

**THE PREVENTION OF HIV TRANSMISSION FROM MOTHER-TO-CHILD: THE OBLIGATIONS OF THE SOUTH AFRICAN GOVERNMENT IN TERMS OF NATIONAL AND INTERNATIONAL LAWS**

by

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Signature

(Mr Mpaka M)

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Date

*To those who are still struggling to benefit from what is their fundamental right, access to health care services in Africa.*

## **SUMMARY**

Women and children are often the most affected by pandemics which have swept through the world, and in this regard the HIV/AIDS pandemic is not an exception. The most common route of HIV infection in HIV positive children under 5 years of age is through Mother-To-Child Transmission (MTCT). In spite of the seriousness of this pandemic, the Constitutional Court has found that the measures taken by the South African government with regard to the Prevention of Mother-To-Child Transmission (PMTCT) has fallen short of what the Constitution requires. This dissertation critically reviews the management of the South African PMTCT programme, and discusses the relevant Court decisions. The study finally clarifies the obligations of the South Africa government in the context of PMTCT under the 1996 Constitution and in terms of international law.

## **KEY TERMS**

HIV/AIDS, Prevention of Mother-to-Child Transmission, obligations of the government, access to health care, access to antiretrovirals (ARVs), international human rights, government policy.

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## CHAPTER 1

### INTRODUCTION AND PROBLEM STATEMENT

#### 1. Introduction

##### 1.1. What is HIV?

The human immunodeficiency virus (HIV) pandemic is one of the most severe health challenges the world faces today. HIV is a virus that infects cells of the human immune system (mainly CD4<sup>1</sup> positive T cells and macrophages), and destroys or impairs their function. Infection with this virus results in the progressive deterioration of the immune system, leading to immune deficiency.<sup>2</sup>

HIV/AIDS has killed millions of people since the early 1980s, when French and American scientists first identified it. A second type of HIV, referred to as HIV-2 has been identified in 1986.<sup>3</sup> However, the rate of transmission of HIV-1 may be higher than that of HIV-2, and people who have HIV-1<sup>4</sup> may develop AIDS earlier than people with HIV-2.<sup>5</sup>

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<sup>1</sup> CD4 means Cluster of Differentiation antigens types 4-a molecule on the surface of some lymphocytes onto which HIV can bind. It is also called "T-helper" cells. They play a central role in the immune response, signaling other cells in the immune system to perform their special functions. A healthy, uninfected person usually has 800 to 1,200 CD4+ T cells per cubic millimeter (mm<sup>3</sup>) of blood. When the CD4+ T cell count falls below 200/mm<sup>3</sup>, a person becomes particularly vulnerable to the opportunistic infections and cancers that typify AIDS, the end stage of HIV disease. <http://www3.niaid.nih.gov/topics/HIVAIDS/Understanding/howhiv.htm> [date of use 11 February 2009].

<sup>2</sup> UNAIDS "Fast facts about HIV" 1 May 2008 available at [http://data.unaids.org/pub/FactSheet/2008/20080519\\_fastfacts\\_hiv\\_en.pdf](http://data.unaids.org/pub/FactSheet/2008/20080519_fastfacts_hiv_en.pdf) [date of use 11 February 2009].

<sup>3</sup> HIV-1 is associated with infections in central, East, Southern Africa, North and South America, Europe and the rest of the world. HIV-2 was discovered in West Africa: Cape Verde Islands, Guinea Bissau and Senegal in 1986 and it is mostly restricted to West Africa. HIV-2 is structurally similar to HIV-1, but is less pathogenic than HIV-1. HIV-2 infection has a longer patency period with slower progression to disease, lower viral counts and lower rates of transmission. Van Dyk A *HIV/AIDS care and counselling: A multidisciplinary approach* 4<sup>th</sup> ed (PESA 2008) 4.

<sup>4</sup> Note that in this dissertation HIV refers to HIV-1.

<sup>5</sup> American Red Cross *HIV/AIDS Facts Book* (January 2003) 9.

There are three common modes of transmission of HIV from one person to another:

- by having sex (anal, vaginal, or oral) with an HIV-infected person;
- by sharing needles or injection equipment with an injection drug user who is infected with HIV or through receipt (transfusion) of infected blood or blood clotting factors; or
- from HIV-infected women to their babies before or during birth, or through breast-feeding after birth.<sup>6</sup>

As a mode of transmission, Mother-To-Child Transmission of HIV (MTCT) accounts for more than 10% of all new HIV infections globally and for over 90% of new infections in infants and young children.<sup>7</sup> This is why this study focuses on this particular mode of HIV transmission and advocates the reduction of the rate of MTCT through the implementation of the right to access to health care for mothers with HIV and their infants.

### **1.2. Does HIV cause AIDS?**

The loss of CD4 in people with HIV is an extremely powerful predictor of the development of the acquired immunodeficiency syndrome (AIDS). Studies of thousands of people have revealed that most people infected with HIV carry the virus for years before enough damage is done to the immune system for AIDS to develop. However, sensitive tests<sup>8</sup> have shown a strong connection between the concentration of HIV in the blood and the decline in CD4+ T cells and the development of AIDS. This means that a higher viral load will

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<sup>6</sup> Centers for Disease Control “How is HIV passed from one person to another?” <http://www.cdc.gov/hiv/resources/qa/qa16.htm> [date of use 12 February 2009].

<sup>7</sup> World Health Organization, Department of HIV/AIDS “Prevention of Mother-To-Child Transmission (PMTCT)” briefing note 1<sup>st</sup> October 2007 <http://www.who.int/hiv/pub/toolkits/PMTCT%20HIV%20Dept%20brief%20Oct%2007.pdf> [date of use 22 January 2009].

<sup>8</sup> Centers for Disease Control “How HIV causes AIDS” <http://www.cdc.gov/hiv/resources/qa/hiv aids.htm> [date of use 12 February 2009].



go hand in hand with a lower CD4 cell count and this can predict whether a person's journey towards the final stage of AIDS will be rapid or slow.<sup>9</sup> This is a strong confirmation that HIV causes AIDS and also the premise that this study is based on.

In spite of the strong evidence on the causation of AIDS, there is a group of scientists<sup>10</sup> known as "AIDS denialists", who question the scientific evidence that HIV is the cause of AIDS.

### **1.3. Transmission of HIV from Mother-To-Child**

Women and children are often the most affected in the pandemics which have swept through the world,<sup>11</sup> and in this regard the HIV/AIDS epidemic is not an exception. According to the World Health Organisation (WHO) women currently represent that part of the population with the fastest increase in HIV infection rates. In the hardest hit countries<sup>12</sup> of Sub-Saharan Africa, more than 60% of all new HIV infections are occurring amongst women, infants, and young children.<sup>13</sup>

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<sup>9</sup> Van Dyk *HIV/AIDS care and counselling* 50.

<sup>10</sup> The most significant scientist to question the HIV/AIDS theory is Professor Peter Duesberg, a virologist at the University of California at Berkeley, who first wrote about this topic in 1987. Dr Duesberg remained unconvinced. He admits that HIV exists, but he maintains that it is harmless, and that AIDS is caused by non-contagious factors including drug abuse, malnutrition, and even the very drugs used to combat HIV. Articles are available at [www.Duesberg.com](http://www.Duesberg.com) [date of use 20 May 2009]. Other dissidents (often called "denialists" by their opponents) include the Perth Group of medical scientists and physicians from Australia. The Perth Group (led by Eleni Papadopulos) claims that nobody has conclusively proven the existence of HIV, so any contention that HIV causes AIDS has no foundation. Articles available at [www.ThePerthGroup.com](http://www.ThePerthGroup.com) [date of use 20 May 2009].

<sup>11</sup> Coovadia H "Mother-To-Child Transmission (MTCT) of HIV-1" in Karim A and Karim Q *HIV in South Africa* (eds) (Cambridge University Press 2005) 183.

<sup>12</sup> Ten countries account for two-thirds of all Mother-To-Child Transmission infections: South Africa, Uganda, Kenya, Tanzania, Zimbabwe, Mozambique, Nigeria, Democratic Republic of Congo, India and Ethiopia available at <http://www.who.int/hiv/pub/toolkits/PMTCT%20HIV%20Dept%20brief%20Oct%2007.pdf> [date of use 22 January 2009].

<sup>13</sup> World Health Organization, Department of HIV/AIDS "Prevention of Mother-To-Child Transmission (PMTCT)" briefing note 1<sup>st</sup> October 2007 <http://www.who.int/hiv/pub/toolkits/PMTCT%20HIV%20Dept%20brief%20Oct%2007.pdf> [date of use 22 January 2009].

UNICEF statistics report that of the 1.1 million babies born every year in South Africa, 300 000 are born to HIV positive mothers. About 93 000 of these babies will be infected by HIV, with 72 000 being HIV positive at birth and 21 000 becoming HIV positive through breastfeeding from the infected mother. Some 50% of these two groups of babies will die before their second birthday if Mother-To-Child Transmission of HIV is not prevented.<sup>14</sup>

Therefore, it is essential to understand the factors known to be associated with the transmission of the virus from mother to infant in order to determine interventions that reduce this transmission.

The virus may be transmitted during pregnancy, labour, delivery, or after the child's birth during breastfeeding. Amongst infected infants who are not breastfed, about two-thirds of cases of MTCT occur around the time of delivery and the rest during the pregnancy (mostly during the third trimester). In populations where breastfeeding is the norm, it may account for more than one-third of all transmissions.<sup>15</sup> In countries without appropriate medical equipment infants can become infected through unsafe procedures such as the use of contaminated needles, medical equipment, blood and blood products.<sup>16</sup>

In the absence of preventive intervention, most studies estimate the probability that an HIV-positive woman's baby will become infected as ranging from 15% to 25% in industrialized countries and as between 25% to 35% in developing countries. These differences are mainly explained by the frequency and duration of breastfeeding. Where there is no preventive intervention and mothers with HIV breastfeed for 18 to 24 months the rate of

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<sup>14</sup> UNICEF "Impact of safe infant feeding child survival" available at [http://www.unicef.org/southafrica/reallives\\_2799.html](http://www.unicef.org/southafrica/reallives_2799.html) [date of use 21 October 2008].

<sup>15</sup> UNAIDS "Mother-To-Child Transmission of HIV" available at [http://data.unaids.org/Publications/IRC-pub01/jc531-mtct-tu\\_en.pdf](http://data.unaids.org/Publications/IRC-pub01/jc531-mtct-tu_en.pdf) [date of use 11 February 2009].

