mother-to-child transmission (MTCT) of HIV and to the health of people living with HIV/Aids and the effectiveness of the medication regimens. However, scant attention has been paid to special nutritional and food needs of this group. This research focus intends to investigate and examine whether laws, policies and programmes meet the food needs of people with or affected by HIV/Aids.

The objectives of the workshop are to:

- provide a platform for debate and discussion on the legal and medical implications of HIV/Aids specifically on the infant's right to nutrition and health care;
- share information on the work that has been done thus far by different stakeholders, including the Socio-Economic Rights Project; and
- create opportunities for networking and establishing collaborative efforts around this research and advocacy focus area.

Participants were drawn from a wide range of sectors, including the medical, legal profession, civil society and government departments.

### **2. HIV/Aids and the rights to health care and nutrition: International and constitutional law**

**Facilitator:** Adv Karrisha Pillay

This session sought to lay a foundation for the next presentations and discussions. It consisted of two aspects: the international and regional law, and the constitutional law perspectives. Each aspect had its own presenter.

**Presenter 1:** *Mrs Michaela Jane Figueira*, Project Co-ordinator, Aids Law Unit, Legal Assistance Centre, Namibia

### **2.1** *The HIV/Aids Epidemic: An international perspective*

Michaela provided an international perspective on the connections between HIV/Aids and discrimination, and the rights to health care and to nutrition. She identified a number of factors that accelerate the prevalence of the epidemic in Africa. These factors include gender and global inequalities, poverty, racism, apartheid, deprivation of education, migrant labour, civil wars and so on. Women are particularly at greater risk of HIV/Aids due to the imbalances of power in gender relations. Most efforts aimed at combating the epidemic tend to assume that people have choices. Michaela argued that this was wrong because individual choices especially in Africa are limited by sharply by deep social inequalities for combating HIV/Aids.

The right to health consists of four elements: availability, accessibility, acceptability and quality. While all of these elements are important, access to affordable treatment is central to the right to health care. The State has the obligation to respect, protect and fulfill this right. Laws and policies should be formulated and implemented to give effect health care rights. It is crucial that civil society is involved in the development and implementation of national plans for the realisation of the right to health.

Furthermore, provision of care, support and treatment (TCS) forms a continuum, and cannot be dealt with in isolation from other elements of realising the right to health care. TCS includes the provision of anti-retroviral treatments (ARV) and other medicines, support and home-based care. MTCT also forms part of the TCS continuum. In order to prevent MTCT, parents-to-be should have access to information, counselling and support.

There is a need to adopt a broader perspective on HIV/Aids-related discrimination. Unequal access to goods and services linked to socio-economic rights, such as access to food, education and housing provide a catalyst for discrimination. Developments at an international level are also relevant in this regard. For example, *Nepad* has become an important document shaping the framework for social and economic development of African States. This key development will influence the way in which governments respond to social problems such as HIV/Aids. There are different opinions on the implications of *Nepad*, but it is noteworthy that HIV/Aids is only mentioned once in the *Nepad* document. The level of commitment of governments to dealing with the impact of the disease is thus brought into question. It is also noteworthy that the Global Fund only receives 1/10 of what it needs for combating HIV/Aids. A financial commitment to the struggle against the disease is vital, and unless all efforts are translated into hands-into-pockets, Aids will continue to lead to discrimination.

**Presenter 2:** Mrs Julia Sloth-Nielson, Professor of Law, Faculty of Law, University of the Western Cape

## 2.2 South Africa's jurisprudence on children's socio-economic rights

Julia provided a background of the litigation strategy used to enforce children's socio-economic rights. She particularly focused on the Constitutional Court's decisions in *Government of the Republic of South Africa v Grootboom* (*Grootboom*) and the *Minister of Health v Treatment Action Campaign (TAC)*. She tailored the presentation to cover the construction of children's rights prior to and post the *Grootboom* case, which was the first to interpret these rights (section 28).

Prior to *Grootboom*, children's rights were premised on the idea that "children come first". These rights were viewed as providing children with a direct right (claim). For example, if children were starving, these rights meant they could go to the government to ask for food. In *Grootboom*, the High Court upheld this view by holding in favour of the children's right to shelter. However, the Constitutional Court (the Court) took a different view. It said that sections 28(1)(b) and 28(1)(c) must be read together and held that the primary responsibility for children lies with parents. It expressed the fear that if children would have first claim to shelter, they would become stepping-stones for their parents to claim immediate realisation of the right of access to adequate housing.

