

Treatment Action Campaign v. Minister of Health

A CASE STUDY¹

This case study is a teaching and learning resource meant to be used by researchers, activists, and academics who work in areas concerning women's human rights. It contains background information and a description of the legal arguments and strategies used in a particular court case. It also contains discussion and analysis of women's reproductive rights and sexual health issues in relation to the case, including discussion questions and additional reading suggestions.

The subject of this case study is the case of the *Treatment Action Campaign v. Minister of Health*. This is a South African case where a few non-governmental organizations, most notably the Treatment Action Campaign (TAC), took the government of South Africa to court over their failure to provide pregnant HIV positive women with drugs that could prevent the transmission of the virus to their child during labour. This case made it to the Constitutional Court of South Africa, the highest court in the country for Constitutional issues, and has received international attention.

Mother-to-child transmission (MTCT) of HIV at first seems to be a children's rights instead of a women's rights issue. This is the way it is often approached by legislators, courts and the media. There are, however, significant women's reproductive rights concerns that are under the surface in this case. There are many issues that can only be seen from a women's rights perspective. Medication to prevent MTCT of HIV can be argued for under a woman's right to be informed and have access to health care options, her right to reproductive choice, her right to have children and her right to equal treatment.

Furthermore, looking at the issue from a women's human rights perspective brings out other issues which must be considered in the implementation of a prevention of MTCT programme.

When MTCT of HIV is looked at only as a children's rights issue the pregnant woman is viewed as a transmitter of disease instead of a woman with rights of her own. Women's rights that surround the issue of MTCT include: issues of informed consent, access to safe and legal abortions, and confidentiality.

CONTENTS

CASE IN BRIEF

Factual Background

- A History of Women's Human Rights
- HIV and Mother-to-Child Transmission (MTCT)
- South African Policy on Preventing MTCT
- Unorthodox Views of the Cause of AIDS

Litigation: Using the Court System to Gain Access to Drugs to Prevent MTCT of HIV

- Plaintiffs' / Respondents' Arguments
- Defendants' / Appellants' Arguments
- Decision of the Courts
 - High Court
 - Constitutional Court

SELECTED ISSUES

Strategy: How and Why Was the Battle for Nevirapine Won?

- Why Use a Human Rights Strategy to Gain Health Care Reform?
- Litigation as Part of a Larger Social Movement
- A Committed Leader: How TAC's Front man Lead the Way
- The Government's Strategy
 - The Government in the Eyes of the Public
 - Medical Evidence in the Courts
- How Exportable is TAC's Strategy?
 - The Need for a Constitutional Democracy
 - The Post-Apartheid Social Atmosphere
- Conclusions, Discussion Questions and Additional Reading

Minimum Core Obligations and Positive Rights

- What Does “Minimum Core” Mean and Where Does it Come From?
- Minimum Core Obligations in South Africa
- Conclusions, Discussion Questions and Additional Reading

Women’s Right to Health

- Women’s Health Concerns Related to MTCT
- Women’s Rights v. Children’s Rights
- Combining Children’s Rights and Women’s Rights
- Women’s Rights or Mother’s Rights?
- Women’s Rights and the Prevention of MTCT
- Women’s Rights and the TAC case
- Conclusions, Discussion Questions and Additional Reading

Right to Found a Family

- A Positive Right to Bear Children?
- Right to Enjoy the Benefits of Scientific Progress
- Conclusions, Discussion Questions and Additional Reading

Discrimination and Equality Rights

- Advantages and Disadvantages of an Equality Argument
- Discrimination and the TAC Case
- Problems with Litigation: A Canadian Example
- Conclusions, Discussion Questions and Additional Reading

ADDITIONAL INFORMATION

- Timeline of Case

- International Treaties
- Legal System of South Africa
- Studies on AZT and Nevirapine
- Plaintiffs / Respondents' Court Documents
- Defendants / Appellants' Court Documents

CASE IN BRIEF

FACTUAL BACKGROUND

A History of Women's Human Rights

Women's rights movements have existed for at least two hundred years. Principles of non-discrimination based on sex have existed in international law since the United Nations created the UN Commission on the Status of Women and the Universal Declaration of Human Rights. While the Universal Declaration of Human Rights made it clear that the rights contained within also applied to women, any rights that would apply exclusively to women were not considered human rights. Practices that many recognize today as human rights violations, such as wartime rape and female genital mutilation, were considered private domestic problems.

The concept of women's rights as human rights is much more recent. In the 1970's and 1980's many women's groups pushed for greater recognition of women's rights. There were world conferences on women held in 1975, 1980, and 1985. In 1981 the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) was created by the United Nations and has slowly been ratified by all industrialized countries (except the United States) and most unindustrialized countries. At the 1993 World Conference on Human Rights in Vienna there was clear and explicit recognition of women's rights as human rights. The same year the General Assembly of the UN passed the Declaration on the Elimination of Violence against Women.

At the Fourth World Conference on Women held in Beijing in 1995 the focus was almost entirely on women's rights as human rights. The conference produced the Beijing Declaration and the Platform for Action. By this time women's human rights were securely in the mainstream.

As opposed to the political rights focus of the past, much of the focus on women's human rights has been on sex and reproduction since it is in this area that many of the most serious abuses take place. CEDAW explicitly recognizes sexual and reproductive rights as human rights, as do most recent women's human rights documents. Today, most countries recognize at least principles of non-discrimination through international or domestic law.

Many countries recognize women's rights in general as human rights. This legal recognition, however, has done little for the poorest and most vulnerable women in the world. Most of the world's poor and illiterate are women. Women are still subjected to female genital mutilation in many countries. Women are still subjected to violence in their homes and on the street. It is important to remember that while declarations, conferences and international covenants can be useful tools in the fight for women's human rights, their existence is only the beginning.

Additional Reading:

Cook, Rebecca, *Reproductive health and human rights: integrating medicine, ethics, and law*, Oxford: Clarendon Press (2003).

Lockwood, Carol Elizabeth (ed), et al, *The International Human Rights of Women : Instruments of Change*, Washington, DC : American Bar Association (1998).

HIV and Mother-to-Child Transmission (MTCT)

HIV/AIDS is a national crisis in South Africa. Women in South Africa are particularly vulnerable to HIV infection due to the structure of society, violence against women, and their physiology. In 2001 the HIV prevalence rate in pregnant women was about 24.5%.² The World Health Organization (WHO) reports that 1,600 infants are infected through birth every day. In South Africa alone approximately 70,000 children will be infected with HIV due to mother-to-child transmission (MTCT) of HIV. HIV infection has increased the childhood mortality rate in Africa

by 100%, with most infected children dying before the age of five. About 15-30% of infected mothers will pass along the virus to their child without treatment through pregnancy and labour (with most becoming infected through labour and not in utero), and a further 10-20% will infect their children through breastfeeding. Treatment with either AZT or nevirapine can lower the chances of MTCT.³

Governments and domestic and international NGO's have attempted to limit MTCT in a number of ways. These include the provision of antiretroviral drugs to lower the risk of transmission, the provision of formula to mothers to reduce breast feeding, taking steps to reduce the infection of women, and information and provision of safe contraceptive options and safe and legal abortions.

Additional Reading:

World Health Organization, *Sexual and Reproductive Health of Women Living with HIV/AIDS: Guidelines on Care, Treatment and Support for Women Living with HIV/AIDS and their Children in Resource-Constrained Settings* (2006). Available Online: <http://www.who.int/hiv/pub/guidelines/sexualreproductivehealth.pdf> (July 10, 2006)

PBS, *The Age of AIDS* [video recording], FRONTLINE (May 30, 2006). Available Online: <http://www.pbs.org/wgbh/pages/frontline/aids/> (July 3, 2006).

South Africa's Policy on Preventing MTCT

During the apartheid when AIDS was first appearing in South Africa and around the world the government paid it almost no attention. After the apartheid ended and Nelson Mandela was elected President little changed. The state was in turmoil and faced a number of challenges, so little attention was paid to AIDS. During Mandela's presidency HIV infection rates doubled every year.⁴ In 1999 Thabo Mbeki ran for president with the campaign that he would deal with the AIDS crisis. He even wore an AIDS ribbon on his lapel during the campaign. Once elected, however, Mbeki took a controversial stand on AIDS by questioning the link between HIV and AIDS. He also repeatedly questioned the safety of anti-retroviral drugs.

Following studies which showed the efficacy and safety of a drug called nevirapine for the reduction on MTCT of HIV and an offer by Boehringer Ingelheim to supply nevirapine free to the South African government for five years, the South African government produced the Protocol for Providing a Comprehensive Package of Care for the Prevention of Mother to Child Transmission of HIV in South Africa. This Protocol called for the establishment of two pilot sites in each province that would offer nevirapine to HIV infected pregnant women along with counselling and breast milk alternatives.

The pilot sites were to be monitored and studied for two years before the government would decide whether to make a similar comprehensive health care package, including nevirapine, more widely available. Doctors in South Africa's private health care system were already permitted to provide nevirapine to their patients as they saw fit. The reason the government gave for limiting the availability of nevirapine to these pilot sites was that they needed "to gain better understanding of the operational challenges of introducing the intervention on a wider scale".⁵ Following this the Medicines Control Council (MCC) formally registered nevirapine for the prevention of MTCT of HIV.

Unorthodox Views of the Cause of AIDS

There are a small number of scientists who claim that HIV does not cause AIDS. They claim that HIV is a harmless virus and that AIDS is caused by poverty, drug use and the drugs used to fight AIDS such as AZT. The scientific community overwhelmingly dismisses these claims and there is a large and well developed pool of scientific data showing HIV causes AIDS.

The President of South Africa, Thabo Mbeki, has repeatedly shown sympathy for the views of these dissidents. Soon after he was elected he made a speech to South Africa's parliament in which he stated, "You see, when you ask the question, 'Does HIV cause AIDS?' the question is, 'Does a virus cause a syndrome?' How does a virus cause a syndrome? It can't."⁶

He again displayed his scepticism during his opening speech at the Durban 2000 AIDS conference where he stated that you cannot “blame everything on a single virus.”⁷ In a letter to world leaders sent in 2000 Mbeki likened the treatment of HIV denialists to “heretics...burnt at the stake” and radicals under the apartheid. He spoke of freedom of speech and ideas. Though he made a compelling argument for the right of these dissidents to speak he did not supply any reason for paying so much heed to them when the overwhelming scientific evidence contradicts their conclusions.

Additional Reading:

Duesburg, Peter and Rasnik, David *The AIDS Dilemma: Drug Diseases Blamed on a passenger virus*, GENETICA 104: 85-132 (1998). Available online:

<http://www.duesberg.com/images/genetica.pdf> (June 29, 2006)

Government of South Africa, *President AIDS Panel Advisory Report*, (2001). Available online: <http://www.info.gov.za/otherdocs/2001/aidspanelpdf.pdf> (June 29, 2006)

Heywood, Mark, *Price of Denial*, DEVELOPMENT UPDATE 5(3) (2004). Available online: <http://www.tac.org.za> (July 23, 2006).

LITIGATION: USING THE COURT SYSTEM TO GAIN ACCESS TO DRUGS TO PREVENT MTCT OF HIV

Following a number of failed attempts to convince the Minister of Health to broaden the prevention of MTCT program, the Treatment Action Campaign (TAC) and two other plaintiffs filed a notice of motion with the Pretoria High Court alleging that the National Minister of Health as well as the Ministers of Health for all the provinces were in breach of their Constitutional and International obligations in failing to provide nevirapine to women outside the limited pilot sites.

Only one province, Western Cape, cooperated early on by sending TAC's lawyers details of the intensive programme Western Cape had in place to reduce mother-to-child transmission of HIV and submitting an affidavit to the court to the same effect. Therefore, TAC decided not to seek an order against the Western Cape but did site it as a defendant in the High Court case because "all provinces in South Africa – even those that were doing the right thing – would benefit from a rational national policy."⁸

On December 14, 2001 the High Court ruled in favour of TAC and ordered the Minister of Health to make nevirapine available in all public hospitals and clinics where testing and counselling facilities existed. The High Court also ordered the Minister of Health to come up with a comprehensive programme to prevent or reduce MTCT and to submit reports to the court outlining that programme.

The Minister of Health requested leave to appeal this decision to the Constitutional Court of South Africa and TAC requested an immediate execution order to force the Minister of Health to make nevirapine available before the case reached the appeal court. The High Court granted the Minister of Health leave to appeal and granted TAC the execution order. The Minister of Health appealed the execution order at the Constitutional Court, but the Constitutional Court upheld the High Court's decision.

On July 5, 2002 the Constitutional Court found that the Minister of Health did have a constitutional duty to give pregnant, HIV positive women access to nevirapine.

PLAINTIFFS' / RESPONDENTS' ARGUMENTS

The plaintiffs argued that a short course of nevirapine is a safe and effective way to reduce mother-to-child transmission (MTCT) of HIV. They based this argument on the numerous studies done on nevirapine, on the recommendation of the WHO, and on the findings of the MCC.

They pointed out that the safety of nevirapine and its tendency to create resistant strains of HIV have only been questioned in relation to long course treatments, and that there is no evidence of similar problems with a single dose.

TAC agreed with the governmental policy of only providing nevirapine to women once they have been properly counselled and tested for HIV and that a comprehensive program that includes the provision of breast milk substitutes is ideal. However, the plaintiffs argued that there are many hospitals capable of providing counselling and testing that are not being utilized and while a basic programme consisting of only testing, counselling and the provision of nevirapine is not ideal, it is not irresponsible either.