<sup>16</sup> Coovadia "Mother-To-Child Transmission (MTCT) of HIV-1" 183.

MTCT is about 35%. The risk of transmission is reduced to 30% when mothers with HIV breastfeed for a period of 6 months without any PMTCT intervention and the rate of MTCT dropped to 20% where they used replacement feeding.<sup>17</sup>

Other factors known to increase the risk of MTCT include advanced stage of disease in the mother, recent maternal infection, and high fetal exposure to infected maternal body fluids during gestation and delivery. It should be noted that in these situations the risk of HIV-2 transmission is about 20 times less than that for HIV-1.<sup>18</sup> This means that the different viral genotypes<sup>19</sup> and phenotypes<sup>20</sup> may also affect the transmission rate.

#### **1.4. The prevention of MTCT**

The effective Prevention of Mother-To-Child Transmission (PMTCT) requires a three-fold strategy: the prevention of HIV infection among potential parents; the avoidance of unwanted pregnancies among HIV positive women; and by the use of combined antiretroviral drugs, elective caesarean section and infant feeding practices.<sup>21</sup> The use of antiretrovirals<sup>22</sup> decreases maternal viral load and improves the mother's CD4 count and the use of elective caesarean section decreases the viral exposure of the infant.<sup>23</sup>

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<sup>17</sup> World Health Organization, Department of HIV/AIDS "Prevention of Mother-To-Child Transmission (PMTCT)" briefing note 1<sup>st</sup> October 2007 3.

<sup>18</sup> Kennedy J *HIV in Pregnancy and Childbirth* (BFM 2003) 38.

<sup>19</sup> In this case the genotype is the genetic constitution of an HIV cell. See in general <http://en.wikipedia.org/wiki/Genotype> [date of use 15 May 2009].

<sup>20</sup> A phenotype is an observable characteristic or trait of the virus: such as its morphology, development or biochemical properties. See in general <http://en.wikipedia.org/wiki/Phenotype> [date of use 15 May 2009].

<sup>21</sup> World Health Organization, Department of HIV/AIDS "Prevention of Mother-To-Child Transmission (PMTCT)" 3.

<sup>22</sup> Antiretroviral drugs are used in the treatment and prevention of HIV infection. They fight HIV by stopping or interfering with the reproduction of the virus in the body. See in general [http://en.wikipedia.org/wiki/Antiretroviral\\_drug](http://en.wikipedia.org/wiki/Antiretroviral_drug) [date of use 15 March 2009].

<sup>23</sup> Coovadia "Mother-To-Child Transmission (MTCT) of HIV-1" 183.

A number of studies<sup>24</sup> have shown that the protective benefit of drugs is diminished when babies continue to be exposed to HIV through breastfeeding. Unfortunately, the cost of infant formula often puts it beyond the reach of poor families in resource poor countries, even if the product is widely available. Many women also lack access to information, clean drinking water and fuel needed to prepare replacement feeds safely. The risk is in the fact that if the substitute milk is used incorrectly, mixed with unsafe water or over-diluted, it could cause infections, malnutrition and even death.

Mixed feeding (breastfeeding mixed with bottle feeding of water or formula, or providing other foods) is not recommended because it can damage the lining of the baby's stomach and intestines and thus makes it easier for HIV in breast milk to infect the baby.<sup>25</sup> In this case the risk of life-threatening conditions from formula feeding may be higher than the risk from breastfeeding.

It is for these reasons that the governmental feeding policy recommends an exclusive short feeding (6 months) whenever the use of breast milk substitutes (formula) is not acceptable, feasible, affordable, sustainable and safe.<sup>26</sup>

In any case, an HIV positive mother should be counselled on the risks and benefits of different infant feeding options and should be helped to select the most suitable option for her situation. Her informed consent would thus be required. This means that a medical practitioner or a counselor must explain to an HIV positive mother and make sure that she understands the implications of the infant formula before she consents to a feeding option.

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<sup>24</sup> Kanabus A and Noble R "Preventing Mother-to-Child Transmission of HIV (PMTCT)" <http://www.avert.org/motherchild.htm> [date of use 5 March 2009].

<sup>25</sup> Kanabus A and Noble R <http://www.avert.org/motherchild.htm> [date of use 5 March 2009].

<sup>26</sup> Department of Health: Infant and young child feeding policy (2007) available at <http://www.doh.gov.za/docs/antenatal-f.html> [date of use 4 July 2009].

Concerning antiretroviral drugs, the Zidovudine (AZT) regime is more effective to prevent HIV infections than the Nevirapine (NVP) regime, but it is also more expensive. Nevertheless, it is important to know that both these PMTCT interventions only reduce, but not eliminate the transmission of HIV to infants.

The policy and guidelines are constantly under review to consider new scientific evidence. In 2004 and later in 2006 the WHO revised the use of ARV drugs with the adoption of simplified and standardized regimens which consists of NVP plus AZT.<sup>27</sup>

The long use of both AZT and the single-dose NVP, combined with replacement feeding, reduces the rate of MTCT by 2% when administered to mothers and infants from 28 weeks. However, the use of AZT and NVP combined with short breastfeeding increases the risk of MTCT with up to 10%. Where only a single-dose of NVP is administered to mothers and infants, combined with replacement feeding, the rate of MTCT is about 11%, but if combined with short breastfeeding (6 months) it is around 16%.<sup>28</sup>

### **1.5. The South African State and the PMTCT crisis**

The discussion on the obligations of the State to prevent MTCT is based on the South African Constitution of 1996<sup>29</sup> and relevant international instruments. Section 27(1)(a) of the Constitution provides that “everyone has the right to have access to health care services, including reproductive health care”, and section 27(2) determines that the “state must take reasonable legislative and other measures” in order to make it happen. Unfortunately the government took a long time to deal with the Prevention of

<sup>27</sup> WHO HIV/AIDS Programme: Antiretroviral Drugs for Treating Pregnant Women and Preventing HIV Infection in Infants: Towards universal access-Recommendations for a public health approach (2006) 26-31.

<sup>28</sup> World Health Organization, Department of HIV/AIDS “Prevention of Mother-To-Child Transmission (PMTCT)” 3.

<sup>29</sup> The Constitution of the Republic of South Africa, 1996 (hereinafter referred to as the Constitution).

Mother-To-Child Transmission of HIV, and when it finally launched its programme, it was only available at a limited number of pilot sites, which numbered two per province instead of nationwide. This conduct was challenged by a pressure group, Treatment Action Campaign,<sup>30</sup> in the Pretoria High Court,<sup>31</sup> and thereafter in an appeal before the Constitutional Court.<sup>32</sup> The discussion of these cases will follow in chapter three of this dissertation.

The Constitutional Court ruling ordered the government to without delay remove the restrictions that prevent the programme from being made available at all public hospitals and clinics. In response to the Constitutional Court ruling the government decided to expand the programme. As a result, the programme is currently available at 100% of hospitals and at more than 90% of primary health care centres countrywide in the public health sector.<sup>33</sup> However, many challenges still have to be solved as will be explained in section two below.

## **2. Problem statement**

The PMTCT programme in South Africa has been a long struggling journey for women with HIV and their babies, the government and Non-Governmental Organizations. Consequently, there have been uncertainties regarding the duties and obligations of the government in this matter.

Today, there is improvement in the implementation of the PMTCT programme in South Africa as the largest such programme in Africa, but there is still a lot that needs to be achieved. For example, there is the need to improve health care systems and access to clean water, especially in the

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<sup>30</sup> The Treatment Action Campaign (TAC) was founded in 1999 as a pressure group for improved access to treatment generally.

<sup>31</sup> *Treatment Action Campaign v Minister of Health* 2002 (4) BCLR 356 (T).

<sup>32</sup> *Minister of Health v Treatment Action Campaign* 2002 (5) SA 703 (CC).

<sup>33</sup> National Department of Health: Policy and Guidelines for the Implementation of the PMTCT Programme 2<sup>nd</sup> ed. 2008 58.

historically disadvantaged areas such as informal settlements and rural areas. The amelioration of the roll out of infant formula is needed and the avoidance of shortage of ARV medicines as experienced in the Free State province should be avoided.

Therefore, the research question is: “What are the obligations of the South African government in terms of national and international law to prevent the HIV transmission from Mother-To-Child?”

### **3. Methodology**

The study entails an analytical review of the obligations of the State to respond to MTCT of HIV under the Constitution of 1996, various South African statutes and relevant international treaties and guidelines. This research involves a literature survey of related books, journal articles, legislation and case law. Various websites were visited to extract relevant information on HIV/AIDS and policy. The study finally entails a critical analysis on the management of the Prevention from Mother-To-Child Transmission of HIV by the South African government.

## CHAPTER 2

# THE RELEVANT OBLIGATIONS OF THE SOUTH AFRICAN GOVERNMENT IN TERMS OF INTERNATIONAL LAW

### 1. Introduction

Before the eighteenth century the concern for people's health fell outside of the scope of the State's responsibilities.<sup>34</sup> Epidemics were generally considered as a sign of poverty and immorality. It was therefore regarded as the responsibility of private actors such as families, churches and charities to care for the sick. The simple public effort aimed at containing the spread of the epidemic diseases was quarantine of the ill.<sup>35</sup> The first notion of a right to health under international law is found in article 25 of the 1948 Universal Declaration of Human Rights which was unanimously proclaimed by the UN General Assembly as a common standard for all humanity.<sup>36</sup> By the passage of time a range of international human rights instruments,<sup>37</sup> declarations<sup>38</sup> and resolutions affirm that good health is a precondition for the enjoyment of all other human rights and they define steps that States should take to realize the highest attainable standard of health.

<sup>34</sup> Fluss S "International public health law: An overview" in Detels R *et al* (eds) 1997 *Oxford Textbook of Public Health* vol I 371-376.

<sup>35</sup> Chirwa D "The right to health in international law: Its implications for state and non-state actors in ensuring access to essential medicine" 2003 *SAJHR* 543.

<sup>36</sup> Yamin A "The right to health under international law and its relevance to the United States" 2005 *American Journal of Public Health* available at <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1449334> [date of use 25 August 2009].