The Court's approach to children's rights was highly criticised by many human rights activists for reducing the scope of these rights. These criticisms were somewhat watered down by *TAC*. The Court emphasised that while parents are considered to be the primary providers of children's related services, it does not mean that the State has no obligation in relation to children in the care of parents. This is a partial 'claw-back' from the *Grootboom* judgment. Given the *Grootboom* approach to children's rights, it remains not clear as to the nature of the State's obligation in relation to the right to basic nutrition. For example, the Court declined to make a decision with regard to the provision of formula milk by the state.

The speaker concluded with the following six points:

1. There are worthwhile distinctions between specific rights. Legal territory can be claimed on the basis of these distinctions. For example, parents cannot provide social services to children.
2. There is scope for direct enforceability of section 28(1)(c). An implication for a litigation strategy in *Grootboom* and *TAC* is that children's rights should not be argued in isolation, but an emphasis should be placed on their interconnectedness. Can one assert the independence of section 28(1)(c) rights?
3. *Grootboom* coined a new term of 'reasonableness' – which was thus associated with the effects of laws and policies on those in desperate need. Children who need formula milk must rate as children in desperate need, and this should be weighed up against the financial feasibility of providing formula milk.

4. Morality of the cause should be separated from the legal obligation. As Judge Dennis Davis pointed out, *TAC* case was won long before it got to the Constitutional Court. There was no political difficulty for the Constitutional Court in finding for the applicants.
5. There is a need to reassert section 28(2) in a targeted way. For example, Judge Goldstone pointed out in the *Fitzpatrick* case that this section could apply to every case involving children.
6. Do we have a coherent jurisprudence on children's rights? No. In *Grootboom*, the Constitutional Court retreated, and to a limited extent also in *TAC*. The water is still muddy.

### **Discussion (on both presentations)**

The question was asked whether it is possible to keep apart the moral and legal implications of the rights. Litigators often do not want to give moral substance to legal rights. In response, Julia said that it is easy to advocate for the distinction of moral and legal implications from the lawyer's perspective, but people who have not studied law would find this difficult. Besides, it can be argued that even the Constitutional Court has declined to adopt the minimum core threshold on the basis of a moral high ground.

Another point raised was that whether core rights should be considered in the framework of available resources. How should these rights be weighed up in the context of people not having even basic access to nutrition? Michaela responded by saying that many African Governments have relied on the 'lack of resources'. Governments are in a difficult position, but there is too much emphasis on the costs of treatment. Treatment and prevention cannot be divorced from one another. Each element of the continuum must be prioritised. Undertaking both of these strategies to HIV/Aids will maximize the efforts to addressing the pandemic.

One participant suggested that the *TAC* case had already been won due to mobilisation that took place around the issue. Could this strategy be useful for children? Julia agreed that this probably is a useful strategy for advancing children's rights. A follow-up question was raised on whether the outcome of the *Grootboom* case would have been different if the case was linked to a broader social movement? Julia further replied by acknowledging the difficulty in answering the question. *Grootboom* was the first litigation of socio-economic rights. There are social movements with regard to housing, but despite the Court's ruling, the *Grootboom* community is still living in the same homelessness situation in Wallecedene. In addition, it was pointed out that the outcome of the *Grootboom* case would not necessarily have been different, but the implementation of the judgment might have been.

If every child has direct rights, as it was the view prior to the *Grootboom* judgment, how do we ensure social equality? The *TAC* case was limited to the negative obligation of the State in terms of the right to health care in the form of the provision of anti-retroviral drugs. However, in the *Grootboom* case, the State had a positive obligation to ensure that children's rights are realised. Julia commented that the basis for the view that children's rights should be direct is in the absence of qualifiers such as 'have access to' and 'progressive realisation'. This conceptualisation suggests that children should have a direct claim. According to Julia, this was the intent of those drafting the Constitution. This pre-*Grootboom* view was accepted

as common wisdom. But now views are qualitatively different. As regards the obligations, their contents are vague.