The plaintiffs contended that the policy that was in place to reduce MTCT of HIV was in breach of the Constitution in a number of ways. First and foremost it breached the right to health guaranteed by section 27 of the South African Bill of Rights. Section 27 contains two main parts. Section 27(1)(a) says that everyone has the right to health care including reproductive care. Section 27(2) says that the state must take reasonable measures to achieve the progressive realization of these rights.

Two of the interveners in the Constitutional Court case (the Institute for Democracy in South Africa (IDASA) and the Community Law Centre (CLC)) characterized section 27 as containing two separate rights which the government was in breach of. They argued that s.27(1)(a) contains a right to a minimum core of health care services that are necessary for the life and dignity of a person and are not limited by s.27(2), and that section 27(2) imposes a duty on the government to create a comprehensive program for the progressive realization of other universal though less essential health care services. This minimum core of services must include testing, counselling, and the administration of nevirapine if necessary to pregnant, HIV positive women because both the life of the child and the ability of the mother to make informed medical decisions are at risk if it is not.

The interveners further argued that the government was in breach of s.27(2) because it has not laid out a comprehensive plan to progressively realize the health care rights of women and children in relation to MTCT of HIV. The Protocol for Providing a Comprehensive Package of Care for the Prevention of Mother to Child Transmission of HIV in South Africa only called for the introduction of pilot sites for two years. The government made no promises after this two year period and instead declared they would consider the issue again when the trial period was over.

The CLC and the IDASA also maintained that the primary burden of supplying health care services to children falls on the state due to s.28 (1)(c) of the Bill of Rights which guarantees children the right to basic health care services. If the parents are unable to supply these basic health care services for the child it is the state's constitutional duty to protect the health of the child. This duty must create a minimum core obligation on the state even if the state has no such obligation under s.27 because s.28 does not contain anything that can be read as a limiting clause.

Aside from the right to health of women and children, TAC pointed to the s.11 right to life, the s.10 right to dignity of the mother and of the child, the s.9 right to equality (because the policy of the government discriminated against poor women and thus black women by allowing nevirapine to be available in the private health care system and not allowing it to be widely available in the public health care system), and finally the s.12(2)(a) right to psychological integrity including the right to make decisions regarding reproduction.

Aside from the rights contained in the South African Bill of Rights, TAC asserted that by preventing doctors from providing life saving medication to their patients the government was in breach of s.195 of the Constitution which states that a high standard of professional ethics must be promoted and maintained. Far from promoting professional ethics, the government was forcing doctors to act unethically, or as was often the case, to buy nevirapine themselves and supply it to their patients.

TAC also pointed to the Patient's Rights Charter which was issued by the Ministry of Health which states that all patients have the right to counselling and information on all their options related to their pregnancy and childbirth. Many hospitals did not provide counselling on MTCT of HIV even though existing counsellors would only need a few extra hours of training on the subject. TAC argued that the Patient's Rights Charter was legally binding and thus the government must provide these counselling services.

Along the same lines, TAC stated that the numerous promises and policy statements issued by the various branches of the government created a legitimate expectation that the government would take reasonable steps to prevent MTCT of HIV and that the government was legally obligated to fulfill these legitimate expectations.

Along with domestic legal obligations the plaintiffs pointed to a number of international agreements that the government of South Africa had signed and ratified. These include:

- Article 1 of the Universal Declaration of Human Rights (All human beings are born free and equal in dignity and rights),
- Article 6 of the International Covenant on Civil and Political Rights (Right to Life),
- Article 12 of the International Covenant on Economic, Social, and Cultural Rights (Right to Health),
- Article 12 of the Convention on the Elimination of Discrimination against Women (Discrimination against Women in Health Care),
- Article 24 of the Convention on the Rights of the Child (Child's Right to Health),
- Articles 2 and 5 of the Convention on the Elimination of All Forms of Racial Discrimination (Racial Discrimination, Equal Access to Health), and
- Article 16 of the African Charter of Human and Peoples' Rights (Right to Health).

The plaintiffs asked the court for two things. First, they asked for an order compelling the government to supply nevirapine to all public hospitals where testing and counselling facilities

exist and to allow doctors to proscribe nevirapine on a case by case basis. Second, they asked for an order requiring the government to commit to a detailed action plan for the further prevention of MTCT of HIV.

DEFENDANTS' / APPELLANTS' ARGUMENTS

The Ministers of Health argued that this issue is not justiciable due to the principle of the separation of powers. The legislature alone has the power to make policy decisions and if the court declared the government's action plan unconstitutional and forced it to implement a different plan the unelected judges would be making policy, which is not their role.

Even if this matter is justiciable, the Ministers of Health claimed that the plan proposed by TAC would be ineffective, irresponsible, and too costly. They alleged that testing and counselling facilities were seriously lacking and that providing hospitals outside the pilot sites with these facilities would be too expensive. Further, if doctors were permitted to medicate patients at will health care budgets would be seriously strained.

They also argued that a comprehensive plan which included the collection of follow up data and the provision of breast milk substitutes would be necessary since, among other reasons, the positive effects of nevirapine can be reduced through breast feeding. Even though nevirapine could be provided at little or no cost, they maintained that the true cost of the program is in counselling, testing, formula, and other hidden administrative costs and because of this a comprehensive program would be far too expensive to roll out all at once.

Even if the plan was affordable, the Ministers said that the provision of nevirapine would be irresponsible since the registration of nevirapine to prevent MTCT was based only on one scientific study (HIVNET 012) and that it was of questionable validity. They also pointed out that the registration by the MCC came with the condition that the manufacturer of the drug continues to supply it with data on the safety of the drug and that there are studies showing

that nevirapine can cause drug resistant strains of HIV. They claimed that until more is known about the safety of the drug it should not be given to the general public.

The Ministers of Health portrayed the program they had for the prevention of MTCT of HIV as comprehensive and claimed that it fulfilled their Constitutional duties under sections 27 and 28 of the Bill of Rights. S.27(1) and s.27(2) must be read together, according to the Ministers, and so there is not a free standing right to a minimum core of health care services. Even though s.28 does not have a limiting clause within it, as s.27 does, it also does not guarantee children an unlimited right to health. Instead, they argued that s.28 must be read in relation to s.27 and children's right to health must be interpreted as an obligation on the state to take reasonable measures to progressively realize the health of children within the available resources, which they have done by creating pilot sights.

The defendants also argued that they were not in breach of equality rights because equality should not be defined as access to the same resources but as ability to achieve the same results. The result everyone wants is healthy children. Since the Ministers claimed that the safety and efficacy of nevirapine, especially over the long term, is unknown, it can not be discriminatory to refuse nevirapine to some people. More simply put, the methods of treatment cannot be discriminatory until it is known if they lead to unequal results.

As to the international agreements the plaintiffs cited, the Ministers claimed that they are not legally binding in a domestic court. International law, according to the defendants, is not domestic law until it has been enacted into law by the parliament of South Africa. Therefore the domestic courts cannot interpret the international agreements nor determine the legal consequences flowing from them. They also argued that though the court must take into account international law when interpreting the Bill of Rights due to s.39 of the Constitution, the court is not bound by international law and is free to make its own interpretation of the rights contained within.

DECISIONS OF THE COURTS

High Court

Botha J determined that the issue should be approached as a s.27(2) matter, but that it was relevant that other sections of the Bill of Rights were at issue. He determined that the government had breached both the negative obligation not to interfere with the realization of health, and the positive obligation to provide a comprehensive and systematic plan to progressively realize the right to health. Botha J did not discuss the possible breach of any other domestic or international obligations except to rule that the principle of legitimate expectation cannot confer a substantive right, and that “the phased implementation of a health care programme is discriminating, that it causes inequality and that it denies access to those who find themselves outside the reach of the sites where implementation is being effected.” He did not, however, rule on whether this particular phased implementation of a health care programme breached the right to equality guaranteed in s.9 of the Bill of Rights.

Botha J relied on *Republic of Africa v Grootboom* to conclude that positive rights are justiciable and judging the reasonableness of governmental policy does not breach the principle of the separation of powers. He instead called it “a perfect example of how the separation of powers should work” when the judicial arm sits in judgment of the reasonableness of the decisions of the executive arm.

As for the disagreements about the scientific evidence between the two sides, Botha J came down firmly on the side of TAC. He concluded that the side effects and mutations were only shown for long term use and there was no evidence of safety issues for short term use. He characterized the conditional registration of nevirapine by the MCC as normal under the circumstances and not indicative of specific safety concerns in relation to the drug.

Botha J also agreed with the plaintiffs as to the irrationality of waiting until the state could afford a comprehensive MTCT of HIV prevention programme to make nevirapine more widely

available. 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, Botha J 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.” 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 “the policy of the first to nine 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 realization of the right to health care.”

Botha J also found that the government had a positive duty to create a comprehensive plan to reduce MTCT of HIV under s.27 (2) of the Bill of Rights. 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.” Therefore, the state was in breach of its obligation to provide a comprehensive plan to prevent MTCT of HIV.

As remedy to these breaches the High Court ordered the Ministers of Health to make nevirapine available in all public hospitals that have the necessary testing and counselling facilities. It also ordered the Ministers to come up with a comprehensive plan for the reduction of MTCT of HIV and to submit reports to the court outlining the progress they have made on this plan.

Constitutional Court

The Constitutional Court made most of the same determinations as the High Court. They found that socio-economic rights were justiciable and that s.38 of the Constitution conferred on the court the power to give “appropriate relief” when a right in the Bill of Rights has been infringed.

They found that “appropriate relief” included the ability to force the government to change its policies.

They also agreed with the High Court’s fact finding, including the finding that nevirapine is efficacious, safe, and affordable and that there was some capacity in hospitals and clinics outside the pilot sites to properly test, counsel and administer nevirapine. They found that the government’s policy to limit nevirapine to the pilot sites was unreasonable and constituted a violation of s.27(2).

The Court considered whether s.27(1) conferred a right to a minimum core of health care services and found that “section 27(1) of the Constitution does not give rise to a self-standing and independent positive right enforceable irrespective of the considerations mentioned in section 27(2).”⁹ The Court did find, however, that the concept of a minimum core obligation was relevant to reasonableness under s.27(2).

The Court also considered the right to health of children guaranteed under s.28 and found that while parents who can afford to provide medical care for their children have the primary responsibility to do so, this does not relieve the state from its obligation to insure the health of children. The Court did not discuss whether to read s.28 as limited in the same way as s.27, but made no mention of reasonableness in their discussion of the possible breach of s.28. This leaves open the possibility of reading s.28 as a stand-alone positive right to essential health care for children.

The Court also did not discuss the possible violation of any other domestic or international obligations or the legal status of international covenants in domestic courts.

The Court found that the government was in violation of s.27 and s.28 in not making nevirapine widely available and in not providing a comprehensive plan for the gradual elimination of MTCT of HIV. They ordered the government to provide nevirapine to all public hospitals and clinics

that have the necessary testing and counselling facilities and to come up with a comprehensive plan for the further reduction of MTCT of HIV. The Constitutional Court overturned the High Court's order to have the Ministers of Health submit reports to the court outlining their progress, due to the government's track record of complying with decisions of the court.

SELECTED ISSUES

STRATEGY: HOW WAS THE BATTLE FOR NEVIRAPINE WON?

Why Use a Human Rights Strategy to Gain Health Care Reform?

The use of a human rights strategy to improve health care has both advantages and disadvantages. One of the main advantages to using the language of human rights is the shame aspect. Human Rights have a moral pull that few other legal arguments can match. When a state is accused of breaching fundamental human rights the world takes notice. When demands are couched in the words of international human rights they are often seen as more legitimate and more pressing than if they were simply pleas for help.

Another benefit to using a human rights strategy is that it leads to a more holistic approach. If the goal is to protect the fundamental human rights of the population instead of to have one type of medication available to a certain group then a number of avenues need to be addressed. HIV can affect the rights of women and children in a number of ways. If TAC had simply lobbied the government to provide the benefit of nevirapine to pregnant women they may have got it, but other important considerations may not have been given their due weight. A human rights approach, on the other hand, brings to the fore consideration of informed consent, confidentiality, women's health concerns, the availability of formula feed, the availability of safe and legal abortion and contraceptives, and other issues that connect to reproduction and HIV. If the battle cry was "give medicine to pregnant women to stop MTCT"

instead of “everyone has the right to health” the preceding considerations would not necessarily be addressed and that could result in a less efficacious policy as well as endanger other rights.

There are, however, drawbacks to using a human rights strategy. The first is the difficulty in litigating positive social and economic rights. Civil and political rights often involve only restraint on the action of the state. Civil and political rights are usually absolute and bind all members of the government with their prohibitions. In this way litigation of civil and political rights is similar to criminal law. Once it is clear that an action breaches a prohibition it is comparably easy to force the cessation of that activity. For example, a common civil and political right is the right not to be subjected to unreasonable seizure of your property. If an individual can prove to the court that the state has unreasonably seized her property then the court can force the return of said property and restrain the state from taking that action in the future. Social and economic rights are usually not of this character. They often involve forcing the state to fulfill a positive obligation. They usually involve vague and progressive obligations instead of absolute demands. Also, in federalist states these obligations are usually spread between more than one governmental actor. “This gradualism and shared responsibility make it much more difficult to shame a particular national government for its poor state of health care”¹⁰ Governmental actors are able to “pass the buck” to other actors who share in the responsibility of realizing these positive rights. Most international human rights documents also place some of the burden of achieving positive social and economic rights on the international community. Therefore, if a state is accused of violating a positive right that state can try to defend itself by pointing to the lack of help from outside the state; a defence not available for breaches of most civil and political rights. The state can also defend itself by claiming a lack of resources or pointing to a future plan for the realization of said right.