<sup>37</sup> The term human rights in this dissertation refers mainly to those rights stipulated in documents such as the Universal Declaration of Human Rights, International Covenant on Civil and Political Rights (ICCPR), International Covenant on Economic, Social and Cultural Rights and others listed in this dissertation. These documents are often referred to as the International Bill of Rights. Dugard J *International Law: A South African Perspective* 3<sup>rd</sup> ed (Juta & CO Ltd 2005) 314.

<sup>38</sup> Para 1 of the Declaration of Alma-Ata of September 1978 proclaims that the attainment of the highest possible level of health is a most important worldwide social goal. Available at [http://www.who.int/hpr/NPH/docs/declaration\\_almaata.pdf](http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf) [date of use 30 August 2009].



Today, the HIV/AIDS pandemic is acknowledged as a human rights issue.<sup>39</sup> Therefore, the protection and promotion of human rights are essential in preventing the spread of HIV/AIDS and in mitigating the social and economic impact of the epidemic. This was expressed in the WHO's first global response to HIV/AIDS, which incorporated a call for the protection of the human rights of persons living with HIV/AIDS.<sup>40</sup>

As the epidemic evolved, it became clear that the protection of human rights in the context of HIV reduces suffering, saves lives, protects the public health, and provides for an effective response to HIV/AIDS.<sup>41</sup>

## **2. Treaties relevant to HIV/AIDS**

HIV/AIDS-related human rights are enshrined in some important international and regional treaties such as the United Nations Convention on the Rights of the Child (CRC) of 20 November 1989, ratified by South Africa in 1995, the UN International Covenant on Civil and Political Rights (ICCPR) of 16 December 1966 ratified by South Africa in 1998, the United Nations Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) of 1979 ratified by South Africa in 1998, the African Charter on the Rights and Welfare of the Child (ACRWC) of July 1990 ratified by South Africa in 2000, and the UN International Covenant on Economic, Social and Cultural Rights (ICESCR) of 1966 signed by South Africa in 1994.

These listed treaties make provision for the following human rights relevant to people living with HIV/AIDS:

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<sup>39</sup> The African Commission on Human and Peoples' Rights Resolution on HIV/AIDS Pandemic- Threat Against Human Rights and Humanity (2001) ACHPR/Res. 53(XXIX) 01.

<sup>40</sup> WHO World Health Assembly Resolution WHA 40.26 "Global strategy for the prevention and control of AIDS" Geneva 5 May 1987.

<sup>41</sup> The OHCHR and UNAIDS "International Guidelines on HIV/AIDS and Human Rights" 2006 4 available at [http://data.unaids.org/Publications/IRC-pub07/jc1252-internguidelines\\_en.pdf](http://data.unaids.org/Publications/IRC-pub07/jc1252-internguidelines_en.pdf) [date of use 12 February 2009].

- *The right to the highest attainable standard of health*: All mothers with HIV and their infants have the right to enjoy the highest attainable standard of health, a right guaranteed by article 12 of the ICESCR, article 24 of the CRC, article 12 of CEDAW and by regional treaties such as article 14 of the ACRWC. This right imposes an obligation on States to take steps necessary for the prevention, treatment and control of epidemics and other diseases, which include the establishment of PMTCT programmes countrywide.

- *The right to health, non-discrimination and choice*: Guaranteed by article 12 of the CEDAW. Especially relevant for vulnerable or marginalized groups such as pregnant women, mothers with HIV and their infants, is the right to non-discriminatory access to health facilities. States must provide essential drugs, ensure equitable distribution of all health facilities, adopt and implement a national public health strategy and plan of action with clear benchmarks and deadlines and ensure reproductive, maternal and child care.<sup>42</sup>

- *The right to life*: All infants born from HIV positive mothers enjoy an inherent right to life, which is guaranteed in article 6 of the ICCPR. It should be noted that the right to life should not be interpreted narrowly, since it cannot properly be understood in a restrictive manner.<sup>43</sup> Therefore, the protection of this right requires that States adopt positive measures to reduce infant mortality due to MTCT.

- *The right to information*: Every HIV positive pregnant woman or mother, as well as children living with HIV/AIDS, have the right to “seek, receive and impart information of all kinds” especially information that may enable them

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<sup>42</sup> UN Economic and Social Council “The right to the highest attainable standard of health”: 11/08/2000. E/C.12/2000/4 (General Comments) paras 30- 31.

<sup>43</sup> Human Rights Committee, “General Comment 6” (16th session, 1982) Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI\GEN\1\Rev. 1 at 6 (1994) para 1.

to give their informed consent in any stage of the PMTCT programme (article 19 of the ICCPR and article 13 of CRC).<sup>44</sup>

The status and application of the above mentioned treaties in the South African domestic law is discussed in the next section.

### 3. The status of international law in South African law

Section 231 of the South African Constitution provides that treaties or international agreements bind and impose obligations on the Republic only after their approval by resolution in both the National Assembly and the National Council of Provinces. This is why the international instruments above listed, in order to be transformed into municipal law, need to be signed by the National Executive, ratified by the National Assembly and the National Council of Provinces, and incorporated into domestic law by national legislation. This confirms the Dualist<sup>45</sup> theory according to which international law and municipal law are completely different systems of law, with the result that international law may be applied by domestic Courts only if adopted by such Court or transformed into local law by legislation.<sup>46</sup>

In the case *Hoffman v South African Airways*<sup>47</sup> the Constitutional Court examined certain treaties ratified by South Africa in order to establish unfair discrimination in the policies and decisions of SAA. The Court stated that the need to eliminate unfair discrimination does not only arise from the South

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<sup>44</sup> Human Rights Watch "South African's obligations under international and national law" See Chapter VII of the report March 2004. Available at [www.hrw.org/en/node/12165/section/8](http://www.hrw.org/en/node/12165/section/8) [date of use 8 November 2008].

<sup>45</sup> In contrast to the Dualist School, the Monists maintain that international law is incorporated into municipal law without any act of adoption or transformation. Dugard *International Law* 47.

<sup>46</sup> Dugard *International Law* 47.

<sup>47</sup> *Hoffman v South African Airways* [2000] 12 BLLR 1365 (CC).

African Constitution, but it also arises from international obligations contained in a range of conventions ratified by South Africa.<sup>48</sup>

Apart from treaties, international custom<sup>49</sup> also plays an essential role in the international legal order. A particular State's consent to a customary rule is usually expressed by its conduct in respect to the said custom. However, it is often difficult to establish the existence of an international customary rule. International Courts have identified two standard requirements for the existence of customary law namely settled practice (*usus*) and *opinio juris*.<sup>50</sup>

The requirement of settled practice refers to the evidence of State practice. This evidence is to be found in a variety of materials such as diplomatic correspondence, policy statements, the decisions of national and international Courts and official reports by States on a particular subject. For example, in the context of HIV and AIDS the South African government annually publishes an official report<sup>51</sup> to indicate its progress in realising its commitments in terms of the Declaration of commitment on HIV/AIDS. According to the International Court of Justice, a practice must constitute constant and uniform usage before it will qualify as custom.<sup>52</sup> The requirement of *opinio juris*<sup>53</sup> means that States must have a sense of obligation that they are bound by a certain rule, the general practice must thus be accepted as law.<sup>54</sup> The existence of custom generally need not be world-wide, but can also be restrained to the region.<sup>55</sup>

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<sup>48</sup> Para 51.

<sup>49</sup> Customary international law has been deemed a source of international law under Article 38(1)(b) of the Statute of the International Court of Justice.

<sup>50</sup> Dugard *International Law* 29.

<sup>51</sup> Republic of South Africa: "Progress report on declaration of commitment on HIV and AIDS", January 2006–December 2007.

<sup>52</sup> *Asylum* case 1950 ICJ Reports 266 (Colombia v Peru) see Dugard *International Law* 30.

<sup>53</sup> Also see at <http://encyclopedia.thefreedictionary.com/opinio+juris> [date of use 25 August 2009].

<sup>54</sup> Dugard *International Law* 33.

<sup>55</sup> Bederman D *International Law Frameworks* (Foundation Press 2001) 15-16.

The preamble of the Vienna Convention on the Law of Treaties of 1969 affirms that the rules of customary international law will continue to govern questions not regulated by the provisions of treaties. Section 232 of the South African Constitution states that “customary international law is law in the Republic unless it is inconsistent with the Constitution”. A distinction should however be made between customary international law and soft law. The former is constituted by certain practices on the part of States which then eventually becomes a customary rule of law. The latter may be defined as “imprecise standards, generated by declarations adopted by diplomatic conferences or resolutions of international organizations that are intended to serve as guidelines to the government’s conduct but which lack the status of ‘law’”.<sup>56</sup> Soft law refers to “all sources of non-binding international law that can provide guidance on the interpretation of international treaties.”<sup>57</sup> Examples in this regard include the *International Guidelines on HIV/AIDS and Human Rights* (UNAIDS Guidelines) adopted by the Office of the High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS (UNAIDS) in 1998, the *Declaration of Commitment on HIV/AIDS* adopted in June 2001 at the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS, and the World Health Organization’s policies and guidelines on HIV/AIDS.

The State practice supporting such a standard (soft law) and the passage of time may lead to a conversion of soft law into a customary rule. However before this happens such a standard merely serves as a guideline for State conduct.<sup>58</sup>

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<sup>56</sup> Dugard *International Law* 37-38.

<sup>57</sup> Hassim A *et al* (eds) *Health and Democracy* 132, available at [http://www.alp.org.za/index.php?option=com\\_content&task=view&id=53&Itemid=132](http://www.alp.org.za/index.php?option=com_content&task=view&id=53&Itemid=132) [ date of use 24 January 2009].

<sup>58</sup> Dugard *International Law* 38.

Section 39 of the Constitution provides that Courts and legal bodies must consider international law, when interpreting the Bill of Rights. In *State v Makwanyane*,<sup>59</sup> the Constitutional Court stated that:<sup>60</sup>

Customary international law and the ratification and accession to international agreements is dealt with in section 231 of the Constitution which sets the requirements for such law to be binding within South Africa. In the context of section 35(1), public international law would include non-binding as well as binding law. They may both be used under the section as tools of interpretation.

With reference to this statement in the *Makwanyane* case, De Waal and Currie argues that the fact that South Africa is currently party to a few international human rights instruments does not prevent a Court from invoking international human rights law for the purpose of section 39(1).<sup>61</sup>

It should be noted that the democratic constitutional order in South Africa which requires Courts to interpret the Bill of Rights in accordance with international law expresses the significance of international human rights in South Africa legal order.<sup>62</sup> Therefore, as far as South Africa has signed, ratified and/or incorporated the listed international human rights instruments, the South African government has an obligation to (successfully) implement the PMTCT programme.