A concern was raised that the Constitutional Court seems to have a vision to dealing with children's rights. Is this deliberate or incidental? Julia was of the view that it is deliberate since the Constitutional Court in the *Grootboom* case probably realised the implications that such an approach would open floodgate of actions. In view of this deliberate approach to children's rights, Julia emphasised the point that children's rights should not be pursued independently. Karrisha agreed that children's rights should always be considered in light of the general provisions. Finally, Julia stressed that litigation is only one strategy to realising the rights, but it is not always useful. There is scope for using a range of strategies to ensure the realisation of these rights.

### 3. HIV/Aids and infant feeding: Scientific perspective

**Facilitator:** Dr Neil McKerrow

**Presenter 3:** *Dr Mark Cotton*, Head of the Department of Paediatrics and Child Health, Stellenbosch University and Tygerberg Children's Hospital

Dr Cotton started off by acknowledging that there is a dilemma regarding infant feeding in the context of HIV/Aids. This dilemma is raised by the fact that HIV can be transmitted from an infected mother to an infant through, *inter alia*, breastfeeding. Breast milk is widely recognised as the best source of nutrition and health for infants. For example, as it provides quality nutrition to infants and anti-bodies that neutralise viruses. The crucial question is what is the best form of feeding for children whose parents are infected with HIV or Aids.

Under good socio-economic conditions, infant mortality for breast-feeding and bottle-feeding is the same. Data presented the effectiveness of breastfeeding in under-resourced areas, and to assess how protective breast-feeding was in reducing MTCT of HIV/Aids. The findings showed that breastfeeding is extremely protective. Breast-feeding for up to 4-5 months is very good. It provides major protection against, for example, diarrhea and pneumonia, until 6-8 months of life. However, there is a need for more data that will show the effects of a widespread formula feeding practice.

It has been recommended that mothers should be encouraged to make an informed choice. They should be given the facts and allowed to make a decision. This is not an easy choice, and it is hard for counsellors to be unbiased. An important question is how infectious breast milk is. There is a risk of infection after birth and if the mother gets an infection, transmission rate is 20 percent up to 50 percent. In other parts of the country such as KwaZulu/Natal, 45 percent of mothers are HIV positive, and many babies become infected.

The crucial question is: *does the risk of transmission of HIV exceed the risks associated with formula feeding?* It was found that the option of mixed feeding as opposed to exclusive feeding had not been considered. Another study found that the groups that mixed fed had more

infections than those than either exclusively breast or formula fed. Those that formula fed had the same amount of infections as those breast-feeding. Thus, it is concluded that mixed feeding is not good.

However, there were some interesting observations in studies conducted in other countries. Formula-feeding mothers had a higher level of education. Mothers were fully informed and thoughtful about their choice. Another question is what about the mothers? There was a three-fold higher mortality rate among breast-feeding mothers. Their nutrition has to be good. Can you really apply that information from such studies to our South African situation? Possibly not. There are complexities of how medical research has helped, but has not answered the dilemma. Formula feeding with enough support is the way to go. Formula feeding is offered free in MTCT pilot sites. It is a major expense. Another factor is the nutritional supplements available to mothers.

**NB:** See [Dr Cotton's powerpoint presentation](#).

## **Discussion**

A participant referred to the HIV/AIDS Conference held in Durban in 2000, where a doctor presented paper questioning the use of full cream milk and Polagen. The presentation revealed that there was no documentation that suggested that Polagen is harmful. Should we do study on this? The question was also raised as to whether today's children are raised on formulas? On the first question, Dr Cotton explained that we do not know the precise impact of Polagen. SA is diverse. We do need to know what is going on in different areas. As for raising babies on formulas, Dr Cotton stated that it is probably fine, and is better than mixed feeding which is inappropriate diet for children.

Do formula fed babies also get HIV? If so, how? Dr. Cotton explained that the majority of infection takes place during the birth process, since the baby is exposed to large amounts of the mother's blood.

A participant stated that over 90 percent of women breast-feed. After 6 weeks, they introduce water. By two months, babies are on solids. Studies in Cape Town and Soweto, where formula feeding for HIV positive women is a norm, mothers returned to breast-feeding because of social pressure. Thus, constituting mixed feeding.