Even if the individual is successful in their claim of a breach of a positive right, that decision is difficult to enforce. The court cannot and should not make governmental policy nor say where the resources for the achievement of this right should come from. In some cases, such as an

individual claiming the positive right to a state funded operation, enforcement is relatively easy. The court can order the state to provide the operation. For more general claims that affect many people over time enforcement becomes increasingly difficult. For example, if a group claims that the state has breached the right to education because the school system is inadequate they may be able to win a court judgment declaring a breach of this right, but without the sustained and intrusive involvement of the court into governmental policy this judgment would be impossible to enforce without the cooperation of the state.

Another hurdle international human rights activists may face is the perception that human rights have an unwelcome “western” influence. International organizations are often controlled to a large part by industrialized nations and thus reflect “western” ideals. Many view international human rights as insensitive to cultural and religious differences and resent the imposition of these standards and ideals on their sovereign nation. Governments will often exploit these sentiments to cast a shadow over foreign legal standards. They will frame the issue as one of the evil “west” trying to bully the democratically elected government of their sovereign state.

Even with these possible obstacles to a human rights approach a sensitive, well-planned and multi-faceted human rights strategy can be very effective in today’s climate. Positive rights can be effectively litigated where either an argument for a minimum core of governmental obligations can be maintained or where the unreasonableness of governmental actions can be shown. Enforcement is possible if demands are clear and the range of possible solutions well defined. Anti-western sentiments can be lessened by shown deference to local traditions, customs and religions, by reference to domestic law and by the leadership of domestic organizations and individuals.

Litigation as part of a larger social movement

Many have attributed TAC's victory to their multi-faceted approach. This is true of their legal arguments, which pointed to domestic, regional and international legal documents. Perhaps more efficacious, however, were TAC's activities outside the specific litigation against the Ministers of Health.

TAC understood that it was no use trying to force the government to provide something if costs made it impossible. Therefore, prior to the case against the Minister of Health, TAC participated in a legal action against pharmaceutical companies that resulted in lower prices¹¹. Much of the government's argument for not providing antiretroviral drugs in the beginning focused on cost. Even a short course of anti-retroviral drugs for the prevention of MTCT was quite expensive. The parliament had passed amendments to the Medicines Act in 1997 which allowed for the production of generic versions of patented drugs. Thirty-nine drug companies filed suit against the government for patent infringement. TAC joined the fight as an amicus curie and helped force the pharmaceutical companies to drop the suit. They then lobbied these companies for lower drug prices. TAC was very successful in this campaign and managed to get the costs of most drugs lowered to reasonable levels.

TAC recognized that though public interest litigation may be used as an important tool of social change, the use of law should be limited and strategic. They believed that the lawyer plays an important albeit limited role within a larger social movement, and that a comprehensive understanding of the political and economic context informs the manner in which the law should be used to further the aims of the movement.¹²

TAC organized marches and rallies, made posters, flyers and t-shirts, lobbied national and international interest groups for support and met with government officials as part of their strategy to reduce MTCT of HIV. TAC saw litigation as only one step in this campaign and used it as not only a way to possibly get a legal remedy but also as a method of disseminating

information and placing pressure on the government to change its policy. For example, “The launch of the application [to the High Court] precipitated an extension of the programme in a number of provinces, as if to contradict TAC’s claims of irrationality and unreasonableness.”¹³ Litigation, or even the threat of litigation, can force a government to reconsider its policies for it knows that they will soon be the subject of judicial scrutiny and can make a topic that was previously only discussed in specialized circles a widely debated and contentious political issue.

TAC was also very conscious of its public image throughout the case. To effectively shame the government into honouring its health care promises TAC realized they must be seen as the ethical and rational party in the dispute. Throughout the case TAC used a strategy of taking the moral high ground and seriously considered the implications every action it took would have on public opinion. TAC took some extreme steps to try to force the government to implement a national treatment programme. In many ways the campaign TAC used was like the anti-apartheid campaign in South Africa from years before. The most salient difference, however, was that TAC was fighting against a government that they recognized as legitimate. TAC had to be very careful not to be seen as trying to overthrow a democratically elected government. Therefore, when the government stalled the implementation of a national treatment plan after the Constitutional Court decision came down TAC’s decision to instigate a civil disobedience campaign was not made lightly. TAC was concerned about alienating its supporters by going too far in opposing a democratically elected government.¹⁴ The civil disobedience campaign consisted of 600 volunteers going into police stations and laying charges of culpable homicide against members of the government. They demanded that either both the Minister of Health and the Minister of Trade and Industry were arrested or they were arrested. Many police stations complied by opening a docket against the Minister of Health before formally arresting the protestors for unlawful entry. While this type of campaign was a risk, it paid off for TAC and was met with widespread support. TAC credits this campaign and the massive marches that it organized in 2003 for the effective rollout of HIV/AIDS treatment programmes.¹⁵

A Committed Leader: How TAC's Front Man Led the Way

TAC also benefited from having a leader that could capture the minds and hearts of the people. Zakie Achmat had both the grassroots credentials and the political allies to make TAC a success story. He came from a background of anti-apartheid activism; he is South African born, HIV positive and a leader in the gay community. He is the perfect face for the struggle for AIDS treatment. While he has no formal legal training, prior to founding TAC he worked with Justice Edwin Cameron at the AIDS Law Project. Zakie Achmat won the respect and support of the public with his fierce commitment to the cause. He was arrested for civil disobedience on a number of occasions and showed no fear of high ranking and powerful opponents. In a drastic move to show solidarity he refused to take anti-retroviral drugs, which he could afford, until they were available to everyone.

It was this kind of passion that won him his most powerful and influential ally: Nelson Mandela. Though quiet about the AIDS crisis during his Presidency, after he left office Nelson Mandela began to speak out about AIDS. In July 2002 the former President and beloved public figure visited Achmat at his home and subsequently the two struck up a friendship. Mandela even donned one of TAC's signature "HIV Positive" t-shirts at a visit to a hospital in Khayelitsha.¹⁶

The Government's Strategy

The Government in the Eyes of the Public

While TAC successfully maintained a positive public image, the government was not able to do this. There were numerous domestic newspapers which criticized and even ridiculed the Minister of Health for her actions. During TAC's non-violent protests the police in certain provinces responded with undue force.¹⁷ Governmental officials made statements to the press indicating they would not comply with the judgment of the court.¹⁸ The government was also unable to present a unified front. Early on Western Cape Province disagreed with the national Minister of Health's programme and instituted its own comprehensive programme to reduce

MTCT of HIV. During litigation other provinces slowly followed suit by opening more than the allotted two pilot sites per province. The division between the national Minister of Health and the provinces who expanded their prevention of MTCT programmes weakened the government's case both inside and outside of the court room as it became apparent that a wider program was indeed possible.

Medical Evidence in the Courts

The Ministers of Health not only claimed that a wider prevention of MTCT programme was economically unfeasible, they also claimed that more medical evidence was needed to prove nevirapine was safe for the general public. They attempted to frame the scientific evidence as vague and too difficult for judges, who are not scientists, to understand. They primary did this by attacking the validity of the HIVNET 012 study and mischaracterising the withdrawal of nevirapine for consideration for approval by the FDA in the United States as well as the conditions put on the registration of nevirapine for the prevention of MTCT of HIV by the MCC.

The government pointed to questions raised about the quality of the methodology of the HIVNET 012 study and the characterization by some of the inconclusiveness of the South African Intra-partum Nevirapine Trial (SAINT) to argue that the safety of nevirapine was in question. The court did not accept these arguments due to the overwhelming evidence of the safety of a single dose of nevirapine and the relatively limited evidence of serious side effects from the prolonged use of nevirapine, which was not at issue in this case. The continued support for the use of nevirapine by the WHO was a major hurdle for the government and ultimately one they could not overcome.

The government also suffered from a fatal flaw in the logic of this argument. In claiming that the questionable safety of the drug was what was preventing them from making it widely available to the public they were admitting to endangering the health of all those who had

access to the drug, i.e. those in the private health care system and those in the vicinity of the pilot sites.

The Ministers of Health also attempted to misrepresent the reasons behind the revocation of nevirapine for consideration by the FDA and of the conditions of registration by the MCC. The MCC registered nevirapine for the prevention of MTCT on the condition that Boehringer Ingelheim continue to supply the MCC with information on the safety and efficacy of the drug. They also pointed to the fact that the MCC changed the information packet included with the drug to provide stricter warnings about its use after it was registered. The court found that this type of conditional registration is very common for new and life saving drugs and that it did not imply that the drug was unsafe. The court also found that the updated packaging was relevant to the safety of the long term use of nevirapine but was in no way related to a single dose.

The state also pointed out that Boehringer Ingelheim had revoked its application to have nevirapine registered by the FDA implying that it was due to safety concerns. The reason for this revocation was that the studies that Boehringer Ingelheim meant to rely on for their application to the FDA did not meet FDA requirements. The court found this had absolutely nothing to do with safety concerns and suggested the state was intentionally trying to mislead the court.¹⁹

The attempt to frame the medical studies as complex and inconclusive is a common defence strategy used in litigation. The other big area of litigation it is used in is in tobacco cases. The conditions for its use in both tobacco cases and the TAC case were quite similar. In these types of cases a more powerful party with access more resources attempts to flood the court with questionable scientific evidence and characterize the other side's science as "junk science." As Mark Heywood explains, "Although intimidating in volume, once deconstructed it was clear that the government papers were full of deception and contradiction. Health Department officials sought to undermine established science and scientific institutions."²⁰ TAC was successful against this strategy due to its connections and supporters both domestically and

internationally who could respond to the overwhelming volume of technical material submitted to the court by the state. TAC only had ten days to reply to a thousand pages of technical medical evidence and was successful in doing so only with the help of many supporters of their cause.

How Exportable is TAC's Strategy?

TAC's victory has left other human rights organizations wondering if they could use some of the same strategies to win victories in other locations and for other types of rights. The question then remains, in what sense can TAC's prevention of MTCT of HIV campaign serve as a model for other human rights struggles?

The Need for a Constitutional Democracy

It is significant that litigation did not take place prior to the full democratization of South Africa. The type of campaign TAC used could arguably only have been effective under a constitutional democracy. The lack of democracy has the obvious problem of repression. States that are not accountable to all people have less reason to tolerate social movements, as was evident in the anti-apartheid struggle. Any legal action over social rights is also impossible since there is usually no separation of powers between the judiciary and the legislature and the legislature is not usually accountable to the courts. In "Social Rights Litigation as Transformation: South African Perspective", Siri Gloppen breaks down the litigation process as consisting of Voice, Responsiveness, Capability, and Compliance. Voice refers to the ability of the victim or complainant to be heard by a court. A victim cannot be heard if the state represses their speech or intimidates them to keep them out of court. Responsiveness refers to the will of the court to hear matters concerning social rights. If judges have political allegiances to the ruling party or are chosen by the party based on similar sympathies then they are unlikely to even hear cases questioning the legislature's social policy. Capability refers to the court's ability to

rule on matters of social rights or the justiciability of social rights. The court needs legal tools to find the legislature to be in breach of a social right. These legal tools can include a constitution, international treaties or simply domestic laws. Compliance refers to the legal standing of the judgments of the court and its ability to enforce its judgments. This depends on the structure of the government, the rule of law and the political culture. If the court is seen as authoritative and legitimate, and if the legislature has accepted the jurisdiction of the court and pronounced itself bound by the rule of law, then the judgments of the court will likely be enforced.

Otherwise they can only be of persuasive value and the legislature can choose to ignore them.²¹ Without a constitutional democracy litigation on social rights will likely fail due to the lack of one or more of these components.

The Post-Apartheid Social Atmosphere

The general atmosphere of South Africa at the time of the MTCT case played a significant role in TAC's strategy. The struggle against the apartheid which effectively ended in 1994 with the election of the African National Congress (A.N.C.) party to power was still fresh in the minds of the people. This created some unique opportunities but also some major challenges for TAC.

A campaign against a legitimate government is very different than a campaign against an unjust and non-representative government. While TAC enjoyed greater political freedom during its campaign against the A.N.C. than it would have under the apartheid, the overwhelming public support for the A.N.C. made garnering allies difficult. Even the leaders of TAC were resistant to challenging the government. Zakie Achmat himself said, "The difficult decision for me was not to take off my suit and go to the streets to fight for treatment...That was easy. The emotionally torturous thing for me to do was to recognize we had to take on the A.N.C. *Our A.N.C.*"²² TAC was asking people who had recently fought for the A.N.C. and who felt a solidarity with the A.N.C. to turn against them. This was no easy task, yet somehow TAC managed to get enough public support to win the battle. It helped that the government appeared to be acting wholly irrationally in many respects. It helped that TAC had a sympathetic victim, helpless children, to

support. However, TAC also took positive steps to make sure they did not alienate their support base. They gave the government numerous opportunities to privately and peacefully develop a settlement. They fostered relationships with government officials to gain support from within the A.N.C. They spent countless hours holding information sessions and producing pamphlets to educate the public on their fight. They worked within legal means whenever possible so as to not challenge the new governmental system, and they tried to tie the ideals of their fight with the ideals of the anti-apartheid movement.

Another problem the recent end of the apartheid created for TAC was the upheaval it produced. The state was trying to create a new system of government and law, foster international relations, and manage an economic transition. While AIDS was a growing crisis in South Africa there were many other important issues to distract attention away from it.

TAC's campaign also benefited from its temporal proximity to the anti-apartheid movement. The people of South Africa were politically involved and aware. A free and open media was in place. Grassroots organizations were already formed and ready for a new challenge and the ideals of equality and human rights occupied a pre-eminent place in society. The combination of these factors created the possibility of a mass social movement.