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<sup>59</sup> *State v Makwanyane* 1995 (3) SA 391 (CC).

<sup>60</sup> Para 35. The *Makwanyane* case refers to section 35(1) the 1993 Interim Constitution, which is the equivalent of section 39(1) of the 1996 Constitution.

<sup>61</sup> De Waal J and Currie I *The Bill of Rights Handbook* 5<sup>th</sup> ed (Juta & CO Ltd 2005) 160.

<sup>62</sup> Nienaber AG *Ethics and human rights in HIV-related clinical trials in Africa with specific reference to informed consent in preventative HIV vaccine efficacy trials in South Africa* (LLD-thesis Pretoria: University of Pretoria 2007) 297.

#### 4. The impact of the international guidelines on the implementation of the PMTCT in South Africa

The International Guidelines on HIV/AIDS resulted from a request made in the early 1990s by the Commission on Human Rights which underlined the need and the imperative to provide guidance to States on how to take concrete steps to protect human rights in the context of HIV.

The result was the International Guidelines on HIV/AIDS and Human Rights published in 1998 by OHCHR and UNAIDS. Guideline 6, for example, provides that: “States should enact legislation to provide for the regulation of HIV-related goods, services and information, so as to ensure widespread availability of qualitative prevention measures, adequate HIV prevention and care information and safe and effective medication at an affordable price.”

In 2002 the Guideline 6 was revised to emphasize that the access to HIV/AIDS-related treatment and access to medication is fundamental in realising the right to health, provided for in the international documents, and that international co-operation is vital in realising equitable access to treatment, care and support for all in need. Since then significant developments have taken place with regard to the right to health and access to HIV-related prevention, treatment, care and support, including antiretroviral therapies.<sup>63</sup>

There have been increased commitments at the international, regional and domestic levels towards the full realization of all human rights related to HIV, including improved access to health care services for people living with HIV. Key among these are: the *Declaration of Commitment on HIV/AIDS*<sup>64</sup> which has set the goal of reducing the proportion of infants infected with HIV by

<sup>63</sup> The OHCHR and UNAIDS “International Guidelines on HIV/AIDS and Human Rights” 4.

<sup>64</sup> UN General Assembly Special Session on HIV/AIDS resolution S-26/2 of 27 Jun. 2001 Declaration of Commitment on HIV/AIDS “Global Crisis—Global Action” available at <http://www.un.org/ga/aids/docs/aress262.pdf> [date of use 12 February 2009].

20% by the year 2005 and by 50% by the year 2010, by ensuring that 80% of pregnant women have access to antenatal care and that the effective treatment to reduce MTCT is available to HIV-infected women and babies.

The *Millennium Development Goals (MDGs)*:<sup>65</sup> the PMTCT directly affects the achievement of three MDGs (to be met by 2015): the reduction of the mortality rate among children under five by two thirds (4<sup>th</sup> MDG), the reduction of the maternal mortality ratio by three quarters (5<sup>th</sup> MDG) and the reverse of the spread of HIV/AIDS (6<sup>th</sup> MDG).

The *Abuja Declaration*<sup>66</sup> has resulted in a “Call to Action” for the elimination of HIV infection in infants and children.

The *General Comment 14 of the Committee on Economic, Social and Cultural Rights*<sup>67</sup> and the *Commission on Human Rights Resolutions* on the right to the highest attainable standard of health<sup>68</sup> and access to medication.

However, the implementation of international instruments within States parties are not always the same. To ensure the respect of international agreements the international community is bound by the principle of *pacta sunt servanda*<sup>69</sup> as determined by the Vienna Convention.<sup>70</sup> This principle according to which States are bound by their agreements, constitutes the

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<sup>65</sup> United Nations Millennium Declaration, General Assembly resolution 55/2 of 8 September 2000.

<sup>66</sup> OAU special summit “Abuja Declaration on HIV/AIDS Tuberculosis and other related infectious diseases” 2001 Nigeria.

<sup>67</sup> General comment 14 on the right to the highest attainable standard of health, adopted on 11 May 2000 (E/C.12/2000/4).

<sup>68</sup> UN High Commissioner for Human Rights “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health” Commission on Human Rights resolution 2002/31 of 22 April 2002.

<sup>69</sup> Latin for “agreements must be kept”. An expression signifying that the agreements and stipulations of the parties to a contract must be observed. See the legal dictionary available at <http://legal-dictionary.thefreedictionary.com/Pacta+Sunt+Servanda> [date of use 4 July 2009].

<sup>70</sup> The Vienna Convention on the Law of Treaties of 1969 entered into force on 27 January 1980. Article 26 states that “Every treaty in force is binding upon the parties to it and must be performed by them in good faith.”



foundation of international law.<sup>71</sup> However, especially with regard to soft law, States have a significant margin of appreciation in this regard.

*The principle of pacta sunt servanda* entitles States to require that obligations be respected and to rely upon the obligations being respected. This good faith basis of treaties implies that a party to the treaty cannot invoke provisions of its municipal law as a justification for a failure to perform.<sup>72</sup> In order to prevent the breach of international agreements several recent treaties<sup>73</sup> contain obligations to cooperate in order to facilitate compliance with the treaty obligations.

In order to give effect to the obligations in the above listed international documents, South Africa has adopted a number of laws and policies that aim to improve access to health care to all people. In 1997, for example, the Health Department outlined its plan to restructure the health system to enhance its capacity to deliver affordable health care, by inter alia improving the affordability of drugs.<sup>74</sup> In 2001 the Medical Schemes Act was amended in order to provide for certain services at public health facilities to which public hospital patients are entitled.<sup>75</sup> In the 2001 the South African Constitutional Court in the case of *Minister of Health v Treatment Action Campaign*<sup>76</sup> referred to the WHO guidelines on the use of Nevirapine to assess whether the government policy on the prevention of Mother-To-Child Transmission of HIV was reasonable.

In 2008 the present South African policies and guidelines on the

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<sup>71</sup> Dugard *International Law* 406.

<sup>72</sup> Article 27 of the Vienna Convention on the Law of Treaties.

<sup>73</sup> For instance the Ottawa Treaty (Mine Ban Treaty) of December 1997 Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-Personnel Mines and on their distribution. Article 8(1) enforces the States Parties to cooperate with each other and to work together in a spirit of cooperation regarding the implementation of the provisions of this Convention.

<sup>74</sup> Department of Health White Paper for the Transformation of the Health System in South Africa. Government Gazette No. 17910, April 16 1997.

<sup>75</sup> Medical Schemes Amendment Act 55 of 2001.

<sup>76</sup> *Minister of Health v Treatment Action Campaign* 2002 (5) SA 703 (CC).

implementation of the PMTCT programme were updated in accordance with the WHO guidelines to give effect to the relevant international agreements.

## 5. Conclusion

International law has played an integral part in the development of human rights and the right to health in particular. Given that the South African Constitution compels Courts to consider international law in interpreting the Bill of Rights, it will remain an important guideline in of the interpretation of rights domestically,<sup>77</sup> in particular the State's obligations regarding the PMTCT.

This discussion confirms that international human rights law has both a direct and indirect impact on health law and on the implementation and development of the health policy in South Africa. As a result, the South African government is obliged, in terms of international law, to give effect to the above discussed international agreements by effectively implementing the PMTCT programme. This does not only include its current availability, but also ensure its success by continuing its availability, since any shortage can undermine the effectiveness of ARVs and cause regimen failure. For this reason the shortages of infant formula in some provinces in September 2007<sup>78</sup> and the shortages of ARVs in 2008 and early 2009 in the Free State Province, may be considered as a breach of South Africa's international obligations.

The next chapter will discuss the obligation of the government to implement the PMTCT programme in terms of national law.

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<sup>77</sup> Hassim *Health and Democracy* 138-139.

<sup>78</sup> "Infant formula shortage affecting PMTCT programme" available at <http://alp.immedia.co.za/research/TTT/> [date of use September 2008].

## CHAPTER 3

### THE RELEVANT OBLIGATIONS OF THE SOUTH AFRICAN GOVERNMENT IN TERMS OF NATIONAL LAW

#### 1. Introduction

The focal point of this chapter is limited to two key issues that together set out the structure within which health law and policy is developed and implemented:<sup>79</sup> The first key issue is the constitutional right of access to health care services and its implications for the development of a health policy in the context of the Prevention of Mother-To-Child Transmission of HIV. The second key issue is an analysis of the government's implementation of the obligations placed upon it by the Constitution and relevant domestic legislation.

Given that the right of access to health care is provided for in section 27 in chapter 2 (Bill of Rights) of the Constitution, it is important to take notice of the general provision which describes the duties imposed on the State by the rights contained in the Bill of Rights before considering the specific provisions of the socio-economic rights themselves.

Section 7(2) provides that "the state must respect, protect, promote and fulfil the rights in the Bill of Rights". The exact meaning of these terms is not defined in the Constitution, but their meaning has been explored in international documents<sup>80</sup> such as General Comment 14,<sup>81</sup> which defines the above mentioned terms in its section 33 as follows:

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<sup>79</sup> Hassim *Health and Democracy* 32.

<sup>80</sup> Heyns C and Brand D "Introduction to socio-economic rights in the South African Constitution" available at [http://www.chr.up.ac.za/centre\\_projects/socio/compilation1part1.html](http://www.chr.up.ac.za/centre_projects/socio/compilation1part1.html) [date of use 4 September 2009].

- The obligation to respect means that the South African government has a negative duty not to interfere with the existing enjoyment of this right. In other words, this obligation includes the State's duty to refrain from denying or limiting equal access for all people to health care services.<sup>82</sup> An example of a violation of this duty, in the context of the right of access to health care would be where the State, without proper justification, limit access to PMTCT in some regions of South Africa.
- The obligation to protect includes the duties of the State to adopt legislation or to take other measures ensuring the protection of the bearers of rights from unwarranted interference by private or non-State parties.<sup>83</sup>
- The obligation to promote imposes a positive duty on the State "to give sufficient information about the right to health in the national political and legal systems, preferably by way of legislative implementation".<sup>84</sup> The government must ensure that people are aware of their rights. This duty is reaffirmed in section 32 of the Constitution which entrenches the right of access to information.
- The obligation to fulfil refers to the positive obligation on the State to ensure the full realisation of the rights in question.<sup>85</sup> Applied to socio-economic rights, the duty to fulfil will depend on the availability of the State's resources.