A participant cautioned that the issue of obliging the state to provide formula milk must be considered in the broader public health context. On the one hand, what happens if mothers with HIV formula feed and their babies are HIV negative? Will mothers who are HIV-negative also formula feed, thinking that breastfeeding is associated with HIV/Aids? On the other, we may also be promoting exclusive breast-feeding. Exclusive breast-feeding may also become stigmatised. We need to put facts and figures in a broader context. There was consensus that issues of infant feeding are very complicated, and that it is difficult to have a fixed position.

A participant referred to the issue of public vs. individual health responsibility. There should be a multi-sectoral approach. Such factors as socio-economic conditions should be addressed. With regard to individual counselling, what message is given to mothers? This notion was supported and it was stressed that social and economic factors of a mother are critical determinants of infant feeding options. For example, infant mortality rates are a result of, for instance, lack of access to water and overcrowding. We need to inform feeding choices through individual counselling. It was added that an informed choice should also be informed by the relevant policy. A participant explained that his project works in rural Eastern Cape, where there is no water and there are broken taps. Under these poor circumstances, infant mortality rates are high, and mothers are poor. Half of them are choosing to formula feed, with reasonable counselling. Some mothers see free formula milk as an asset. Some will still breast feed but will take the formula milk. Free formula milk is influencing decisions mothers are making. Individual choices do not take place in a vacuum.

Dr McKerrow stated that there is not problem with the initial uptake. What women do with the formula milk and how else they feed their babies is of particular concern. There are risks associated with mixed feeding. The concern is what happens if women stop breast-feeding and they do not have any formula. Whether the State provides formula milk or not, there will be mixed feeding. We need to help mothers make an informed choice and choose the most appropriate feeding practice in the circumstances.

Dr. Cotton concluded that we cannot exclude breast-feeding. Generally speaking, mothers need to breastfeed. There are sociological factors involved in this. Mothers are often afraid of being labelled as HIV positive if they do not breast-feed. Because of these pressures, there is a danger that women may tell you (as the doctor or nurse) what you want to hear, even though they may not be consistently applying the feeding methods that are recommended.

In summary, Dr McKerrow stated that breast-feeding is the optimal choice. But in an HIV world it is highly risky. The alternative of formula feeding poses many risks to infants, and can increase the mortality rate. Mixed feeding also increases the risk of infection. In making recommendations to a mother, we should be influenced by the context in which she lives. The mother's ability to implement her choice is influenced by her living conditions.

#### **4. HIV/AIDS and the infant's right to basic nutrition, and women's reproductive health care rights**

**Facilitator:** Mr Danie Brand

This session was divided into two parts. The first part focuses on the implications of the HIV/Aids on the right to basic nutrition and the obligations of the state in relation to such implications. The second part focuses on the inter-relatedness of the health care including reproductive health care rights of women and the rights of children to nutrition and health care.

**Presenter 4:** *Mr Sibonile Khoza*, Researcher, Socio-Economic Rights Project, Community Law Centre (UWC)

#### **4.1** *HIV/Aids and the infant's right to basic nutrition*

Prior to presenting his paper entitled: 'HIV/Aids and the infant's right to nutrition: *Does the state obligation to prevent mother-to-child transmission of HIV include the provisioning of formula milk?*', Sibonile alluded to the fact that the issue of infant feeding in HIV environments is as controversial in the medical corridors as it is in legal cycles. These issues cannot be resolved by the workshop, but the forum should be seen as an important step to finding solutions.

Scientifically, there are indications that all three stages of MTCT (i.e. during pregnancy, during labour or at birth, and through breastfeeding) can be reduced through the provision of anti-retroviral treatments such as nevirapine, and through the avoidance of breast-feeding and the introduction of formula milk. If the risk associated with formula milk is higher, breast-feeding is recommended. In the *TAC* case, the government ruled that medical professionals should address the matter during counselling. The ruling does not make clear if government has an obligation to provide formula milk.

There is State obligation to provide formula milk for feeding in HIV environment where it such formula is appropriate and medically indicated. This obligation arises from the right of infants to basic nutrition as read with the right to basic health care, the right of everyone to have access to health care, including reproductive health care. In examining international law, the relevant international instruments (many to which South Africa is party) and their provisions relating to nutrition and health care converge to pointing out that South Africa is bound to provide formula feed to prevent postnatal transmission of HIV.