Conclusions

TAC was victorious in its fight against the government of South Africa for a number of reasons. They used a strategy of litigation, mass demonstrations, national and international lobbying and civil disobedience. They had passionate, committed and respected leaders. They maintained public support through informational campaigns and grassroots activism. They worked within the legal system and created a support base within the A.N.C. so as to not challenge the legitimacy of a recently formed democratic government. They managed to rally a country that attaches a profound stigma to HIV around an issue of HIV treatment and force a government

who fought tooth and nail against it to change their policies. Their victory is significant and contains many lessons for social activists.

This, however, does not mean that it is a model appropriate for all social movements. The legal structure, the political history, and the culture of South Africa, as well as the particular issues of this campaign, all factored into TAC's victory. It is quite possible that this right could have been won another way in South Africa. Purely grassroots activism or appeals to international courts or tribunals might have been as, or more, effective. It is likely that this exact method would not have been as successful in another country, or in regards to a different issue. It is important, therefore, to keep the broader context in mind when looking for successful strategic models.

Discussion Questions

- Would their arguments have been as persuasive to the court, to the people of South Africa, or to the international community if they had been based on women's rights?
- If the Constitutional Court had overturned the High Courts decision to direct the government to allow nevirapine to be given to HIV infected pregnant women and their children what other recourse could TAC have taken?
- How exportable are TAC's strategies to other geographical areas or other issues?

Additional Reading:

Albertyn, Cathi, *Prevention, Treatment and Care in the Context of Human Rights: Expert Group Meeting on "The HIV/AIDS Pandemic and its Gender Implications"*, EGM/HIV-AIDS/2000/WP1, Windhoek Namibia, November 13-17 (2000)

Albertyn, Cathi, *Using Rights and the Law to Reduce Women's Vulnerability to HIV/AIDS: A Discussion Paper*, Canadian HIV/AIDS Legal Network and the AIDS Law Project South Africa (2000)

Berger, Jonathan, *Litigation Strategies to Gain Access to Treatment for HIV/AIDS: The Case of South Africa's Treatment Action Campaign*, WISCONSIN INTERNATIONAL LAW JOURNAL, 20, 595-614 (2001-2002).

Friedman, Steven, Mottiar, Shauna, *A rewarding engagement? The treatment action campaign and the politics of HIV/AIDS*, POLITICS AND SOCIETY, 33(4), 511-565 (2005).

Heywood, Mark, *Preventing Mother to Child HIV Transmission in South Africa: Background, Strategy and Outcomes of the Treatment Action Campaign's Case against the Minister of Health*, SOUTH AFRICAN JOURNAL OF HUMAN RIGHTS 19 (2003).

Available Online: <http://www.tac.org.za>

Jones, Peris, *"A Test of Governance": Rights-Based Struggles and the Politics of HIV/AIDS Policy in South Africa*, POLITICAL GEOGRAPHY 24(4), 419-47 (2005).

Power, Samantha, *The AIDS Rebel*, THE NEWYORKER (May, 2003).

MINIMUM CORE OBLIGATIONS AND POSITIVE RIGHTS

What Does "Minimum Core" Mean and Where Does It Come From?

The idea of a minimum core of social and economic rights was suggested by the United Nations Committee on Economic, Social and Cultural Rights. The idea is that every person is entitled to a base level of economic and social rights. For example, every person could be entitled to a specific level of health care, income, education, and so on. The UN suggests that not only individual states but also the international community are responsible for ensuring this minimum core of social and economic rights. The minimum core interpretation of social and economic rights would allow individuals to argue that both their own government and the international community is in breach of international law (provided they have ratified a social and economic rights treaty) if they have not met their minimum core obligations.

The difficulty in defining a minimum core of social and economic rights is often debated. Some think it is impossible to define the scope of such a right while others think there are certain

things that must necessarily fall within its bounds. For example, some argue that access to emergency surgery for life threatening medical conditions would certainly be part of the minimum core of health care rights and access to income to feed yourself and your dependants would necessarily be part of the minimum core of economic rights.

Minimum Core Obligations in South Africa

The South African Constitutional Court had twice previously ruled on the idea of a minimum core of economic rights before the TAC case reached them. The first case to reach the Constitutional Court on social and economic rights was *Soobramoney v. Minister of Health* in 1997. In this case a diabetic man sued the Minister of Health for violating his right to health by failing to provide regular renal dialysis to prolong his life. The Court found that this was not a violation of the right to health because the hospital was reasonable in its allocation of scarce resources.

The next case on social rights to be argued in front of the Constitutional Court was *The Government of Republic of South Africa v. Grootboom, et al.* In this case Irene Grootboom argued that the state had violated her right to housing by forcibly evicting her and others from their shacks and tents set up on vacant (though privately owned) property and by bulldozing and destroying their homes and private property. The Court found that the government had not met its Constitutional obligation to take reasonable steps to progressively realize the right to adequate housing within their available resources. They found the government's actions were unreasonable because the government had taken basically no steps to solve the homelessness problem. The Court specifically refused to find that the state had a minimum core obligation and found that while the right to housing in South Africa is in part informed by international law it is distinct from it.

The Court used similar reasoning in the TAC case. Interveners in *TAC v. Minister of Health* argued that the South African Constitution guaranteed a minimum core of essential health care

services necessary to maintain the dignity of all people. They argued for this by framing the right to health provision of the South African Constitution as imposing two separate obligations on the state. Section 27 of the South African Bill of Rights guarantees the right to health. It is broken into two sections. The first states that everyone has the right to health; the second states that the state has the obligation to take reasonable steps to progressively realize this right within its available resources. The plaintiffs argued that this creates both a minimum core obligation on the state and the obligation to take reasonable steps to further health care beyond the minimum core of rights. The Constitutional Court found that section 27 must be read as a whole and imposes no minimum core obligation on the state. The only obligation on the state, according to the court, is to act reasonable within its available resources to promote the good health of the people. The Court found no minimum core obligation based partially on precedent from Grootboom and Soobramoney, partially because it thought immediately providing a core set of economic rights would be impossible, and partially because it thought that the Court is not capable of determining what this minimum core of rights would consist of. The failure of this line of argument had few practical implications in this case because the Court found the actions of the government did not pass the reasonableness requirement under section 27.

The plaintiffs also made arguments that even if section 27 only created an obligation on the government act reasonably, the right to health of children contained in section 28(1)(c) does not mention reasonable steps and thus confers an obligation on the state to supply a minimum core of basic health care services to children. Section 28(1)(c) says that every child has the right to basic nutrition, shelter, basic health care services and social services. Section 28 does not contain a limiting provision like section 27 does. The court did not rule on this argument so it is still open to courts in South Africa to find that while there is no general obligation to provide a minimum core of health care services, there is in the case of children.

One of the possible ramifications of relying only on a standard of reasonableness within available resources is it does not necessarily force the government to prioritize where its

resources are going. The Court would be able to find the state had not breached its obligation to provide health care if resources were limited due to military spending or corporate tax breaks. A minimum core obligation would force the state to set aside a certain amount of money for social and economic rights and the state would have to budget around these expenditures. Some theorists believe this is the only way to ensure social welfare and some think this would be a violation of the separation of powers and would allow unelected judges the power to make policy.²³

Conclusions

Even though international law supports the interpretation of health care rights as imposing a minimum core obligation on the state and on the international community as a whole, no such obligation exists in South Africa at the present time. While such an interpretation may cause problems with enforcement and definition, it may be the only way to create accountability in the allocation of funds. The need for this type of accountability should be weighed against the possible dangers this type of judicial power could have. Legitimate governments should be able to make policy choices and unelected judges should not. However, as the South African government proved, even democratically elected officials can grossly violate human rights. Legislatures should be prevented by the courts from making legislative choices that violate the fundamental rights of the people. If a certain standard of health is a fundamental human right then legislatures should be forced to make it a priority and expend the appropriate resources on it. The pressure of a definable and concrete standard of services could be the only way to force a state to devote adequate resources to the promotion of socio-economic rights.

Discussion Questions

- Does a minimum core obligation violate the doctrine of the separation of powers and endanger democracy?
- Is it the responsibility of the international community or the national government to insure that the minimum core rights are being fulfilled?

- What rights should be part of the minimum core and how should these rights be determined?
- Could s.7 of the Canadian Charter of Rights and Freedoms be read as imposing a minimum core obligation on the state?

Additional Reading

Bilchitz, David, *Towards a Reasonable Approach to the Minimum Core: Laying the Foundations for Future Socio-Economic Rights Jurisprudence*, SOUTH AFRICAN JOURNAL OF HUMAN RIGHTS, 19(1), 1-26 (2003).

Forman, Lisa, *Ensuring Reasonable Health: Health Rights, the Judiciary, and South African HIV/AIDS Policy*, JOURNAL OF LAW, MEDICINE AND ETHICS (Winter 2005).

Kende, Mark, *The South African Constitutional Court's Construction of Socio-Economic Rights: A Response to Critics*, CONNECTICUT JOURNAL OF INTERNATIONAL LAW, 19 (Summer 2004).

WOMEN'S RIGHT TO HEALTH

The right to health is guaranteed by international treaties that South Africa has signed and ratified such as the International Covenant on Economic, Social, and Cultural Rights as well as by the South African Constitution. The first South African court case to find that the government owed the people positive rights under the Constitution was the *Republic of Africa v Grootboom*. In this case the Constitutional Court found that the right to housing in the South African Bill of Rights created positive obligations on the government to take reasonable steps to provide adequate housing.

The Constitutional Court in *Minister of Health v. Treatment Action Campaign* used the same reasoning to find that the right to health contained in the Bill of Rights created a positive obligation on the government to take reasonable steps to provide adequate health care. The

Court focused on the violations of the right to health of children, but the lack of a comprehensive MTCT of HIV prevention programme is also a violation of the right to health of women.

Women's Health Concerns Related to MTCT

Women have the right to be informed of all the health care options available to them and to have reasonable access to these services. A pregnant woman is entitled to proper HIV counselling and testing so that she knows what effect the pregnancy will have on her health. Pregnancy can be dangerous to the health and wellbeing of HIV positive women. A woman may decide not to continue a pregnancy if she thinks there is a good chance that the child will be infected with HIV. If there is a safe and cost effective way of lowering this risk a woman is entitled to be informed of it and have access to it so that she can make decisions about her medical care. If a woman does not have access to drugs to lower the risk of transmission she may opt for an abortion rather than risk her health and infect her child. Safe and legal abortions have possible health, ethical and social consequences. In many areas of the world safe and legal abortions are not available to all women and thus they must undergo dangerous procedures. The WHO estimates that 19 million women undergo unsafe abortions every year and that they result in 68,000 deaths.

Section 27 of the South African Bill of Rights and Article 12 of the Convention on the Elimination of All Forms of Discrimination against Women specifically include the right to reproductive health. The right to reproductive health should include the right to have healthy and viable children whenever possible. HIV affects a woman's ability to have healthy children and thus the state is under an obligation to take reasonable steps limit this deleterious effect.

It could be argued that it is also a violation of the right to health to cause undue mental suffering to a patient. A pregnant HIV positive woman is already under a great deal of stress. If

unreasonable barriers are erected that make it more difficult for her to realize her goal of having a healthy child than that is a violation of her right to mental health.

Children's Rights v. Women's Rights

While TAC included appeals to women's rights in their arguments, both the High Court and the Constitutional Court focused on children's rights, as do most commentators on the case. The reasons why children's rights predominate in discussions of this case are obvious. Children's lives are at risk when steps are not taken to prevent the transmission of HIV from mother to child. Children are wholly innocent and it cannot be claimed that they have contracted this virus from being sinful or immoral. The sickness and death of a child is often seen as more of a tragedy than that of an adult and has the ability to garner international attention. All of these reasons create an incentive for advocates to argue issues from a children's right perspective and cause any women's rights concerns to be pushed to the background.

Combining Children's Rights and Women's Rights

Historically women's rights have been argued together with children's rights. This is due to a number of factors. The first is that, as previously mentioned, children's rights often have more weight in the public discourse and so, to gain attention for a women's rights issue, a shrewd advocate will often attach it to a children's rights issue. The second is that gender norms have created a great emphasis on the role of women as mothers. Both men and women often see women as caregivers. A woman is supposed to desire motherhood and a mother is supposed to be selfless in her love and care for her children. This is not an ideal of motherhood and womanhood, for many it is the only natural way. In many societies the institution of motherhood proclaims that a woman's first thought should be for her children and only after their needs are met should she consider her own needs. Therefore, when a women's health, financial wellbeing, education or housing is threatened the implications that will have on her

care giving capacity are naturally brought to the fore, both in social discourse and in the mind of the woman.

Children's rights have not always reciprocated this relationship. Children's rights activists do not need to stress connections with women's right in order to be heard. When the rights of a child are threatened the connection that has with the rights of her or his mother is not always obvious.

The fact is women's rights and children's rights are often inexorably connected. "It is during the pre- and post-natal periods that there are the strongest links between women and children. This is understandable, as this is the one time in a child's life when the lives of women and children are inextricably intertwined."²⁴ The health of the pregnant woman has a direct bearing on the subsequent health of the child. Whether the pregnant woman can afford medicines, vitamins, proper nutrition, adequate shelter, and labour assistance can all affect how healthy the child will be. The child has an interest in whether her or his mother is in a violence free environment during her pregnancy. The child has an interest in the working conditions of her or his mother during her pregnancy. The lack of a support network including daycare, welfare, counselling services, rent controlled housing, labour regulations and food banks can all factor into a woman's decision not to carry a pregnancy to term . During pregnancy at the very least, children's right cannot be divorced from women's rights.