Socio-economic rights are not traditionally included in a bill of rights. In contrast to the traditional civil-political rights, which act as a "shield" to

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<sup>81</sup> General Comment No. 14 of 2000. The right to the highest attainable standard of health: 11/08/2000. E/C.12/2000/4. (General Comments).

<sup>82</sup> General Comment No. 14 of 2000 section 34.

<sup>83</sup> Section 35.

<sup>84</sup> Section 36.

<sup>85</sup> Section 36.

protect the individual from intrusion by the State, socio-economic rights are often described as a “sword” calling on the State to act positively.<sup>86</sup>

Socio-economic rights are to amount to more than paper promises. They must serve as useful tools in enabling people to gain access to the basic social services and resources needed to live a life consistent with human dignity.<sup>87</sup> These rights include the right of access to health care services provided for in section 27 of the Constitution.

## **2. The government’s obligations under the Constitution of 1996**

The Bill of Rights which is described as a cornerstone of South Africa’s democracy<sup>88</sup> by the Constitution, regulates the content of health laws and policies. The Bill of Rights provides a varied list of fundamental rights that are relevant to the improvement and implementation of health policies, and the Bill sets out the State’s positive and negative obligations in relation to these rights.<sup>89</sup>

These rights include the right to life,<sup>90</sup> the right of access to health care,<sup>91</sup> the right not to be unfairly discriminated against directly or indirectly on the basis of gender or pregnancy,<sup>92</sup> the rights of children,<sup>93</sup> which include the right to basic health care and social services. The “child's best interests” is also recognized as a key principle when treating any matter concerning children.<sup>94</sup>

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<sup>86</sup> Klug H “Access to health care: Judging implementation in the context of AIDS: *Treatment Action Campaign v Minister of Health*” TPD 21182/2001 (unreported) 2002 SAJHR 114.

<sup>87</sup> Pieterse M “Resuscitating socio-economic rights: Constitutional entitlements to health care services” 2006 SAJHR 476.

<sup>88</sup> Section 7(1).

<sup>89</sup> Hassim *Health and Democracy* 33.

<sup>90</sup> Section 11 of the Constitution.

<sup>91</sup> Section 27.

<sup>92</sup> Section 9.

<sup>93</sup> Section 28.

<sup>94</sup> Section 28(2).

This section will focus on section 27(2) of the Constitution which provides that the State has an obligation to take “reasonable legislative and other measures, within its available resources, to achieve the progressive realisation” of the right of access to health care, and in the present case access to the PMTCT programme for pregnant women with HIV.

In the *Grootboom* case,<sup>95</sup> the Constitutional Court’s ground-breaking decision on the socio-economic rights in the 1996 Constitution,<sup>96</sup> a demarcation of the State’s positive obligations had been made in view of the formulation of section 27 namely the obligation to “take reasonable and other measures”; to “achieve the progressive realization” of the right; and “within its available resources”.<sup>97</sup> These are discussed in the sections that follow.

### **2. 1. The State’s obligation to “take reasonable and other measures” to implement the PMTCT programme**

This obligation entails that the State must take reasonable measures to ensure that the right of access to health care is respected, protected, promoted and fulfilled, and that over time, access to quality and comprehensive health care is achieved nationwide. This may be realized by the passing of laws by Parliament, the making of appropriate policies, etc.<sup>98</sup>

To comply with this obligation, the government in 2001 launched the HIV and AIDS/STI strategic plan for South Africa 2000-2005<sup>99</sup> and the PMTCT programme. Unfortunately, the PMTCT programme was only implemented at a limited number of pilot sites, which numbered two per province instead of being implemented nationwide. The main reason for the limited

<sup>95</sup> *Government of the Republic of South Africa v Grootboom* 2001(1) SA 46 (CC).

<sup>96</sup> De Waal and Currie *The Bill of Rights handbook* 576.

<sup>97</sup> *Grootboom* para 38.

<sup>98</sup> Hassim *Health and Democracy* 34.

<sup>99</sup> The HIV and AIDS/STI Strategic Plan for South Africa 2000-2005 available at <http://www.doh.gov.za/aids/index.html> [date of use September 2008].

implementation of the programme by the government was the uncertainty about the possible toxicity of the antiretroviral named Nevirapine (NVP). This meant that the government's decision only allowed pregnant women with HIV who could attend the pilot sites and those who were able to afford the private facilities, to enjoy the benefits of the programme.

The government's conduct was challenged by the Treatment Action Campaign (TAC) in the Pretoria High Court in August 2001,<sup>100</sup> and the case was subsequently brought before the Constitutional Court.<sup>101</sup> The Constitutional Court found that the evaluation of the government policy to limit Nevirapine to research and training sites constituted a breach of the State's obligations under section 27(2) read with section 27(1)(a) of the Constitution.<sup>102</sup> The Court also affirmed that measures taken by the government were not reasonable, because it was not clear on paper when the programme will be made available outside of these sites, and what could happen to those mothers and their babies who cannot afford access to private health care and do not have access to the research training sites.<sup>103</sup>

In *Grootboom* the Constitutional Court referred to the social and historical context of problems, and the textual context of relevant rights within the Bill of Rights as a whole to determine the reasonableness of the government decision.<sup>104</sup> In other words, if the legislative and policy measures overlook or are in conflict with other constitutional obligations to respect human dignity and the right to equality, they will be considered as unreasonable.<sup>105</sup>

It seems that the government only partially met its obligation when it introduced the HIV&AIDS and STI strategic plan for South Africa 2000-2005

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<sup>100</sup> *Treatment Action Campaign v Minister of Health* 2002 (4) BCLR 356 (T).

<sup>101</sup> *Minister of Health v Treatment Action Campaign* 2002 (5) SA 703 (CC).

<sup>102</sup> Para 80.

<sup>103</sup> Para 81.

<sup>104</sup> *Grootboom* paras 43-44.

<sup>105</sup> De Waal and Currie *The bill of Rights handbook* 579.

and the PMTCT programme, in the sense that the formulation of the programme was only the first requirement for meeting the State's obligations contained in section 27(2). However, it failed to meet the additional requirement for reasonableness in both the conception and implementation of its policy.<sup>106</sup>

Given the fatal nature of HIV infection for the majority of people in South Africa, and the type of measures adopted by the government in respect of the PMTCT programme, it could not be said that government had adopted a reasonable measure within its available resources for the realization of a right of access to health care.<sup>107</sup> As the Court stated in *Grootboom* "mere legislation is not enough. The State is obliged to act to achieve the intended result, and the legislative measures will invariably have to be supported by appropriate, well-directed policies and programmes implemented by the executive."<sup>108</sup>

To give effect to the order of the Constitutional Court in the *TAC* case the Minister of Health introduced the HIV&AIDS and STI strategic plan for South Africa 2007-2011, through which the PMTCT programme has been expanded nationwide. As a result, the programme is currently available at 100% of hospitals and more than 90% of primary health care centres countrywide in the public health sector, and close to 2,2 million pregnant women have utilized the service for the past four years.<sup>109</sup>

Although the coverage of the programme was extended, the government had to update the guidelines on PMTCT to meet the requirement of reasonableness in the implementation and results of its policy, and to also

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<sup>106</sup> *Grootboom* para 42.

<sup>107</sup> Ngwenya C "Access to health care and the courts: A note on *Minister of Health v Treatment Action Campaign*" 2002 *SAPR/PL* 466-467.

<sup>108</sup> *Grootboom* para 42.

<sup>109</sup> National Department of Health: Policy and guidelines for the implementation of the PMTCT programme 2<sup>nd</sup> ed 2008 58.



meet the WHO PMTCT protocol.<sup>110</sup> As a result the government reviewed the guidelines of the programme. In January 2008, the updated National Protocol for the PMTCT of HIV introduced the dual-antiretroviral prophylaxis, consisting of Nevirapine plus AZT rather than the single dose Nevirapine recommended in the Department's 2003 PMTCT protocol.<sup>111</sup> This revised protocol is estimated to reduce peri-partum mother to child transmission to between 5 and 6%. However, these new guidelines were soon criticised for not meeting the exact WHO recommendations that are considered effective. For example, the government omitted the use of AZT/3TC, known as the 'cover-the-tail' strategy and it requires pregnant women with HIV to start ART at a CD4 count of  $\leq 200$  cells/mm<sup>3</sup>,<sup>112</sup> when the WHO recommends  $< 350$  cells/mm<sup>3</sup>.<sup>113</sup> It may be argued that these measures taken by the State are still not completely reasonable.

Fortunately, on the occasion of the World AIDS Day 2009, President Jacob Zuma announced the government's intention to meet the WHO recommendations in improving both the prevention and the treatment of HIV/AIDS in South Africa. These measures by the government include making treatment available to HIV positive pregnant women with a minimum CD4 count of 350/mm<sup>3</sup>. In addition, all infected children under one year of age will start the treatment irrespective of their CD4 count. The implementation of all these announcements will be effective from April 2010.<sup>114</sup>

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<sup>110</sup> The WHO PMTCT protocol published in 2006 is contained in the document entitled "Antiretroviral drugs for treating pregnant women and preventing HIV infection in infants: Towards universal access recommendations for a public health approach" available at [http://www.who.int/hiv/pub/mtct/arv\\_guidelines\\_mtct.pdf](http://www.who.int/hiv/pub/mtct/arv_guidelines_mtct.pdf) [date of use September 2009].

<sup>111</sup> National Department of Health 13.

<sup>112</sup> National Department of Health 40-43.

<sup>113</sup> Leake M "HIV/AIDS in South Africa" available at <http://www.avert.org/aidssouthafrica.htm> [date of use 14 October 2009].

<sup>114</sup> Address by President Jacob Zuma on the occasion of World AIDS Day, Pretoria Showgrounds December 2009 available at <http://www.info.gov.za/speeches/2009/09120112151001.htm> [date of use 17 January 2010].

It however, at this stage at least, remains an open question whether and to what extent these envisaged measures will be realised by the State.