According to constitutional provisions, the State has an obligation to provide formula milk in terms of section 28(1)(c). Following the interpretation accorded to children's socio-economic rights thus far, the primary responsibility to provide nutrition for infant lies with those parents that can afford such service. However, the State still retains the obligation to provide basic nutrition to those children that are cared for by their parents where the latter does not have sufficient means to provide for these services. Sibonile also criticised the interpretation accorded to children's rights in *Grootboom* and which was subsequently followed in the *TAC*, for not giving clarity as to when the State has an obligation under the children's right provisions.

Furthermore, the Court in *TAC*, by simply leaving the issue of formula milk to the health professionals, the Court confused the medical and legal issues. The Court's mandate is to determine the scope of the obligation in terms of the rights provisions. This is a legal question. As to who actually gets the benefits of the right – for example in terms of health care – is a medical question. For instance, by pronouncing that the State has an obligation to provide nevirapine, the Court did not mean that all pregnant women with HIV should receive nevirapine. But the issue of who receives nevirapine is an individual choice of these women and a medical question for the doctors. In this sense, the Court avoids meddling in

the choice of the mother and also refrains from prescribing to doctors what to give to specific patients.

Sibonile ended his presentation by submitting an alternative argument. He argued that the obligation to provide formula milk in HIV feeding environments can be located in s27 of the Constitution – the right to have access to health care. He argued that the holding in the *TAC* case for only the provision of nevirapine for the prevention of MTCT is particularly concerning in the light of the constitutional principles developed in the *Grootboom* case. For example, this holding is not consistent with the principle of coherence of a policy, which requires that the problem should be addressed holistically, nor is it consistent with the principle of responding to the urgent needs of those in desperate situations.

**NB:** See [Sibonile's paper](#)

**Presenter 5:** *Ms Anneke Meerkotter*, Researcher, Gender Project, Community Law Centre (UWC)

#### **4.2 Women's reproductive health care rights**

Anneke presented on the inter-section between women's rights and children's rights to nutrition in the context of HIV. She pointed out that current debates on nutritional needs in HIV environments have mainly focused on infant formula milk and breast-feeding. These debates have tended to undermine the equally important need for nutritional support to women with HIV, especially rural women who face difficulties in accessing grants, live in poverty, and suffer from food insecurity.

Women and men have the right to determine the course of their reproductive lives through access to information and services that necessitates that determination. Women in particular have a right to make choices regarding infant feeding options. Providing options to women to make decisions is consistent with the duty to promote and fulfill their health care rights. She argued that it would be an infringement of women's dignity if, once they are aware of the dangers of MTCT and want to use formula feed, they are not given means to do so. Even *TAC* advocates for and endorses the notion of providing all necessary and relevant information for women to make decisions about their health (rights). This notion is not only protected and promoted in the Constitution but also widely recognised in the international human rights law, *inter alia*, the Convention on the Elimination of Discrimination Against Women (CEDAW) and the Beijing Declaration of 1995.

According to the World Health Organisation's Recommendations of June 2001, all women whose status is unknown and those that are tested negative, exclusive breastfeeding remains unequivocally recommended. However, when replacement feeding is acceptable, feasible, affordable, sustainable and safe, avoidance of all breastfeeding by HIV infected women is recommended. Otherwise, exclusive breastfeeding is recommended during the first months of life. Over and above the provision of information, WHO recommends also that there should be follow-up clinical care and support, including family planning and nutritional

support. Upon making a final decision on infant feeding practice, women should be given all the necessary support for themselves and their babies.

While the Court in *TAC* was clear about the necessity of providing information to women in order to make decisions, it mentioned that it was not of the view that the State however incurs an obligation to provide formula milk. But providing nevirapine was an essential prerequisite for the prevention of MTCT. However, she pointed out that the down side of the *TAC* case is that there was not enough information before the courts, such as the one that Dr Cotton has provided earlier, to make the decision on the issue of the provision of formula milk. Therefore this lack of information facilitated the opting out of the Court in this regard. The respondents technically avoided arguing this position.

Anneke also stated that nutrition requires meaningful and realisable policies. There is a dire need to broaden the net for addressing issues around nutrition such as inequalities within the society. She pointed out that there are numerous problems that need to be addressed. For example, various levels of legislation and constitutional rights should explore, deepen and concretise materially the issues around lack of adequate nutrition and food insecurity. These problems require various strategies and tools, including litigation backed up by social campaigns. She cautioned of the dangers of focusing on children's nutritional needs separately from the food needs of the entire households within which these children live.