Due to women's role in society as caregivers, the interconnection of women's rights and children's rights remains long after birth. The right to education of a child can be threatened if the child must stop going to school in order to help provide for the family. This is sadly often the case for single mother families. If the primary or only caregiver to the child must work long hours to financially support the family, the child will suffer. If a child sees her or his mother abused, dehumanized, or discriminated against, the child will suffer. If the primary or only caregiver to the child becomes sick or dies due to inadequate health care, the child will suffer. Children need care, they need resources, and they need positive role models. In many

countries the responsibility to provide these things falls almost exclusively on women. If women's rights are violated they often cannot properly fulfill this function and children suffer for it.

Women's Rights or Mother's Rights?

There are problems with only considering the connections between women's right and children's rights. The problem is that it often leads to women being valued and deemed worthy of having rights primarily because of their reproductive capacities. It is important to look at women's rights as human rights, i.e. as rights they are entitled to simply in virtue of being human. These rights include the right to autonomy, security of the person, health, life, education and work. Therefore, when a pregnant woman claims she has the right to receive health care it is not only because her health will impact the health of her future child, it is because she is a person and as such has the right to health care. When a single mother argues she has the right to adequate housing it is not only because she is responsible for the care of children, it is because she herself is deserving of shelter and care.

Children's rights are sometimes framed in such a way that they could do harm to women's rights. The Convention on the Rights of the Child, for instance, states in the preamble that the family is "the fundamental group of society and the natural environment for the growth and well-being of all its members and particularly children."²⁵ Some feminists have argued that this stress on family is deleterious to women's rights. Women, especially women in traditional cultures, experience powerlessness, violence, rape, and even death at the hands of their family. This is not to say that family is inherently evil and bad for women, it is only to say that children's rights activists should be careful in exulting the virtues of the family without qualification.²⁶

It may seem as though these are purely academic distinctions and that there are no practical implications on whether you argue from a children's rights (or even a woman as caregiver's rights) perspective or a women's rights perspective. This, however, is not the case. This is clear

when you look at cases where women's rights and children's rights conflict. A good example of this is the Canadian Supreme Court case of *Dobson v. Dobson*. In this case a child was injured in utero and sued his mother for causing these injuries due to her dangerous driving. Under Canadian civil law the born alive fiction allows children born alive and viable to sue third parties for injuries they suffered in utero even though they were not legally a person at the time of the injury. The Supreme Court in *Dobson*, however, found that mothers cannot be sued by their children for injuries suffered in utero due to the infringement on the rights of women it would cause. The court balanced the right the child had to compensation for his injury with the right of the mother to autonomy and found that the mother's rights outweighed the child's rights. If this case was only judged from a children's rights perspective or if Mrs. Dobson was only accorded rights in virtue of her reproductive capacity the decision of the Court would likely have been different.

Women's Rights and the Prevention of MTCT

Dobson v. Dobson was a case where there was an obvious conflict of women's and children's rights. The possible conflict is not always so readily apparent until a rigorous women's rights analysis is completed. Such is the case of the issue of the prevention of MTCT of HIV. It seems as though there would be no real conflict between the right to life and health of infants and women's rights when it comes to the transmission of HIV. Mothers do not tend to want their children to have HIV. There are, however, women's rights issues related to the implementation of any transmission prevention programme.

The quest to save children from HIV infection cannot lose sight of the fact that women have the right to make informed choices about what happens to their bodies. Some argue for mandatory HIV testing for pregnant women, and if positive, mandatory transmission prevention treatment. This would constitute a major violation of a woman's right to autonomy. There are many states that operate under an opt-out policy for testing pregnant women for HIV. This kind of testing system can also lead to violations of women's rights. Many women are not

adequately informed that they may opt out, are coerced by health care providers to submit to testing, and denied full pregnancy care if they do opt-out of testing.

Many focus on the prevention of transmission of HIV from an infected woman to her child overlooking the fact that a preventable tragedy has already occurred. The fight to prevent children from contracting HIV from their parents would be well served by trying to prevent women from becoming HIV positive in the first place. It is only when children's rights are pursued with no regard for women's rights that conflicts can occur. The focus should be on providing women with the tools for protecting themselves from HIV and for making informed reproductive decisions if that fails.

The Glion Call for Action issued by the WHO recognizes this. It states that there are four necessary elements to a prevention of MTCT campaign: "1. preventing primary HIV infection in women, 2. preventing unintended pregnancies in women with HIV infection, 3. preventing transmission for HIV for infected pregnant women to their infants, and 4. providing care, treatment and support for HIV-infected women identified through PMTCT [prevention of mother-to-child transmission] or voluntary counselling and testing (VTC) programmes and their families."

A programme of this magnitude would include educational programmes, women's support networks, and the availability of barrier methods of contraception along with the creation and enforcement of other positive and negative women's rights so that women are not held hostage to the demands of men. Women need the legal system to give them the power to insist that their sexual partners use protection. This power could be achieved by having laws that do not discriminate against women in marriage, by giving women social and economic rights so that they can leave an abusive relationship and are not forced to turn to prostitution to support themselves and their children, and by outlawing certain cultural practices that put women at risk for HIV infection, such as widow inheritance. Women need the legal system to protect them from rape and prosecute those who commit it. A comprehensive programme to

prevent HIV in both women and children would put measures in place to protect the confidentiality of women so they felt safe getting tested for HIV. It would supply contraceptives and counselling on the use of contraceptives so HIV positive women could control their fertility. It would give HIV positive women the option of having a safe and legal abortion so as not to risk their own health or the health of their potential child. It would provide unbiased counselling for women so that they are able to give free and informed consent for testing and treatment. It would offer counselling on the risks and benefits of breastfeeding when HIV positive so that a woman can make an informed choice about what is best for her and her child, and provide formula and access to clean water if she desires in order to make her choice as feasible as possible. It would fund clinics, programmes and legal enforcement measures in rural communities so these rights, laws and policies do not just exist on paper but actually effect the lives of the most vulnerable women. A comprehensive HIV prevention programme would realize that the best way to achieve a healthy and productive population is to have healthy women give birth to healthy children, not to create a society of orphans. The best way to achieve this is to give women as many practical options as possible. Nevirapine, while a good option for women who are already infected, pregnant, and who choose to give birth to the child, has many drawbacks. A single dose given to the women during labour cannot save or even prolong the life of the woman. It cannot provide care for the child after her or his mother is dead. It cannot prevent the mother from passing on the virus to her child through breastfeeding or from passing on the virus to another sexual partner. It is a great, cost effective, “when all else fails” measure, but protecting women’s rights in general is the only way to ensure healthy productive women, and it is healthy, productive women who give birth to and care for healthy, productive children.

Women’s Rights and the TAC Case

TAC made use of both children’s rights and women’s rights in their arguments for the prevention of mother-to-child transmission of HIV. TAC, however, did not argue for the type of comprehensive HIV prevention programme suggested above. This may have been because

they felt they had the strongest case for a more limited programme and wanted to pursue a step-by-step strategy for pushing for a comprehensive HIV prevention programme. All TAC argued for was for nevirapine and formula to be made available in hospitals in the public health care system that had existing testing and counselling facilities. The Constitutional Court agreed that nevirapine should be made available but stopped short of ordering the government to provide formula. The court mentioned that nevirapine should not be administered without proper counselling and testing of HIV. The Court did not discuss any other women's rights issues related to the implementation of a prevention of mother-to-child transmission of HIV programme. While this judgment was not the place for the court to make specific suggestions for further HIV prevention initiatives, the Court could have used this opportunity to call on the government to take greater steps to prevent the transmission of HIV to women in the first place. The Court also could have stressed the importance of informed consent, confidentiality and respect for women's rights in these matters. The fact that the Court spent so little time discussing the impact that this issue has on women and focused almost exclusively on the rights of children shows how easily women's rights can be forgotten when children's rights are in question.

Conclusions

Women have the same rights to health as everyone else does. These rights belong to women, not because they are mothers, wives, or caregivers, but because they are people. The health of women impacts the health of the community because of their role as mothers, wives, and caregivers. This connection should not be ignored. However, women's role in society and their biological functions should never outshine their humanity. The lives of women are just as important as the lives of their children. Even in cases where the outcome of a children's rights argument and a women's rights argument seems to be the same, women's rights should be accorded equal weight. Even in cases where children's rights arguments seem the most persuasive, women's rights should never be put in the background. To push aside women's rights is to leave women vulnerable to abuses of their health, dignity and autonomy. It is to reinforce the idea that women are valuable as a means to reproduction and not as an end in

themselves. From both a practical standpoint and an ethical standpoint women's rights should be pursued concurrently and with the same vigour as children's rights. This means that a prevention of MTCT of HIV programme should first and foremost strive to prevent the infection of women with HIV. If this fails women should be given all the tools possible to make sure they can avoid pregnancy if that is their choice or to have a safe and healthy pregnancy resulting in a healthy child if that is their choice. Proper regard for the right to health of women is not only a moral imperative, it is the only way to properly combat HIV/AIDS.

Discussion Questions

- Given that Canada has ratified the International Covenant on Economic, Social and Cultural Rights, should there be a positive right to healthcare in Canada?
- What are the normative and practical consequences of arguing for women's rights qua their role as mothers instead of as simply women?
- Should less money be spent on prevention of MTCT programmes and more spent on the prevention of the initial infection in women?
- Does the institution of motherhood positively or negatively impact women's rights?

Additional Reading

Center for Reproductive Rights, *Pregnant Women Living with HIV/AIDS: Protecting Human Rights in Programs to Prevent Mother-to-Child Transmission of HIV* (2005).

Available Online: <http://www.reproductiverights.org> (June 16, 2006).

Center for Reproductive Rights, *HIV/AIDS – Reproductive Rights on the Line* (2002).

Available Online: <http://www.reproductiverights.org> (June 4, 2006)

de Bruyn, Maria, *HIV/AIDS and Reproductive Health – Sensitive and Neglected Issues*, Ipas (2005). Available Online:

http://www.ipas.org/publications/en/HIVLITREV_E05_en.pdf (June 4, 2006).

Evans, Judith, *Children's Rights and Women's Rights: Challenges and Opportunities*, DEVELOPMENT, 44(2) 7-14 (2001).

Fitzpatrick, Joan, Slye, Ron C, *Republic of South Africa v. Grootboom / Minister of Health v. Treatment Action Campaign*, THE AMERICAN JOURNAL OF INTERNATIONAL LAW, 97(3), 669-80, (2003).

Jain, Devaki, *Children's Rights and Women's Rights: Some Connections and Disconnections*, DEVELOPMENT, 44(2) 58-62 (2001).

Kitts, Jennifer, Lal, Sonika, *Towards Greater Integration of HIV/AIDS and Sexual and Reproductive Health and Rights*, Action Canada for Population and Development (2005).

Available Online:

<http://www.acpd.ca/pdf/Report%20on%20Integration%20of%20HIVAIDS%20and%20SRHR%202006.pdf> (June 26, 2006).

Olsen, Frances, *Children's Rights: Some Feminist Approaches to the United Nations Convention on the Rights of the Child*, INTERNATIONAL JOURNAL OF LAW AND THE FAMILY, 6, 192-220 (1992).

Rich, Adrienne, *Of Woman Born: Motherhood as Experience and Institution*, New York: W.W. Norton & Company (1976).

Schoofs, Mark, *AIDS: The Agony of Africa, Part 5: Death and the Second Sex*, THE VILLAGE VOICE (Dec. 1-7, 1999). Available Online: <http://www.villagevoice.com/> (July 5, 2006).

Spectar, J.M., *The Hydra Hath but One Head: The Socio-Cultural Dimension of the AIDS Epidemic and Women's Rights to Health*, 22(1) BOSTON COLLEGE THIRD WORLD LAW JOURNAL, 1-34 (2001).

RIGHT TO FOUND A FAMILY

When discussing women's sexual and reproductive rights the right to decide when not to have children is often in the foreground. A woman's right to abortion and contraception are not the only rights women have in relation to their reproductive capabilities. Article 16(1)(e) of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) says that women have the right to "decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to

exercise these rights.” The International Covenant on Civil and Political Rights (CCPR) states that all people have the right to marry and found a family. This applies regardless of sex, socio-economic status or disability. The General Comment explaining this right states that it “implies, in principle, the possibility to procreate and live together. When State parties adopt family planning policies, they should be compatible with the provisions of the Covenant and should, in particular, not be discriminatory or compulsory.”²⁷ Therefore, women with HIV have the right to have children.

This right could be read as only a negative right to be free from governmental interference on matters of marriage and childbirth or it could include some positive obligations on the state to facilitate the founding of a family. Many states have attempted to enact laws to prevent HIV positive women from marrying or having children, have used forced sterilization campaigns, or have made it governmental policy to try to dissuade these women from conceiving or carrying a pregnancy to term. People often justify these policies by claiming “that women's ‘culpable’ conduct causes ‘innocent’ suffering and must be stopped.”²⁸

These are all clear violations of the right to found a family as well as equality, autonomy and security of the person rights. South Africa does not have and has never had laws that prevent women with HIV from having children. Therefore, if the right to found a family is read as only a negative right then South Africa is not in breach of its legal obligations in this respect.

A Positive Right to Bear Children?

The right to found a family can also be read as requiring the government to take positive steps to promote this right. It seems in the least that the Women’s Convention should be read that way since it speaks of the right to the “means to enable them to exercise [reproductive] rights.” It could, for example, require that the government take reasonable step to provide infertility treatment, or to implement educational initiatives to prevent the spread of sexually transmitted diseases that can cause infertility. Not only does infertility have the obvious effect

of preventing women from having children, infertile women can often not marry or are abandoned by their husbands when they cannot produce children in many cultures. Social, religious or familial pressure to have children can turn women without children into outsiders in their communities.