In 1990 the mortality rate for children under five years of age was estimated at 60 per 1 000 live births and in 2007 it was estimated at 59. The Millennium Development Goals target for South Africa by 2015 is a mortality rate of 20. The continued high in child mortality rate in South Africa is largely due to the HIV pandemic, specifically the transmission of HIV from Mother-To-Child (MTCT).<sup>115</sup> In spite of the National Strategic Plan for HIV, AIDS and STIs, 2007-2011 which recognises PMTCT as a mainstay of the response against HIV and AIDS in children, the government's measures are not equal to the seriousness of the situation. It is submitted that this constitutes an infringement of section 27, since the State's measures are not reasonable.

## ***2. 2. The State's obligation to "achieve the progressive realisation" of health care services in the context of the PMTCT***

The National Health Act<sup>116</sup> which gives effect to section 27 of the Constitution determines that one of the objectives of this Act is to fulfill the right of South Africans to the progressive realization of the constitutional right of access to health care services, including reproductive health care. Therefore, the responsibility of the Minister is to protect, promote, improve and maintain the health of the population, within the limits of the State's available resources.<sup>117</sup>

This obligation requires the State to move as expeditiously and effectively as possible towards the goal of the full realisation of the right in question. Accessibility should be progressively facilitated, with legal, administrative, operational and financial hurdles examined and where possible lowered over

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<sup>115</sup> District Health Barometer report 2007/08 section 4.4 published in 2009 available at [http://www.healthlink.org.za/uploads/files/dhb0708\\_sec4.pdf](http://www.healthlink.org.za/uploads/files/dhb0708_sec4.pdf) [date of use 15 October 2009].

<sup>116</sup> 61 of 2003.

<sup>117</sup> Section 2(c)(i)(iv) 3(l) (a) of the National Health Act 61 of 2003.

time.<sup>118</sup> The fact that the complete realisation of the right of access to health care is achieved progressively does not change the State's obligations in this regard. Therefore the State must take the required steps as soon as possible.<sup>119</sup>

The Constitution Court in *Grootboom* cited paragraph 9 of General Comment 3 to affirm its view on the issue of progressive realization. This paragraph reads as follows:

The fact that realization over time, or in other words progressively, is foreseen under the covenant should not be misinterpreted as depriving the obligation of all meaningful content. It is on the one hand a necessary flexibility device, reflecting the realities of the real world and the difficulties involved for any country in ensuring full realization of economic, social rights. On the other hand, the phrase must be read in light of the overall objective, indeed the *raison d'être*, of the covenant which is to establish obligations for States parties in respect of the full realization of the rights in question.<sup>120</sup>

By not providing timeframes for the implementation of its measures, the government failed to indicate that it will progressively realize these measures or the PMTCT programme. In addition, in the context of the PMTCT crises there was no evidence to suggest that the government was taking steps so that it would be in a position to expand the programme if this became necessary. As a result, more than 330 000 lives were lost to HIV/AIDS in

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<sup>118</sup> UN Committee on Economic, Social and Cultural Rights, *General Comment 3: The Nature of State Party Obligations*, U.N. Doc. HRI/GEN/1/Rev.1 at 45 (1994), para. 9.

<sup>119</sup> De Waal and Currie *The Bill of Rights handbook* 582.

<sup>120</sup> *Grootboom* para 45.

South Africa from 2000 and 2005, because a feasible and timely antiretroviral (ARV) treatment programme was not implemented.<sup>121</sup>

To meet the terms of this obligation, the government should articulate a comprehensive national programme to provide an efficient programme on PMTCT and clear timeframes should be set in order to ensure eventual access to everyone. In addition, to ensure effective implementation, the PMTCT programme should include instructions on the delivery of babies and the administration of ARVs and infant formula by all key service providers such as health care professionals and the relevant support staff (nurses, counselors).<sup>122</sup> The programme should also include an information campaign to advise pregnant women and mothers with HIV of their right to these services and how to gain access to them, as well as information on the use of a breastfeeding substitute.

But this has proven to be difficult especially at the beginning of the PMTCT programme, since the programme was affected by the lack of infrastructure in regions which were historically disadvantaged. There was a need to reorganise the primary health care system because it was not possible to run any programme without a primary health care or basic health care system in place.

In view of this, it may seem that it was logical for the government to implement the programme first within the pilot sites, in order to fulfill its duty to progressively realize the right of access to the PMTCT programme. Unfortunately, even the programme in the pilot sites did not have reasonable time frames for its implementation.

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<sup>121</sup> Research from the Harvard School of Public Health (HSPH) in a study published online by *the Journal of Acquired Immune Deficiency Syndromes (JAIDS)* (<http://www.jaids.com/>) cited by Meldung N "Researchers estimate lives lost due to delay in antiretroviral drug use for HIV/AIDS in South Africa" available at [http://www.innovationsreport.de/html/berichte/studien/researchers\\_estimate\\_lives\\_lost\\_due\\_delay\\_120788.html](http://www.innovationsreport.de/html/berichte/studien/researchers_estimate_lives_lost_due_delay_120788.html) [date of use 10 November 2008].

<sup>122</sup> WHO/Department of HIV/AIDS: Prevention of Mother-To-Child Transmission.

In sum, progressive realisation requires, at least, that a number of goals be set for government policy, that a minimum level of service be specified and that the government establishes detailed plans and programmes for increasing the quality of health care over time with measurable indicators, targets and deadlines. The minimum steps to be taken by the State could be evaluated by the Courts. Moreover, failure by the government to meet those targets may mean that it is in breach of its constitutional duty to progressively realise the right to health care services for all,<sup>123</sup> and therefore the State could be challenged before the Courts.

At present, even though the situation has been improved, there are still the consequences of the lack of reasonable planning and time frames in the roll out of ARVs and infant formula. The lack of reasonable planning resulted in several shortages in September 2007<sup>124</sup> and the moratorium on providing patients with ARVs during November to March 2009 in the Free State Province.<sup>125</sup>

### **2.3. The State's obligation to realise the PMTCT programme "within its available resources"**

The right of access to health care is not unlimited. The qualification in section 27(2) of the Constitution "within the available of resources" is an internal limitation of this right. The right can thus only be realised to the extent that the State has the available resources. Where there is lack of available

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<sup>123</sup> Bilchitz D "The Right to health care services and the minimum core: Disentangling the principled and pragmatic strands" 2006 *ESR Review* 5.

<sup>124</sup> The AIDS Law Project (ALP) had received several complaints from various health districts around the country that HIV positive mothers in government Prevention of Mother-to-Child Transmission (PMTCT) programmes have not been receiving infant formula for their babies due to stock-outs. Doctors working in Gauteng reported the shortage of infant formula feed in Soweto in 2008. It has also been alleged that some districts in Mpumalanga were without formula for several months at the beginning of 2008. "Infant formula shortage affecting PMTCT programme" available at <http://alp.immedia.co.za/research/TTT/> [date of use September 2008].

<sup>125</sup> Budget and Expenditure Monitoring Forum: ARV programmes under threat due to budgeting failures, press conference attended at the ALP Head Quarter Tuesday 22 September 2009.

resources, the failure of a State to realise this right is therefore not a violation of the right.<sup>126</sup>

In this regard the ICESCR Committee determined that if the failure to meet at least the minimum core obligations are justified on the grounds of 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.”<sup>127</sup>

In *Soobramoney*,<sup>128</sup> the applicant, a 41-year-old man, was in a critical condition with chronic renal failure and would die if he did not receive treatment in the form of renal dialysis. He approached a renal unit of a state hospital. Although such treatment was available, his request was declined essentially on the ground that he did not meet the medical criteria for dialysis. He challenged this decision before the High Court but his application was not successful.<sup>129</sup> He appealed to the Constitutional Court where the application similarly failed. The Constitutional Court found that the hospital’s conduct was not an infringement of the applicant’s rights considering the fact that the state hospital and the provincial Department of Health could not organize a larger renal unit, because they had to work within the confines of a budget.<sup>130</sup>

In 1998 the then health minister Dlamini Zuma announced that given the fact that the government paid much more to provide free maternity care to poor mothers and free health care to all children under six years old, South Africa would not be making Zidovudine (AZT) available for PMTC.<sup>131</sup> The minister

<sup>126</sup> De Waal and Currie *The Bill of Rights handbook* 583.

<sup>127</sup> 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.

<sup>128</sup> *Soobramoney v the Minister of Health (KwaZulu-Natal)* 1998 (1) SA 765 (CC).

<sup>129</sup> *Soobramoney* paras 1-6.

<sup>130</sup> *Soobramoney* paras 19-36.

<sup>131</sup> Nattrass N *The moral economy of AIDS in South Africa* (Cambridge University Press 2004) 47.

refused to budget for the programme, even when the manufacturer of AZT heavily discounted the drug's price and offered Nevirapine (NVP) free of charge to South Africa for five years.

In justifying the decision not to introduce AZT in the context PMTCT, national government officials argued that the cost of testing pregnant women for the virus, of providing the necessary counselling, and of supplying infant formula were too high.<sup>132</sup> Although the affordability of ARVs has been a relevant issue, the government's stance (since 2000) on the availability of drugs for the treatment of pregnant women with HIV, were based on doubts about the safety and efficacy of antiretroviral drugs, and even on doubts of some officials about the scientific basis of AIDS causation and treatment.<sup>133</sup>

It should be noted that the right of access to health care in section 27 does not guarantee an obligation to provide free health care for all. It means that in a positive sense, it accords everyone a positive right to pursue health care and imposes upon the State a corresponding duty to create conditions for the realisation of such a right. The quantity and quality of health care will ultimately depend on available resources and political commitment.<sup>134</sup>

However, the WHO Action Programme on Essential Drugs<sup>135</sup> has defined and listed ARVs as essential medicine.<sup>136</sup> Therefore, it is the State's

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<sup>132</sup> Natrass *The moral economy of AIDS in South Africa* 47.

<sup>133</sup> Zwi K "Cheaper antiretrovirals to treat AIDS in South Africa: They are at their most cost effective in preventing mother to child transmission" 2000 *British Medical Journal* available at <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1127350> [date of use 23 September 2008].

<sup>134</sup> Ngwena "Access to health care as a fundamental right" 9.

<sup>135</sup> UN Committee on Economic, Social and Cultural Rights, *General Comment 14: The Right to the Highest Attainable Standard of Health*, UN Doc.E/C.12/2000/4 (2000), at paras. 43(d) and 44.