**NB:** Anneke's powerpoint presentation

### **Discussion (on both presentations)**

A question was asked as to what happens when the rights of women and children do not longer converge? For example, sometimes women do not want to be tested or to take nevirapine, or formula feed their babies. In the context of women's right to make choices, it may not be in best interest of children. Regarding women, is there a need for a mandatory policy of testing or the taking of nevirapine?

In response, Anneke said that there is a real case where a woman did not believe that HIV causes AIDS, and she refused to stop breast-feeding and ran off with the baby. Mothers are entrusted with the primary responsibility of caring and nurturing their children. They decide what is in the best interest of the child. This is as far as the current law relating to a parent – child relationship suggests. With respect to universal testing, one would need to argue how this approach is in the best interest of the child. Currently, HIV testing is based on moral persuasion of an individual. There are no legal obligations to testing. Therefore, the existing tool is to encourage people to do voluntary testing of HIV. It should be noted that there is a stigma attached to testing, and as a result, people often do not want to get tested. It is important that openness is also encouraged.

A point was raised that there is tension between reproductive rights and children's rights. Parents are making decisions that adversely affect children's rights. Thus, it is difficult to advocate for women's rights exclusively and independently of children's rights.

It was also pointed out that some people are aware of the risks of formula milk, but misuse it because we do not have adequate facilities. What could be suggested in the meantime? Who should play a role of giving this information? And do they have the capacity? In response, Sibonile said that the issue of providing information is a counselling matter and thus should be addressed by health care professionals on a case-by-case basis (through the counselling process). Currently, formula milk is provided in some health care institutions, yet there is no policy. There need to be a clear policy guideline on this issue. He said that it does not suffice to make provision for an exercise of a choice without provision for supporting such a choice. So, without the provision of formula milk at public health institutions, what choice would a poor mother have in relation to infant feeding?

Given the way in which the issue of exercising an informed choice has been argued, there was a concern that social and economic inequalities would play a major role in determining who gets nutritional support in a form of formula milk. For example, if the mother is living in well-off conditions and chooses to formula feed, the state will give her formula milk. If a mother who is poor and makes a sensible choice, the State does not give her formula milk. Why are we not arguing that all mothers with HIV should be given food, including nutrition for children, so that the choice is not influenced by economic status? The State should provide a non-discriminatory grant. Anneke said that food should be provided to women to support them to breastfeed. Formula milk is provided in some provinces and health institutions, but not all. The child support grant only applies to children up to the age of seven. Irrespective of their HIV status, children can go to hospitals, and be assessed by health care workers for their nutritional needs.

## **5. HIV/Aids and infant feeding: Policy perspective**

**Facilitator:** Ms Liesl Gernatholtz

**Presenter 6:** *Mrs Ann Behr*, Assistant Director, Directorate of Nutrition, National Department of Health, Pretoria

Ann started off by stating that government has a commitment to nutrition and to offer protection against disease. Through its Intergated Nutrition Programme (INP), the Department of Health aims to ensure food security. This commitment stems from a catalogue of the constitutional and international provisions relating to nutrition and adequate food. Infant nutrition policy needs to be planned within the context of various provisions found in a wide range of documents and agreements such as the South African Constitution, the Convention on the Rights of the Child and the International Code of Marketing of Breastmilk Substitutes.

MTCT and the debate around infant feeding is a major challenge for Africa. On the one hand, there is a problem of infection through breastmilk which is highly acclaimed as the best nutritional source for children. On the other, recommended substitute feeds such as formula milk also have limitations in poor resource settings. These recommended feeds have the potential to increase infant mortality in poor socio-economic conditions. Current policy on infant nutrition promotes breastfeeding in HIV free environments and proposes the

adoption of either exclusive breastfeeding or formula feeding where a woman is HIV positive. Infant formulas are provided only in the research and training sites for mothers who choose not to breastfeed.

According to the WHO recommendations on infant feeding, the crucial challenge is to determine whether it is acceptable, feasible, affordable, sustainable and safe to adopt formulas, otherwise exclusive breastfeeding is recommended. Other factors include providing antenatal and postnatal counselling in which a mother socio-economic circumstance is assessed to determine the form of feeding (for HIV infected mothers) that would be feasible for a particular mother. These counseling would entail an ongoing monitoring aspect of the growth and development of a child, and assess the needs of the mother to properly care for her child.