The unreasonable withholding of medication that would help prevent MTCT of HIV could also be considered a violation of the right to found a family in that it prevents many women from making the choice to have children because of the health risks to the child. Professor Cook, for example, argues that the right to found a family must include “the right to maximize the survival of a conceived or existing child.”²⁹ Professor Cook speaks of this right in reference to early marriage and the availability of abortion and contraceptives to space children. However, this right would seem to apply equally to HIV infected mothers who want to maximize the survival of their children.

Many object to this line of reasoning because if a mother cannot afford to buy the medication to prevent MTCT she will not be able to afford antiretroviral drugs for herself. If she cannot buy the medication for herself it is likely that she will die in the next few years. Without treatment the median survival time for HIV infection is about nine years.³⁰ Many think it is irresponsible for a woman to choose to have a child even if the child’s health could be assured if she is likely to be too sick to care for it or die before it can reach adulthood. HIV has created 11 million orphans in Africa, many of whom are also infected with HIV.³¹ Even with ART treatment and formula feed there is still a chance that the infant could be infected with HIV. It is considerations such as these that make some people resistant to prevention of MTCT of HIV programmes because they fear that it will encourage HIV positive women to conceive children.³²

These issues certainly weigh on many women’s minds when they are trying to determine whether or not to have children or what to do about an unplanned pregnancy. No matter what anyone else might think of a woman’s choice, it is hers and hers alone. The state should take all

reasonable measures to ensure that that choice is as safe and feasible as possible. If medication to prevent the child from becoming ill is available and within the means of the state it should be freely given to any woman who chooses it.

Right to Enjoy the Benefits of Scientific Progress

Article 15 of the International Covenant on Economic, Social, and Cultural Rights (CESCR) states that everyone has the right to “enjoy the benefits of scientific progress and its applications.” This right is often invoked along side the right to bear children to argue for the right to receive reproductive assistance. Much of the argumentation on this front comes from infertile couples wishing to receive state funded in-vitro fertilization or other fertilization treatments. This right could also apply to HIV positive people seeking the benefit of new drugs. The traditional argument against the widespread enforcement of this right is cost. New technology is often prohibitively expensive for governments to fund. In the TAC case, however, the benefit of scientific progress TAC was seeking was largely without cost. Since the drug was deemed safe by a vast majority of experts the state had no legitimate ground for keeping this new technology from women who needed it. This application of the right to the benefit of scientific progress is relatively uncontroversial. Other than the resistance to allowing HIV positive women the right to bear children at all, there are few who wish to keep drugs that could save the life of an infant from pregnant women. The controversial aspect of this right in relation to HIV positive women is when it is applied to HIV positive women who cannot become pregnant on their own. HIV/AIDS can cause many problems for men and women who wish to have children. There are many couples where only one partner is infected and who wish to conceive a child while protecting the uninfected partner. There are both men and women who have problems conceiving because of AIDS related infections. Many of these people seek the help of fertility experts only to be turned away because of their HIV status. They argue that the right to the benefit of scientific progress without discrimination includes the right to receive fertility treatment regardless of being infected with HIV.

Conclusions

The negative right to bear children is clear under international law. No matter what anyone may think of the moral standing of the decision to have children when infected with HIV a woman has the right to make her own reproductive choices. The status of a positive right to bear children is much more contentious. Many argue against assisted reproduction on religious grounds. Many think money could be better spent on other areas. In the TAC case the assistance requested had little to no cost. The women were able to conceive “naturally” and so there was not a religious dimension in the way their often is to these issues. These women wanted assistance so that they could have healthy children. The right to bear children should at least encompass situations such as these. HIV positive women have the right to have children. Arguments that a prevention of MTCT of HIV programme might encourage them to exercise this right are irrational. The state cannot do something indirectly that it cannot do directly. The state cannot legally prevent HIV positive women from having children so it cannot practically prevent them from doing so by withholding medication that would make this possible when there is no justification for doing so.

Discussion Questions

- Should all women, regardless of the health risks to the child, be legally allowed to give birth?
- Does the right to found a family include positive duties on the state to assist in the realization of healthy children?
- Should doctors be allowed to refuse fertility treatment to HIV positive women on ethical grounds?

Additional Reading

Cook, Rebecca J, *Human Rights and Reproductive Self-Determination*, 44 AMERICAN UNIVERSITY LAW REVIEW, 975-1016 (1995).

Cook, R., *International Protection of Women's Reproductive Rights*, NEW YORK UNIVERSITY JOURNAL OF INTERNATIONAL LAW AND POLITICS, 24 (1992).

de Bruyn, Maria, *Reproductive choice and women living with HIV/AIDS*, Ipas (2002).
Available Online: http://www.ipas.org/publications/en/repro_choice_hiv_aids.pdf
(June 14, 2006).

Forder, Caroline, *Human Rights Aspects of Assisted Procreation: A European Perspective*, 1(2) JOURNAL OF WOMEN'S HEALTH AND LAW 167-207 (1999-00).

Packer, C., *The Right to Reproductive Choice: A Study in International Law*, Turku: Abo Akademi University, Institute for Human Rights (1996).

DISCRIMINATION AND EQUALITY RIGHTS

Equality rights are almost without exception found in every international human rights document and national constitution. Unlike the right to health or other second generation positive rights, which hold questionable legal status in many parts of the world, the right to equality retains much of its force when argued as only a negative right. A comprehensive right to equality dictates that whatever a government undertakes, whether or not it has a legal obligation to perform that service, it must do so without discriminating against a particular group. Therefore, if the government has undertaken the responsibility to provide healthcare services, the services it provides cannot discriminate against women. Failing to provide medication that only a woman needs is a form of gender discrimination if there is no reason for the failure to provide it. The right to health must be exercised to the equal benefit of men and women. Women's sexual and reproductive health has been treated by many governments throughout history as an extra benefit instead of a necessity, if it has been considered at all. Professor Rebecca Cook explains that health problems brought about by pregnancy and

childbirth were “explained as destiny and divine will.”³³ Pregnancy was considered and is still considered by many as a natural process that cannot be served by modern medicine and legislation. Some think of death and disability caused by pregnancy as part of the circle of life and unpreventable. Women’s reproductive and sexual health concerns also must deal with the deep stigma surrounding sex that exists in most if not all countries. Sex and reproduction are seen as private if not embarrassing and taboo subject matters which have no place in public discourse. The relegation of sex and reproduction to the private sphere and the characterization of pregnancy and childbirth as “natural” in some special way have created a health care system that is unresponsive to many women’s needs. Women’s sexual health and reproductive rights must be treated as valid and pressing concerns by governments and not as a luxury to be dealt with when and if excess funds become available. One way to achieve this is by utilizing the equality rights enshrined in most human rights documents.

Advantages and Disadvantages of an Equality Argument

The two main advantages of an equality argument are its widespread availability and its ability to address pervasive and systemic discrimination. As mentioned above, equality guarantees are found in most, if not all, human rights documents. Even countries that do not have a strong record of positive human rights protection have guarantees of equality. Sex is a legally recognized ground of discrimination all over the world. There are only a few countries in the world that recognize a human right to health care services, or any other positive right. Even those countries that have signed and ratified international treaties such as the International Covenant on Economic, Social, and Cultural Rights do not always recognize a substantive right to health care. Therefore, in many countries arguing for positive rights from an equality perspective is one of the only options available.

The other advantage to equality arguments is that they can showcase widespread discrimination in government spending when other types of arguments cannot. For example, a government could guarantee to take reasonable steps to progressively realize the right to

housing within the means of the state and still take actions in relation to housing that most would consider to be in violation of fundamental human rights. Let us imagine that that state issued a plan to realize the right to housing that consisted of funding the development of low income housing in certain key areas and promising further unspecified housing initiatives at a later date. A person living in an area that is not slated for low income housing development may wish to sue the state for failure to realize the right to housing but they would have the significant hurdle of proving that the plan issued by the state was not taking reasonable steps to realize this right. If the government could prove that it could not afford to create housing for everyone then the government would have a legitimate defence. Let us imagine, however, that the areas the government chose to begin development in were inhabited by a strong white majority and the areas they left to some unspecified date were inhabited by a strong black majority. Now it is clear that the state is not properly fulfilling its promise to promote the right to housing because its policies are discriminatory. In this example it is only by using an equality argument that the policies of the government can be properly critiqued and shown to be unreasonable. Cases in real life are often not quite so clear. It can be very difficult to prove that the policies of the state are discriminatory. Positive rights are imperfect. Governments do not and can not give people the absolute right to health, housing, education, and the like. Even the richest states cannot afford to provide perfect positive rights. Governments will always be able to point to a lack of resources as an excuse for a failure to provide a positive right, and sometimes this excuse is valid. When it is not valid, advocates often must point to principles of equality to show that the state is not properly fulfilling its obligations.

Even when the policy of the state can be shown to be inadequate without appealing to equality rights it is still advisable for human rights proponents to consider policies from an equality perspective. In the above example if the people living in the areas not chosen for development could show that the policy was unreasonable for some reason other than discrimination they might achieve the goal of having access to low income housing but the racist nature of the state might not be addressed. If a state is discriminatory in its allocation of funds for housing it is likely to be discriminatory in its allocation of other funds.

Discrimination and the TAC Case

TAC argued that the failure of the state to provide nevirapine to HIV positive pregnant women was in breach of the equality rights of women and minorities (since it was poor black women who were mostly affected). The South African Constitutional Court, however, did not treat the case as a discrimination case and neither do most commentators. There are many reasons why this is not treated as a discrimination case. The South African Bill of Rights and the previous case law made it clear that there is a positive right to health care in South Africa to some extent. It is often easier to argue these cases as infringing on the right to health or the right to life than equality rights. Arguing that certain practices constitute discrimination is very difficult when the discrimination is in the failure to provide something. Examining the issue from an equality perspective, however, can shed insight into the systemic way women's health concerns in general, and women's sexual health and reproductive rights in particular are marginalized by states all over the world.

Problems with Litigation: A Canadian Example

The Canadian Charter of Rights and Freedoms does not contain the right to health. Section 15(1), however, does state "every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination...based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability." In *Auton v. British Columbia* parents of autistic children challenged the failure of the government of British Columbia to fund a certain treatment for autism. They based part of their argument on s.15(1) of the Charter. The Supreme Court of Canada found that there was no violation of the right to equality because "funding for all medically necessary treatment" is not a benefit provided by law.³⁴ The finding of the Court in this case is a perfect demonstration of the difficulty in arguing equality rights. Since there is no right to comprehensive health care services in Canada the court ruled that the provision of certain treatments was a benefit not provided by law and thus s.15(1) did not apply. Many think this is the wrong conception of s.15(1) since it provides no

judicial review for governmentally conferred benefits. Under this interpretation the Canadian government could choose to fund benefits for only white people and not for other races or it could fund benefits for men and not women. There was no mention of international law in the decision of the Court in *Auton* even though Canada has signed and ratified both the International Covenant on Economic, Social, and Cultural Rights (CESCR) and the Convention on the Rights of the Child which deal with equality rights and health care. International law should inform domestic law and the court was remiss in not discussing their international obligations. The CESCR guarantees the highest standard of physical and mental health attainable to everyone without discrimination of any kind.³⁵ Funding medical services for one group and not another could easily contravene this right whether or not the health care service is provided for under domestic law. The Canadian Supreme Court sidestepped the question of whether or not refusing funding for the treatment of autistic children was discriminatory in either purpose or effect by using an unduly narrow interpretation of equality rights.

Conclusions

Women all over the world face discrimination, especially in reference to their sexual health and reproductive rights. Health care spending in many countries reflects this. People infected with HIV are also discriminated against inside and outside of the health care system in many countries. This is due to the fear of contracting the virus, the belief that those infected are immoral and have brought it upon themselves and the social taboos concerning sex. Therefore, women infected with HIV often face a tremendous amount of discrimination in reference to their sexual health and reproductive rights. Court cases focusing on the right to health of all people can help elevate the suffering of some of these women but cannot address the larger issues. There is a reason why the health rights of these women are ignored by states. Examining the reasons behind the discriminatory state policies can shed light on other areas where these women are discriminated against, other groups who are discriminated against in like ways, and can push a society towards a more holistic recognition of human rights.

Discussion Questions

- How can a state weigh competing health concerns in its attempt not to discriminate against any group in its allocation of scarce resources?
- Should the Constitutional Court of South Africa have discussed the discriminatory purpose or effect of the government's policy?
- Should governments have to operate under a principle of non-discrimination when conferring benefits as well as legal entitlements?

Additional Reading

Cook, R., *Exploring Fairness in Health Care Reform*, JOURNAL FOR JURIDICAL SCIENCE, 29(3), 1-27 (2004).

Finley, Margot, *Limiting Section 15(1) in the Health Care Context: The Impact of Auton v. British Columbia*, UNIVERSITY OF TORONTO FACULTY OF LAW REVIEW, (2005).