<sup>136</sup> WHO defines *essential drugs* as those drugs that are deemed to satisfy the health care needs of the majority of population and that should be available in the appropriate dosage forms and strengths at all the times. Takrouri A "PMRS Essential Drug List" 2005 available at

obligation to ensure their accessibility to the general population by making them affordable. One of the tools to achieve this goal is the Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement<sup>137</sup> and the Doha<sup>138</sup> Declaration which permit governments, to under certain circumstances, issue compulsory licenses<sup>139</sup> to authorise a third party to manufacture or to import at a low cost the generic version<sup>140</sup> of a patented product for the domestic market.<sup>141</sup>

This could be a means for South Africa to fulfill its obligation to provide ARVs to pregnant women with HIV and their babies but, unfortunately, the government did not issue compulsory licenses for ARV drugs in the gestation of the PMTCT programme. It may be argued that under these circumstances the government behaved unconstitutionally<sup>142</sup> in refusing to take a reasonable measure.

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<http://www.pmr.ps/last/pdfs/PMRSEssentialDrugList.pdf> [date of use 12 October 2009].

<sup>137</sup> World Trade Organization (WTO): The Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement) came into force on January 1995.

<sup>138</sup> World Trade Organization (WTO)-Ministerial conference: Declaration on the TRIPS Agreement and Public Health WT/MIN(01)/DEC/2, 20 November 2001.

<sup>139</sup> Compulsory licensing is one of the flexibilities on patent protection provided by the TRIPS Agreement in its article 31. According to this flexibility, a government can allow a third party other than the patent holder, to copy patented products and processes without fear of prosecution. Normally, to copy drugs for this reason, the generic company has to negotiate with the original manufacturer to agree royalties (money paid to the patent holder to make up for the loss of profit exclusivity). However, following the 2001 Doha agreement a country can issue a compulsory licence for a drug that treats a disease causing a severe health emergency in that country without royalties being paid. See Zaccagnini M "AIDS, drug prices and generic drugs" available at <http://www.avert.org/generic.htm> [date of use 29 November 2009].

<sup>140</sup> A generic drug is an identical copy (bioequivalent) of a brand name (or proprietary) drug. Generics are exactly the same as their branded counterparts in dosage form, safety, strength, route of administration, quality, performance characteristics and intended use. The notable difference between the two is the price. Generic drug is cheaper than the original version. Available at <http://www.avert.org/generic.htm> [date of use 29 November 2009].

<sup>141</sup> "Compulsory licensing of pharmaceuticals and TRIPS" September 2006 available at [http://www.wto.org/english/tratop\\_e/TRIPs\\_e/public\\_health\\_faq\\_e.htm](http://www.wto.org/english/tratop_e/TRIPs_e/public_health_faq_e.htm) [date of use 12 October 2009].

<sup>142</sup> Bollyky T "Balancing private rights and public obligations: Constitutionally mandated compulsory licensing of HIV/AIDS related treated treatments in SA" 2002 *SAJHR* 558.



In considering whether to issue compulsory licenses the government had to remove some legal obstacles by amending the Medicines and Related Substances Act 101 of 1965<sup>143</sup> and the Patents Act 57 of 1978.<sup>144</sup> These statutes are designed to provide for affordable health care services to the general population, including affordable ARVs by using generic medicines. There was thus a need to align these Acts with the TRIPS Agreement principles.

The available resources are still an issue in the realisation of the South African PMTCT programmes. The current Minister of Health, Aaron Motsoaledi, has confirmed that nationally, there is a billion rand shortfall in HIV programme budgets for the 2009 financial year. Representatives of the Free State Department of Health have stated that a new moratorium on ARV initiation is on the horizon unless additional funds are made available from the National Treasury.<sup>145</sup> It is in a situation like this that the government must demonstrate that every effort has been made to use all resources that are at its disposal.

### **3. Lessons from the *Treatment Action Campaign v Minister of Health* cases**

The government's policy on the PMTCT of HIV was challenged by a number of associations lead by the Treatment Action Campaign (TAC). The High Court and the Constitutional Court decisions, perhaps "the most politicized of

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<sup>143</sup> This Act provides for inter alia the registration of medicines (which may be expedited in certain circumstances) and for measures for the supply of more affordable medicines to protect public health, such as the generic substitution of medicines and parallel importation.

<sup>144</sup> The Patents Act provides for the use of patented inventions by the state and the issuing of compulsory licenses for patented medicines.

<sup>145</sup> Budget and expenditure monitoring forum, press conference at the ALP Head Quarter Tuesday 22 September 2009.

all the socio-economic rights cases that have reached the Constitutional Court,<sup>146</sup> are discussed below.

### **3.1. The Pretoria High Court decision**

As explained above the government launched the PMTCT programme that was only available at a limited number of research and training sites, which numbered two per province instead of being implemented nationwide. This government conduct was challenged by the Treatment Action Campaign (TAC) before the Pretoria High Court in August 2001.<sup>147</sup>

In his judgement Botha J determined that the issue in this case should be approached as a section 27(2) matter. He determined that the government had breached both the negative obligation not to interfere with the realisation of access to health care, and the positive obligation to provide a comprehensive and well-directed plan to progressively realise the right to health care.

Considering the State's duty not to interfere with access to health care, he concluded that while a comprehensive programme is optimal and testing facilities such as the pilot sites are necessary, widespread availability of Nevirapine is the rational first step. As to the cost concerns the Ministers raised for the provision of a basic programme of testing, counselling and Nevirapine, Judge Botha found that "there is in my view incontrovertible evidence that there is a residual of latent capacity in the public sector outside the 18 pilot sites to prescribe Nevirapine."<sup>148</sup> He also found that allowing doctors to prescribe Nevirapine without restraint would not cause too much strain to the health care budget. For these reasons the Court found that:

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<sup>146</sup> Hassim *Health and Democracy* 40.

<sup>147</sup> *Treatment Action Campaign v Minister of Health* 2002 (4) BCLR 356 (T).

<sup>148</sup> At 383.

The policy of the first to ninth respondents in prohibiting the use of nevirapine outside the pilot sites in the public health sector is not reasonable and that it is an unjustified barrier to the progressive realisation of the right to health care. It is a breach of their negative obligation to desist from impairing the right to health care.<sup>149</sup>

About the reasonableness of the State's measures Judge Botha also found that the government had a positive duty to create a comprehensive plan to reduce MTCT of HIV under section 27(2). In applying the *Grootboom* test of reasonableness he concluded that:

A programme that is open-ended and that leaves everything for the future cannot be said to be coherent, progressive and purposeful. The programme falls to be criticized for much the same considerations that were mentioned in the *Grootboom* case. The programme of the respondents lacks the impetus that is required for a programme that must move progressively. If there is no time scale, there must be some other built-in impetus to maintain the momentum of progression. Therefore, the state was in breach of its obligation to provide a comprehensive plan to prevent MTCT of HIV.<sup>150</sup>

Because of the latent capacity in the public health care sector and given the successful implementation of the PMTCT programme in the Western Cape and in Gauteng, the government failure to extent the programme could not be justified.<sup>151</sup> As a result, the TAC was successful in its challenge of the government's policy.

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<sup>149</sup> *Treatment Action Campaign v Minister of Health* 2002 (4) BCLR 384.

<sup>150</sup> At 385.

<sup>151</sup> Klug H "Access to health care: Judging implementation in the context of AIDS" 121.

Soon after the High Court decision, the State had noted its application for leave to appeal. This resulted in a suspension of the High Court order. Subsequently the TAC launched a further application for an order to execute that part of the original judgment allowing for Nevirapine to be used where the capacity existed for its safe and effective use. The State opposed the further application and spent the next few months trying to prevent any implementation before the Constitutional Court heard and decided the appeal.<sup>152</sup>

### **3.2. The Constitutional Court decision**

In its decision the Constitutional Court was faced with two key issues. The first issue was whether the State was entitled to limit the provision of Nevirapine for the purposes of PMTCT to the 18 identified sites, “even where it was medically indicated that adequate facilities existed for the testing and counselling of the pregnant women concerned”? The second issue concerned the question whether the State had “devised and implemented within its available resources a comprehensive and coordinated programme to realize progressively the rights of pregnant women and their newborn children to have access to PMTCT”.<sup>153</sup>

On the first issue, the Court decided that the government’s policy to limit Nevirapine to the research and training sites was “an inflexible one”.<sup>154</sup> Where testing and counselling facilities were available, this “potentially lifesaving drug could have been administered within the available resources of the State without any known harm to mother or child”. The use of Nevirapine for PMTCT should thus both be permitted and facilitated if it was

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<sup>152</sup> Hassim *Health and Democracy* 40.

<sup>153</sup> *Minister of Health v Treatment Action Campaign* 2002 (5) SA 703 (CC) para 135.

<sup>154</sup> Para 80.

medically indicated, effectively overturning the ban on the use of Nevirapine for PMTCT outside of the 18 pilot sites.<sup>155</sup>

On the second issue, the Court decided that the State's rigidity on the first issue "affected its policy as a whole". In short, it said that the State had no reasonable PMTCT plan. The Court ruled that, where testing and counselling services already existed, counsellors should also be trained on the use of Nevirapine for PMTCT. In addition, it ordered the State to take reasonable measures to ensure that testing and counselling services were made available progressively throughout the public health system.<sup>156</sup>

### **3.3. Lessons from the Constitutional Court decision**

The lessons from the *TAC* cases in advancing socio-economic rights are summarised by Hassim<sup>157</sup> as follows:

**a) *It confirms that the State must prioritise major public health needs:*** The Constitutional Court recognised that the HIV/AIDS pandemic is "the greatest threat to public health in our country".<sup>158</sup> Therefore, the challenges raised by this pandemic must be addressed by the government as a matter of priority, with a corresponding allocation of resources.<sup>159</sup>

**b) *Addressing emergency and other needs:*** Considering the "progressive realization" of the PMTCT, the Court order established four steps to be taken by the government for the full realisation of the programme. These steps are the following:

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<sup>155</sup> Para 80.

<sup>156</sup> Para 95.

<sup>157</sup> Hassim *Health and Democracy* 42.

<sup>158</sup> *Minister of Health v Treatment Action Campaign* 2002 (5) SA 703 (CC) para 93.

<sup>159</sup> Para 93.