There are challenges to the infant feeding issue. These include concerns:

- The provision of free formula may contribute to higher rates of mortality and morbidity.
- Exclusive feeding is not always complied with.
- The spillover effects of formula
- What happens after 6 months of formula support?
- Counselling, monitoring and support.

**NB:** Ann's powerpoint presentation

### **Discussion**

A question was raised as to whether there has been any experience of mothers who do not produce milk after the first two days. How does that affect infection? It was explained that if lactation is not established before 48 hours, the practice of giving glucose water is encouraged. Since breastfeeding is a psychological phenomenon, factors such as fear can make it not flow.

It was asked whether mothers who choose to give birth at home get health care support or whether they have to always go to clinics. It was stated that childbirth is culturally very sensitive. While the department would encourage that birth is given at public health institutions, individual circumstances and cultural issues may influence home based childbirth. However, there are primary health care, home based care, outreach programmes and support groups that are established for lay women and supported with regular meetings and workshops.

It was also noted that provinces adopt and implement policies differently. With respect to social support, a common policy norm is that if the mother breast-feeds, the clinic follows up to monitor the child, the social worker will visit the home and provides food parcels for the mother if needed. However, this is not always the case in all provinces. A follow up question was asked whether there is a national policy with respect to formula feeding in the context of HIV//Aids. And if there was, how could one explain variances in different provinces? In response, Anne pointed out that there is definitely a national policy on breast-

feeding, but not on formula milk in the context of HIV/Aids. A follow up question was asked as to what extent is this absence of a formula feeding policy informed by the court's decline in making a decision on the provision of formula milk in the *TAC* judgment? No comment or response was made on this question.

It was noted that there is a dilemma with regard to the infant formula within the ranks of the National Directorate for HIV/Aids. No clear decision has been made thus far in this regard. It appears that a large sector of the population is very pro-breastfeeding. The best is to fully explain and allow the mother to choose given her circumstances.

Attention was drawn to complexities and crosscutting nature of the issue and whether there have been measures to coordinate or integrate the efforts in the development of a policy around infant feeding. Relevant departments such as Water, Health, and Education that should be taking part in the development of a policy were mentioned. What are the updates around policy development? Ann declined to comment on the second question because the department is currently involved in discussions with a research working group (group of experts) to develop a policy, but details are for yet for public forums. She stated that the department of health has undertaken a number of projects jointly with the departments of Social Development, Water and Agriculture. However, Ann was not clear whether there is coordination and integration of efforts in the development of infant formula policy.

The question was asked as to what extent does the Ann think that women are making the right decision. Do they have enough information? Ann replied that the department aims to ensure that mothers have ample access to information at community level, even before they fall pregnant and as the child grows. There are many awareness campaigns. Women form their own support groups. Information is also passed through local or community radio stations. However, there was an argument dispelling the claim that there is ample information given to women especially at grassroot level. Choices are not made based on enough information. In some instances, mothers have not had enough information about breastfeeding or formula feeding. Ann said that providing enough information is not only a department's issue, but also a community matter. She concluded that the department has a huge challenge to develop policies. Implementation of these policies requires greater community involvement.

Liesl summarised the session by stating that the issues remain multi-faceted and complex. There are more questions than answers, and we need to continue with research.

## **6. Key themes emerging from the workshop and strategies for the way forward**

**Facilitator:** *Ms Jacqueline Gallinetti*, Senior Researcher, Children's Rights Project, Community Law Centre (UWC)

Jacqueline provided a summary of the key themes emerging from the workshop's proceedings as follows:

- a) It was highlighted that social inequalities account for the prevalence of HIV/Aids infection and affect the realisation of the right to nutrition and health care. These

inequalities are a product of a wide range of factors such as racism, poverty and gender inequalities, and they lead to HIV based discrimination. Therefore, there is a need identify and break the cycle of social inequalities with the aim to enhance the realisation of the right to health care and nutrition for people with or affected by HIV/Aids.