ADDITIONAL INFORMATION

TIMELINE OF CASE

1994	Discovery of mono-therapy with AZT reduces MTCT of HIV ³⁶ Nelson Mandela elected President of South Africa
1997	South Africa passed Medicines Act
Feb. 4 1997	South African Constitution Act 1996 comes into effect

<p>1998</p>	<p>Thai / Bangkok Study– a short course of AZT still brings about significant reductions in MTCT</p> <p>AIDS Law Project, the AIDS Consortium, and the Perinatal HIV Research Unit began to lobby the department of health to implement a program to prevent MTCT</p>
<p>Feb. 1998</p>	<p>Thirty-nine drug companies filed suit in Pretoria High Court over Medicines Act</p>
<p>May 18 1998</p>	<p>Gauteng Department of Health announces the establishment of 5 pilot sites where programmes to reduce MTCT would be introduced</p>
<p>Oct. 9 1998</p>	<p>Minister of Health announces the federal government will no long support the MTCT reduction plan of the Gauteng Health Department</p>
<p>Dec. 1998</p>	<p>The Treatment Action Campaign (TAC) is founded</p>
<p>1999</p>	<p>Thabo Mbeki becomes President of South Africa</p>
<p>July 1999</p>	<p>Results of HIVNET 012 trial reported which show that nevirapine can be used to reduce MTCT</p>
<p>Oct. 28 1999</p>	<p>Speech by President Mbeki calling into questions the safety of AZT</p>

<i>Nov. 16 1999</i>	Minister of Health Announces she has instructed the Medicines Control Council (MCC) to review the use of AZT
<i>Feb. 8 2000</i>	Press briefing by the Minister of Health rejecting the MCC report which supported the use of AZT to prevent MTCT of HIV
<i>April 3 2000</i>	President Mbeki sends letter to world leaders about AIDS policy in South Africa
<i>May 2000</i>	Minister of Health Produces its HIV/AIDS Strategic Plan for 2000-2005
<i>May 6 2000</i>	First meeting of the Presidential AIDS Advisory Panel for South Africa
<i>June 2000</i>	The preliminary results of the South African Intra-partum Nevirapine Trial (SAINT) began to leak out reinforcing the HIVNET 012 trial
<i>July 26 2000</i>	Letter sent by TAC to the Minister of Health threatening legal action if the minister does not make a commitment to prevent MTCT
<i>July 2000</i>	International AIDS Conference in Durban
<i>July 7 2000</i>	Boehringer Ingelheim announces that they will supply nevirapine to the South African Government for free for five years

<i>August 2000</i>	MinMEC (a committee composed of the Minister of Health and the Provincial Members of the Executive Committee (MEC) for Health) decided to first test nevirapine at 2 pilot sites in every province for 2 years after it is registered before deciding whether to make it available to the public ³⁷
<i>Nov. 12 2001</i>	Application by TAC to compel the government to produce the minutes of the August meeting of MinMEC
<i>Nov. 26 2001</i>	Government opposes the production of the minutes saying they are confidential. TAC withdraws appeal.
<i>April 17 2001</i>	Letter from TAC to the Chairperson of the MCC concerning the reasons why nevirapine had not yet been registered
<i>April 18 2001</i>	Formal registration of nevirapine for the prevention of MTCT of HIV by the MCC
<i>April 26 2001</i>	Letter sent by TAC to the Minister of Health concerning the delay in implementing pilot sites in four provinces
<i>April 30 2001</i>	Letter from the Minister of Health to TAC concerning pilot sites

<i>July 17 2001</i>	TAC sends letter to the Minister of Health demanding legally valid reasons for why MTCT preventions programs were being limited to pilot sites ³⁸
<i>Aug. 21 2001</i>	TAC, Dr. Haroon Salojee, and the Children's Rights Centre (CRC) in Durban file a notice of motion and founding affidavit with the Pretoria High Court of South Africa
<i>Nov. 25-26 2001</i>	Rallies and marches take place all around South Africa in support of the TAC case, including a 600 person all night vigil outside the court
<i>Dec. 14 2001</i>	TAC wins the High Court case against the Minister of Health
<i>March 1 2002</i>	Pretoria High Court hears application by the Minister of Health for leave to appeal to the Constitutional Court and an Application by TAC an immediate execution order
<i>March 11 2002</i>	Pretoria High Court issues judgments granting the Minister leave to appeal and granting TAC an execution order
<i>March 15 2002</i>	Minister of Health files appeal against execution order
<i>March 18 2002</i>	TAC files reply to Minister's appeal

<i>March 25 2002</i>	Judgment given by Pretoria High Court on whether interlocutory orders could be appealed. The Judge found they could not.
<i>March 26 2002</i>	Minister seeks leave to appeal the execution order from the Constitutional Court
<i>April 4 2002</i>	The Constitutional Court refuses the Minister leave to appeal the execution order
<i>May 2 2002</i>	<p>Constitutional Court case begins</p> <p>“Stand up for Your Rights” marches take place all over the country in support of the TAC case</p> <p>The Constitutional Court denied Professor Mhlongo’s application for admission as amicus curiae to dispute the findings of the studies that lead the MCC to approve of nevirapine for MTCT prevention.</p>
<i>July 5 2002</i>	The Constitutional Court dismisses the appeal by the Minister of Health
<i>Dec. 2 2002</i>	TAC lodges complaint with the Human Rights Commission against the Minister of Health and the MEC of Health of Mpumalanga
<i>Dec. 17 2002</i>	TAC starts contempt of court proceedings against the Minister of Health and the MEC of Health of Mpumalanga

<i>Feb. 14 2003</i>	TAC organizes “Stand Up for Our Lives” march to Parliament for HIV/AIDS treatment
<i>March 20 2003</i>	TAC launches civil disobedience campaign
<i>August 2003</i>	Government agreed to begin planning a national treatment programme
<i>2004</i>	South Africa started to distribute drugs

International Treaties

Universal Declaration of Human Rights

The Universal Declaration of Human Rights was adopted and proclaimed by the United Nations on December 10, 1948. While it is not a legally binding document, it has become part of customary international law because countries generally treat it as being such. The Declaration includes thirty articles that enumerate rights such as the right to life, liberty and security of the person, the right to an education, and the right to be free from torture.

International Covenant on Civil and Political Rights

The International Covenant on Civil and Political Rights (CCPR) came into being on December 16, 1966. It was founded on the Universal Declaration of Human Rights, which was split into two documents in order to encourage more signatories. The CCPR is a legally binding document once it has been ratified by individual countries. It contains 53 articles guaranteeing certain civil and political rights such as the right to life, the right to be free from torture and

slavery, the right to be presumed innocent, and the right to vote in free elections. A total of 152 states have ratified the CCPR including Canada, The United States, and South Africa. The Human Rights Committee of the UN monitors compliance with this treaty.

The CCPR also contains two optional protocols. The first optional protocol allows individuals from states who have ratified this protocol to submit complaints to the Human Rights Committee. States who have accepted the authority of this committee to hear these matters are bound by their decisions. There are 104 state parties to the first optional protocol including Canada and South Africa. The second optional protocol abolishes the death penalty. There are 50 state parties to the second optional protocol including South Africa.

International Covenant on Economic, Social, and Cultural Rights

The International Covenant on Economic, Social, and Cultural Rights (CESCR) came into being on December 16, 1966, at the same time as the International Covenant in Civil and Political Rights. It was founded on the Universal Declaration of Human Rights, which was split into two documents in order to encourage more signatories. The CESCR is a legally binding document once it is ratified by individual countries. It contains 31 articles guaranteeing certain economic, social, and cultural rights such as the right to health, education, special protection of mothers, and enjoyment of the benefits of scientific progress. A total of 149 have ratified the CESCR including Canada. The United States and South Africa have signed the CESCR but have not ratified it. The Committee on Economic, Social and Cultural Rights monitors compliance with this treaty.

Convention on the Elimination of All Forms of Discrimination against Women

The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) came into being on September 3, 1981. CEDAW is a legally binding document to those countries that have ratified it. CEDAW contains 30 articles that guarantee women such things

as the right to vote, the right to paid maternity leave, the right to equality before the law, and the right to health particularly during and after pregnancy. A total of 177 countries have ratified the CEDAW including Canada and South Africa. The United States is the only developed country not to have ratified CEDAW. The Committee on the Elimination of Discrimination against Women monitors compliance with this treaty.

On December 10, 1999 the UN opened an optional protocol for CEDAW for signatures. This protocol allows individuals or groups from states that have ratified the protocol to submit communications of violations of women's rights directly to the Committee on the Elimination of Discrimination against Women. The Committee then can make recommendations to the state and request a response from the state and, if necessary, ask for follow-up information from the state at a later period. A total of 60 countries have ratified this protocol including Canada. Neither the United States nor South Africa has ratified this protocol.

Convention on the Rights of the Child

The Convention on the Rights of the Child (CRC) came into being on November 20, 1989. The CRC is a legally binding document for those countries that have ratified it. The CRC contains 3 sections. The first section contains 41 articles containing such rights as the right to life, health and education for children. Children are generally defined by the CRC as people under the age of 18. The second and third sections of the CRC deal with compliance, signatures, ratification and other administrative issues. A total of 192 countries have ratified the CRC including Canada and South Africa, though Canada has made some reservations concerning the CRC. The United States has signed but not ratified the CRC. The CRC is monitored by the Committee on the Rights of the Child.

The CRC also contains two optional protocols. The first optional protocol concerns the involvement of children in war. A total of 107 states have ratified this protocol including United States and Canada. South Africa has not ratified this protocol. The second optional protocol

concerns the sale of children, child pornography and child prostitution. A total of 107 states have ratified this protocol including the United States, Canada and South Africa.

African Charter on Human and Peoples' Rights

The African Charter on Human and Peoples' Rights entered into force on October 21 1986. It was enacted by the Organization of African Unity, which later became the African Union (AU). It has been ratified by every member state of the AU. The oversight of the Charter is done by the African Commission on Human and Peoples' Rights, which was set up in 1987. The Commission originally had the responsibility of hearing complaints of violations of the Charter, but could not make binding decisions. In 1998 a protocol was adopted that called for the creation of the African Court on Human and Peoples' Rights.³⁹ The African Court on Human and Peoples' Right was to be established in 2004. Before it was established the African Union decided it would be amalgamated with the African Union Court of Justice. In 2005 the AU decided that the African Court on Human and Peoples' Rights should be established despite the fact that the Court of Justice was not yet operational. On January 22, 2006 the Executive Council of the AU elected 11 judges to sit on the African Court on Human and Peoples' Rights. The court will be able to make binding decisions on matters of human rights violations by states who have accepted the court's jurisdiction. At present 23 states, including South Africa, have ratified the optional protocol accepting the jurisdiction of the court. The court will be able to consider not only the African Charter on Human and Peoples' Rights but also any other international treaty dealing with human rights that the state has ratified. The court will also grant standing to non-governmental organizations and individuals.⁴⁰

The Charter contains three sections. The first section is on individual rights and duties. The chapter on rights contains 26 articles guaranteeing rights such as the right to life, liberty and security of the person, the right to equality before the law, and the right to health. The second chapter on duties contains three articles on duties that individuals owe to others and to their state including the duty to respect others, to pay taxes, and to promote African unity. The

second part of the Charter deals with the safeguarding of these rights and duties by the establishment of the African Commission on Human and Peoples' Rights. This part also deals with the mandate of the Commission and its procedure. The third part deals with the Charter itself and when and how it is ratified and altered.

In 2005 a protocol to the Charter on the rights of women entered into force. This protocol contains guarantees of equality rights, political rights, economic rights, as well as a section devoted entirely to sexual health and reproductive rights. Article 14 guarantees women the right to control their fertility, to choose any method of contraception, and to receive proper pre-natal, delivery and post-natal health services, among others. At present 18 countries, including South Africa, have ratified this protocol.

For More Information:

A handbook for advocacy in the African human rights system: Advancing reproductive and sexual health. Second edition: Ipas

http://www.ipas.org/english/publications/international_health_policies.asp

Center for Reproductive Rights, "Bringing Rights to Bear: An Advocate's Guide to the Work of UN Treaty Monitoring Bodies on Reproductive and Sexual Rights" (2002)

http://www.crlp.org/pdf/pub_bp_brb.pdf

Legal System of South Africa

The substantive law of South Africa is based on Roman-Dutch law. When the English defeated the Dutch settlers in 1806 the English did not impose their laws on the people of (now) South Africa and left intact the substantive law. The procedural law of South Africa, however, is largely based on the English system with adversarial trials and a hierarchy of courts. South Africa also operates under the principle of Stare Decisis which means that the decisions of

higher courts bind the decisions of lower courts. Other sources of law in South Africa are statute, custom, the South African constitution, and international laws and treaties.

South Africa's judiciary is composed of the Constitutional Court, the Supreme Court of Appeal, thirteen High Courts, and many Magistrate Courts. Magistrate Courts hear local matters dealing with minor criminal offences or small civil disputes. High Courts can hear appeals from the Magistrate courts and serious criminal offences. They also are the court of first instance for large civil disputes. The Supreme Court of Appeal is the highest court for all cases except constitutional cases and can hear appeals from all of the High Courts. On Constitutional matters the Constitutional Court is the highest court. It is composed of 11 judges and deals exclusively with Constitutional issues. An appeal can go to the Constitutional Court either straight from one of the High Courts or from the Supreme Court of Appeal. As in Canada, the appeal courts deal with questions of law and do not generally revisit questions of fact but instead rely on the findings of the trial court.

Civil Procedure

The rules of civil procedure for the High Courts are contained within the High Court Rules of Court. Proceedings can be launched in the High Courts in one of two ways: proceedings by way of actions and proceedings by way of application. In a proceedings by way of action evidence is given to the court orally by sworn witnesses. In a proceedings by way of application evidence is given to the court by written affidavits.