*-Emergency needs:* Public health facilities with the necessary capacity to prescribe Nevirapine (where it was medically indicated) should be established with immediate effect.<sup>160</sup>

*-Short-term needs:* The State was ordered to permit and facilitate the use of Nevirapine for purposes of the PMTCT programme.<sup>161</sup>

*-Medium-term needs:* The government was ordered to train counsellors on the use of Nevirapine for PMTCT.<sup>162</sup>

*-Long-term needs:* The Court ordered the government to extend the PMTCT programme nationwide.<sup>163</sup>

**c)** *It clarifies the relationship between the State's duty in section 27 and the right relating to children in section 28:* The Court made it clear that even though the primary obligation to provide basic health care services to newborn children rests on their parents, this did not exempt the State of its duty to provide access to health care services to those parents who are "unable to support themselves and their dependents".<sup>164</sup>

#### **4. The issue of the separation of powers and the TAC cases**

Shortly after the High Court<sup>165</sup> ordered the government "to prescribe Nevirapine when it is medically indicated", the Minister of Health made a statement in the press that the High Court's order challenged the principle of separation of powers in dictating the HIV/AIDS policy to the government, which is not a competency of the Judiciary. Consequently, the government relied on the doctrine of separation of powers when it appealed to the Constitutional Court.<sup>166</sup>

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<sup>160</sup> Para 135(3)(a).

<sup>161</sup> Para 135(3)(b).

<sup>162</sup> Para 135(3)(c).

<sup>163</sup> Para 135(3)(d).

<sup>164</sup> Paras 74-79.

<sup>165</sup> *Minister of Health v Treatment Action Campaign* 2002 (4) BCLR 356 (T).

<sup>166</sup> Ngwenya "Access to health care and the courts" 465.

The doctrine of separation of powers, a cornerstone of the democratic State, has generally been accepted as recognising the independence of the organs of the State. It attempts to prevent the different organs of the State from taking power from one another and ensure that these organs hold each other to account.<sup>167</sup> In this regard, the function of the Judicial authority has traditionally been to interpret legislation and to resolve disputes, while the Executive should make policy and enforce it.<sup>168</sup>

However, this doctrine is not absolute. The Constitutional Court made it clear that although

there are no bright lines that separate the roles of the Legislature, the Executive and the courts from one another, there are certain matters that are pre-eminently within the domain of one or other of the arms of government and not the others. All arms of government should be sensitive to and respect this separation. This does not mean, however, that courts cannot or should not make orders that have an impact on policy.<sup>169</sup>

Instead, the Court determined that: “Where a breach of any right has taken place, including a socio-economic right, a court is under a duty to ensure that effective relief is granted.”<sup>170</sup> In this case the State failed to meet the requirement set in section 27(2) of the Constitution and the Court had to oblige it to respect and fulfil its Constitutional duty. The Court’s intrusion into the domain of the Executive has therefore been mandated by the Constitution itself.<sup>171</sup> In terms of section 165 (5) of the Constitution, “an order or decision issued by a court binds all persons to whom and organs of State

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<sup>167</sup> Hassim *Health and Democracy* 56-57.

<sup>168</sup> Van Wyk C “The enforcement of the right of access to health care in the context of HIV/AIDS and its impact on the separation of powers” 2003 *THRHR* 394.

<sup>169</sup> *Minister of Health v Treatment Action Campaign* 2002 (5) SA 703 (CC) para 98.

<sup>170</sup> Para 106.

<sup>171</sup> Van Wyk “The enforcement of the right of access to health care” 395.

to which it applies”, including the Executive. This meant that the government did not have any choice other than to implement the Court order.

## 5. Conclusion

For the first time in South African legal history, the idea of a fundamental right to health care for all has been given conspicuous constitutional expression in section 27 of the Constitution.<sup>172</sup>

On one level, section 27 of the Constitution is about conferring formal equality to all pregnant women with HIV and their babies to access health care services. This means that considering the sad experience of Apartheid, the intention of section 27(1)(a) is to provide a right of access to health care services, free from unfair discrimination or any other undue interference by the State.<sup>173</sup> The constitutional protection of access to health care covers four dimensions namely non-discrimination, physical accessibility, economic accessibility (affordability) and information accessibility.<sup>174</sup>

On another level, section 27 undoubtedly accords pregnant women with HIV and their babies a positive right to receive health care and imposes upon the State a corresponding duty to create conditions for the realisation of such a right, in terms of a comprehensive programme. In this way the Constitution seeks to achieve more than a mere right to pursue health care.<sup>175</sup> Section 27 imposes on the health care sector the values of social justice, equality under the law and respect for human rights. The intention to provide access to health care services, free from any undue interference, is even more

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<sup>172</sup> Ngwenya C: “Access to health care as a fundamental right: The scope and limits of section 27 of the Constitution” 2000 *SAPR/PL* 2.

<sup>173</sup> Human Rights Watch “South Africa’s obligations under international and national law” See Chapter VII of the report, March 2004. Available at [www.hrw.org/en/node/12165/section/8](http://www.hrw.org/en/node/12165/section/8) [date of use 8 November 2008].

<sup>174</sup> General Comment No. 14 of 2000 section 12(b).

<sup>175</sup> *Minister of Health v Treatment Action Campaign* 2002 (5) SA 703 (CC) para 100.



apparent in the inclusive reference to “reproductive health care” in section 27(1)(a).<sup>176</sup>

The government must always keep in mind the provision of section 237 of the Constitution which states that “all constitutional obligations must be performed diligently and without delay.” When the health policy is challenged as inconsistent with the Constitution, the Courts have to consider whether, in formulating and implementing such policy, the State has given effect to its constitutional obligations, and the Judiciary should ensure that the Executive does not abuse its power or act unreasonably or irrationally.

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<sup>176</sup> Ngwena C and Cook R “Rights concerning health” in Brand D and Heyns C (eds) *Socio-Economic Rights in South Africa* (PULP 2005) 131.

## CHAPTER 4

### CONCLUSION

The most common route for HIV infection of children under five years of age is through Mother-To-Child Transmission. Therefore, preventing Mother-To-Child Transmission of HIV would be the main form of intervention to reduce HIV infection amongst children.<sup>177</sup> The South African PMTCT programme, conceptualized in 2000, has since 2001 first been implemented at pilot sites, with the primary aim to decrease the number of HIV infected babies born to HIV positive mothers.<sup>178</sup>

Since the formulation of the PMTCT programme, the government has taken a series of measures that the Constitutional Court found to fall short of what is constitutionally required.<sup>179</sup> These inadequate policies have contributed to the minimal decline in the infant mortality rate between 1990 (60 deaths per 1000 infants) and 2007 (59 death per 1000 infants).<sup>180</sup>

Despite the high prevalence of HIV/AIDS and the importance and priority of the PMTCT programme, the programme has not been monitored sufficiently. It is irresponsible for the Department of Health to not regularly evaluate the programme in which the government spends huge amounts. In addition, concerning the availability of ARVs in terms of the PMTCT programme, the government can no longer afford any shortage since this will lead to a failure in the treatment of HIV positive mothers and a waste of all funds spent previously on the programme.

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<sup>177</sup> National Department of Health 12.

<sup>178</sup> National Department of Health 4.

<sup>179</sup> *Minister of Health v Treatment Action Campaign* 2002 (5) SA 703 (CC) para 96.

<sup>180</sup> District Health Barometer report 2007/08 section 4.4 published in 2009 available at [http://www.healthlink.org.za/uploads/files/dhb0708\\_sec4.pdf](http://www.healthlink.org.za/uploads/files/dhb0708_sec4.pdf) [date of use 15 October 2009].

This study reviewed the obligations of the South African government to respond to the MTCT of HIV with reference to the Constitution of 1996 and international law. Section 27(2) of the Constitution, similar to various international human rights instruments such as the ICESCR, ACRWC, CEDAW and others, aims to protect the general population against undue interference by the State and imposes on the government the duty of making health care services accessible to all, within the State's available resources.<sup>181</sup>

A failure by the government to work towards the establishment of a comprehensive PMTCT programme violates the human rights<sup>182</sup> of women with HIV and their babies. This is reflected in the Constitutional Court's judgment in *Hoffman*, where the Court found that prevailing social prejudice against people with HIV/AIDS amount to "a fresh instance of stigmatization" and "an assault on their dignity."<sup>183</sup>

To successfully realise its mandate the government must vigorously assume its obligations under the Constitution and international law instruments,<sup>184</sup> in order to avoid the repeat of the historical inequity regarding the access to health care services. NGOs such the TAC and the AIDS Law Project (ALP) must continue to play the role of "watch dog" and, when necessary, challenge the constitutionality of the decisions of the State before the Court, especially since the Judiciary has a mandate to ensure that the government does not abuse its power or act unreasonably.

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<sup>181</sup> Ngwena and Cook "Right concerning health" 151.

<sup>182</sup> Forman L "The imperative to treat: The South African state's constitutional obligations to provide antiretroviral medicines" 2003 *Health Law Institute* 13.

<sup>183</sup> *Hoffman v South African Airways* para 28.

<sup>184</sup> Ngwena and Cook "Right concerning health" 151.

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**LIST OF ABBREVIATIONS**

- ACRWC** African Charter on the Rights and Welfare of the Child
- AIDS** Acquired immunodeficiency syndrome
- ALP** AIDS Law Project
- ANC** Antenatal care
- ARV** Antiretroviral
- ART** Antiretroviral therapy
- AZT** see ZDV below
- CDC** United States Centers for Disease Control and Prevention
- CD4** Cluster of differentiation antigens types 4
- CEDAW** Convention on the Elimination of All Forms of Discrimination Against Women
- CRC** Convention on the Rights of the Child
- ELISA** Enzyme-linked immunosorbent assay
- HAART** Highly active antiretroviral therapy
- HIV** Human immunodeficiency virus
- ICCPR** International Covenant on Civil and Political Rights
- ICESCR** International Covenant on Economic, Social and Cultural Rights
- MDGs** Millennium Development Goals
- MTCT** Mother-To-Child Transmission of HIV
- NGO** Non-governmental organisation
- NVP** Nevirapine
- OAU** Organisation African Unity

**OHCHR** Office of the High Commissioner for Human Rights

**PMTCT** Prevention of Mother-To-Child Transmission

**SAA** South African Airways

**STI** Sexually transmitted infections

**TAC** Treatment Action Campaign

**UN** United Nations

**UNAIDS** Joint United Nations Programme on HIV/AIDS

**UNGASS** United Nations General Assembly Special Session

**UNICEF** United Nations Children Education Fund

**WHO** World Health Organization

**WTO** World Trade Organisation

**ZDV** Zidovudine, the generic name for Azidothymidine (AZT)