- b) It was further emphasised that an approach to children's rights should be premised on their indivisible and interdependent nature of all rights. It was highlighted that in the light of the current interpretation accorded to children's rights by the Constitutional Court, it is crucial that children's rights are linked to other rights, including those of their mothers.
- c) It was argued that the state has an obligation to realise children's right to basic nutrition and alternatively, to have access to health care. However, it emerged from the discussions that there is need to clarify whether the issue of MTCT through breastfeeding and the absence of a policy for the provision of formula milk falls under the right to nutrition or right to survival of a child.
- d) It was pointed out that the socio-economic rights issues that affect the realisation of women and children's rights in the context of HIV/Aids should be addressed. Attention was drawn to the potential conflict between women's and children's rights.
- e) It was noted that infant feeding in the world of HIV from the medical and policy perspective remains the most challenging and unresolved matter throughout the region. There is still a greater need to undertake research in different parts of the country to inform policy development. What is clear is that issues are broader than just infant feeding. A wide range of poor socio-economic conditions of a large number of people infected and affected by HIV/Aids has to be addressed as a matter of priority. It was emphasised that both the research studies and the development of policy around this issue would require intersectoral cooperation between relevant government departments, academics, research institutions, civil society organisations (NGOs) etc.
- f) In the absence of a policy, the crucial issue is to assist HIV infected women with children to feed to make an informed choice. This includes making the information accessible and correct. In addition, we need to continue with research, advocacy and lobbying as well as the monitoring initiatives focusing both in the development and implementation of policies with the aim of enhancing the realisation of the nutrition and health care rights of people living with and affected by HIV/Aids.

In charting the wayforward, the following strategies emerged:

- a) Courts are only a means of enforcing rights. Civil society must be actively involved in lobbying and advocacy on the budgetary processes and in ensuring that budget allocations are sensitive and respond to children's needs.

- b) Further educational and awareness programmes on the legal and public health perspectives are needed to provide a comprehensive insight to the infant feeding in the context of HIV/Aids. The programmes must reach out to the most needy and marginalized groups such as those in rural areas who often do not have access to the vast amount of information that is currently available.
- c) Policy implementation should be supported and monitored. This should be done in cooperation with the wide range of institutions such as the South African Human Rights Commission, Commission on Gender Equality, and civil society organisations and other stakeholder doing similar work.
- d) Identification and collection of relevant documents and resource materials are a prerequisite for any strategic initiative. For example, there is a recent document on the recommendations of the United Nations General Assembly which deals with children's socio-economic rights but neglects paying attention to child justice. This document could be of relevance to the issues of children's right to nutrition, health care and survival.
- e) Collaborative efforts and formulation of alliances are crucial strategies for maximising the impact of the rights activism. ACCESS and the Basic Income Grant (BIG) Coalition were identified as one of the leading collaborative movements focusing in the field of socio-economic rights, particularly social security and social assistance rights. The formulation of new and independent (and separate) structures was discouraged. Strategic activism that could emerge around children's right to nutrition should be joined with in these existing alliances. This would also be consistent with the suggestion that children's rights should be approached from an interrelated point of view. It was proposed that the Treatment Action Campaign takes a lead in this issue since it is already monitoring the implementation of the TAC judgment to which this issue emanated.

The workshop acknowledged that the issue of infant feeding in the context of HIV/Aids is a complex and controversial one. Thus, it would be difficult to develop a tangible way forward in the forum. However, it was encouraged that the abovementioned strategic proposals be taken seriously and efforts be made to action them. At the very least, the workshop has succeeded in providing a forum for various sectors to debate and share information around the infant feeding and HIV/Aids question. All stakeholders are encouraged to begin and continue to network and participate in the developments around this question.

To this end, it was suggested that a follow-up session be held in 2003 which will look broadly at the issue of food and health care in the context of HIV/Aids.

## **7. Closure**

Sibonile closed by passing a vote of thanks to all the presenters, facilitators and participants for the invaluable insight presented and vibrant debates and discussions that took place during the workshop. Special thanks were expressed to Michaela Figueria who came from

Namibia on short notice invitation. Lastly, but not least, Sibonile passed words of gratitude to the funders of the Socio-Economic Rights Project who made the workshop possible, the Foundation for Human Rights in South Africa and for their presence and participation during the workshop. Finally, he also thanked the Project staff, Gaynor Arie organizing the logistics of the workshop and Danwood Chirwa for his inflicting support.