Application proceedings are prescribed by law in certain circumstances, are not permissible in others, and can be elected by the applicant in others. If the applicant has the choice to proceed by application or by action the applicant must consider whether there is a dispute of fact that cannot be resolved by written submissions alone. If the court finds that there is a dispute of fact that can only be settled by oral argument the court has three options. The court can dismiss the application if the applicant should have known it could not proceed by written

evidence alone. It can order a trial if the applicant could not have known a dispute of fact would arise that required oral arguments. Finally the court can hear oral evidence on a specified issue if the question of fact is narrow.

To begin an action by way of application a notice of motion must be filed with the court along with a founding affidavit. These set out the facts relied on by the applicant. The respondent must then file a replying affidavit with her or his version of the facts. The applicant can file other affidavits in response if appropriate. Applicants must submit to the court all relevant facts in their possession, even if they are unfavourable to their case.

To begin an action by way of action the plaintiff must serve a summons to initiate proceedings. After the summons both parties must submit pleadings to the court outlining the dispute between them. Following this is the discovery phase where the parties exchange evidence, examine the other party's witnesses and attempt to settle the dispute or narrow issues at a pre-trial. At the trial the oral evidence is given and the parties can address the court.

After all the evidence is given to the judge in either the application or the action the judge renders her or his verdict and awards costs. If a party is not satisfied with the judgement they can appeal to a higher court, however, no civil appeal is guaranteed by law.

The Constitution

The South African Constitution Act took effect on February 4 1997. The South African Constitution is similar to the Canadian Constitution. It creates a federalist state with the provinces having exclusive jurisdiction over provincial roads and traffic, cultural matters, liquor licenses and other minor areas of purely local concern. The provinces are able to legislate on other matters such as health care, housing, education and the environment, but the federal government can override provincial legislation. The Constitution also provides for the separation of powers into a legislative, and executive and a judiciary branch.

The South African Constitution also contains a Bill of Rights. The Bill of Rights contains both negative rights, such as the right not to be subjected to slavery, and positive rights, such as the right to healthcare. Section 36 of the Constitution allows for limitations on individual rights if they are “reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom.” Section 37 allows certain rights to be violated in cases of emergency.

For More Information:

Van der Merwe, C. G. (2004). Introduction to the Law of South Africa. The Hague, Netherlands : Kluwer Law International.

STUDIES ON AZT AND NEVIRAPINE

AZT AND NEVIRAPINE

Both AZT and nevirapine are drugs used for antiretroviral therapy in the treatment of HIV. AZT was the first drug approved for treatment of HIV. AZT is also known as zidovudine, azidothymidine, or ZDV. It works by preventing the virus from converting its own genetic material (RNA) to the DNA of the cell it has infected. If the virus cannot convert the DNA of the cell it cannot replicate and therefore the progression of the virus is slowed.⁴¹ The Thai / Bangkok Study found that AZT can be used to help reduce Mother-to-Child Transmission (MTCT) of HIV. To reduce MTCT AZT must be administered starting at least at 36 weeks of pregnancy, as well as given during labour. Some courses of treatment also call for the infant to be given AZT for six weeks after birth. This cost of treatment ranges from about \$50 to \$1,000 per pregnancy.⁴² GlaxoSmithKline originally held the patent for AZT but that expired in 2005 so generic versions of the drug can now be manufactured.

Nevirapine, which is also known under the trade name Viramune®, reduces the production of enzymes called reverse transcriptase. The HIV virus uses these enzymes to make more of the

virus. Therefore, by lowering the activity of these enzymes the progression of the virus is slowed.⁴³ The HIVNET 012 study and the later South African Intra-partum Nevirapine Trial (SAINT) have shown that nevirapine can also be used to prevent MTCT with even better results. To help prevent MTCT a single dose of nevirapine is given to the mother during labour and the child following birth. The cost of this treatment is about \$4 per pregnancy. Nevirapine is currently under patent by Boehringer Ingelheim.

HIVNET 012

HIVNET 012 is a study that took place over 18 weeks in Kampala Uganda which demonstrated that a short course of nevirapine given to mother and child during and shortly after labour is effective in reducing Mother-to-Child Transmission (MTCT) of HIV. The results of the preliminary study were released in July 1999 with a five year follow-up completed in 2004. In the study 642 HIV positive women were randomly selected for the trial. About half the women received a single oral dose of nevirapine at the onset of labour and a single oral dose of nevirapine was given to the infant at 24-72 hours old. The other half of the women were given an oral dose of AZT every three hours from the onset of labour to delivery. The infant was given AZT twice a day for seven days. Nearly all the children were breast fed until at least 16 weeks. By week 16 the estimated risk of MTCT of HIV was 25.1% for AZT and 13.1% for nevirapine. Side effects were few, mild and similar between the two test groups.

The results of the HIVNET 012 study have been called into question due to the perception by some of the lack of scientific rigour and deficiencies in quality control⁴⁴. The study was not meant to serve as a backbone for the approval of nevirapine for the prevention of MTCT by health organizations but its results were so striking that is what it became. However, many other independent trials have validated the results of HIVNET 012 and the WHO continues to support its findings⁴⁵.

For More Information:

HIV Prevention Trials Network, *HIVNET 012*,

http://www.hptn.org/research_studies/hivnet012.asp

THAI / BANGKOK STUDY

The phase three randomised placebo-controlled trial to evaluate the safety and efficacy of short course oral antenatal zidovudine to reduce prenatal HIV transmission, Bangkok, Thailand (Thai / Bangkok study) was a randomized, double-blind, placebo controlled study that found that a shorter course of AZT was sufficient to help prevent Mother-to-Child Transmission (MTCT) of HIV. From May 1996 to December 1997, 397 HIV positive women participated in the study. 99% of the women attend all weekly antenatal visits and 90% of the expected labour doses were given. Half the women received AZT and half the women received a placebo. The drugs were taken twice a day from approximately 36 weeks of gestation to labour and then every three hours during labour. The mothers were asked not to breastfeed and were given formula. The results of the study were about a 50% drop in the risk of transmission when the short course of AZT was administered opposed to the placebo group. The 50% drop in the risk of transmission is less than the 66% drop found in studies on long course treatments of AZT. This could be because the course of treatment was shorter (approximately 3.5 weeks instead of 11 weeks), the drug was given twice a day instead of 5 times a day, the drug was given orally instead of intravenously, the infants were not given the drug after birth, or because of different populations or other variations. The cost of this treatment is \$50 as opposed to about \$800 for long course treatments. The lower cost and the fact that it can be started later into pregnancy and requires less follow up makes it a good alternative to long course AZT treatment for the reduction of MTCT of HIV in developing countries where the long course treatment is not feasible.

For More Information:

Shafer, Dr. Nathan, et al. *Short-Course Zidovudine for Perinatal HIV-Transmission in Bangkok, Thailand: a Randomised Controlled Trial*. THE LANCET, 353(9155), 773-780 (1999). Available Online: <http://www.sciencedirect.com>

SOUTH AFRICAN INTRA-PARTUM NEVIRAPINE TRIAL (SAINT)

The South African Intra-partum Nevirapine Trial (SAINT) was a randomized, open-label study in 11 public hospitals between May 1999 and February 2000. Half of the 1317 women who participated in the study were given short course AZT and half given nevirapine. The women given nevirapine were given one dose during labour, one 24-72 hours after delivery. The infant was given one dose after birth. Women were advised on feeding practices but not specifically asked not to breast feed. Approximately 42% of the infants in both groups were breastfed. Estimated infection rates were 12.3% in the nevirapine group and 9.3% for the AZT group.

For More Information:

Moodley, Dhayendre, et al., *A Multicenter Randomized Controlled Trial of Nevirapine Versus a Combination of Zidovudine and Lamivudine to Reduce Intrapartum and Early Postpartum Mother-to-Child Transmission of Human Immunodeficiency Virus Type 1*.

JOURNAL OF INFECTIOUS DISEASES, 187, 725-735 (2003). Available Online:

<http://www.journals.uchicago.edu>

1 Written by Kristin Bailey: B.A. (Hon.) Philosophy, University of Western Ontario, J.D. Student, University of Toronto.

2 The National Department Of Health, *Protocol for Providing a Comprehensive Package of Care for the Prevention of Mother to Child Transmission of HIV in South Africa: Draft Version 5*, (April 2001) at 4.

3 World Health Organization, *Mother-to-Child Transmission of HIV*, Available online: <http://www.who.int> (June 26, 2006).

4 PBS, *The Age of AIDS*, FRONTLINE (May 30, 2006). Available Online:

<http://www.pbs.org/wgbh/pages/frontline/aids/> (July 3, 2006).

5 *Supra* note 1.

6 *Supra* note 3.

7 Mbeki, Thabo, *Speech at the Opening Session of the 13th International Aids Conference 9 July 2000* Available Online: <http://www.anc.org.za/ancdocs/history/mbeki/2000/tm0709.html> (June 26, 2006).

8 Heywood, Mark, *Preventing mother-to-child HIV transmission in South Africa: Background, strategies and outcomes of the Treatment Action Campaign's case against the Minister of Health*. SOUTH AFRICAN JOURNAL ON HUMAN RIGHTS, 19(2) 295 (2003). Available Online: <http://www.law.wits.ac.za/sajhr/> (June 26, 2006).

9 At 39.

10 Roth, Kenneth, *Human Rights and the AIDS Crisis: The Debate Over Resources*, CANADIAN HIV / AIDS POLICY AND LAW REVIEW, 94 (2000) at 5.

11 *Pharmaceutical Manufacturers' Association of South Africa v The President of the Republic of South Africa and others*. See Heywood Mark, *Debunking 'Conglomo-talk': A Case Study of the Amicus Curiae as an Instrument for Advocacy, Investigation and Mobilisation*, Final, 3 Dec 2001

Competition Commission Complaint Against GlaxoSmithKline and Boehringer Ingelheim. See <http://www.tac.org.za>

12 Jonathan Berger 'Litigation Strategies to Gain Access to Treatment: the Role of South Africa's Treatment Action Campaign' (2002) 20 Wisconsin International Law Journal 598

13 Mark Heywood, *Preventing Mother-to-Child HIV Transmission in South Africa: Background, Strategies and Outcomes of the Treatment Action Campaign Case against The Minister of Health*, SAJHR 19 (2003)

14 Steven Friedman, Shauna Mottiar, *A Rewarding Engagement? The Treatment Action Campaign and the Politics of HIV/AIDS*, POLITICS & SOCIETY, 33(4) 534-5 (December 2005).

15 <http://www.tac.org.za>

16 Power, Samantha, *The AIDS Rebel*, THE NEW YORKER (May 2003).

-
- 17** Human Rights Watch, *South Africa Should allow Peaceful AIDS Protest* (March 21, 2003). Available online: <http://hrw.org/english/docs/2003/03/21/safric5419.htm> (June 4, 2006).
- 18** The Star, *More Damage Control after Manto Says No* (25 March 2002).
- 19** Supra note iv at 308
- 20** Ibid at 298
- 21** in Peris Jones and Kristian Stokke (eds), *Democratising Development: The Politics of Socio-Economic Rights in South Africa*, Leiden: Martinus Nijhoff Publishers (2005).
- 22** Supra note vii
- 23** See for example, Bilchitz, David, *Towards a Reasonable Approach to the Minimum Core: Laying the Foundations for Future Socio-Economic Rights Jurisprudence*, SOUTH AFRICAN JOURNAL OF HUMAN RIGHTS, 19(1) 1-26 (2003). and Kende, Mark, *The South African Constitutional Court's Construction of Socio-Economic Rights: A Response to Critics*, CONNETICUT JOURNAL OF INTERNATIONAL LAW, 19 (Summer 2004).
- 24** Evans, Judith, *Children's Rights and Women's Rights: Challenges and Opportunities*, DEVELOPMENT, 44(2) (2001) at 10.
- 25** <http://www.ohchr.org/english/law/crc.htm>
- 26** For a discussion on this issue see Jain, Devaki, *Children's Rights and Women's Rights: Some Connections and Disconnections*, DEVELOPMENT, 44(2) (2001).
- 27** United Nations, Human Rights Commission, General Comments, CCRP/C/21/Rev.1/Add. 2 (1990). Available Online: <http://www.unhchr.ch/tbs/doc.nsf/0/6f97648603f69bc12563ed004c3881?OpenDocument> July 6 2006
- 28** Sangree, Suzanne, *Control of Childbearing by HIV-Positive Women: Some Responses to Emerging Legal Policies*, BUFFALO LAW REVIEW (Spring 1993) at 327.
- 29** Cook, R, *International Protection of Women's Reproductive Rights*, NEW YORK UNIVERSITY JOURNAL OF INTERNATIONAL LAW AND POLITICS 24(645) (1992) at 701-2.
- 30** <http://www.who.int>
- 31** <http://www.unicef.org>

-
- 32** For discussion of this see De Bruyn, Maria, *Reproductive choice and women living with HIV/AIDS*, IPAS (December 2002). Available online: http://www.ipas.org/publications/en/repro_choice_hiv_aids.pdf (June 4, 2006).
- 33** Cook, Rebecca, *International Human Rights and Women's Reproductive Health*, STUDIES IN FAMILY PLANNING 24(2) (1993) at 73.
- 34** *Auton (Guardian ad litem of) v. British Columbia (Attorney General)*, [2004] 3 S.C.R. 657 at 30 and 47.
- 35** Article 2 and 12.
- 36** O'Connor, EM, et al, *Reduction of Maternal Infant Transmission of Human Immuno Deficiency Virus Type 1 with Zidovudine Treatment*, NEW ENGLAND JOURNAL OF MEDICINE 331 (1994).
- 37** Mark Heywood, *Preventing Mother-to-Child HIV Transmission in South Africa: Background, Strategies and Outcomes of the Treatment Action Campaign Case against The Minister of Health*, SAJHR 19 (2003) at 286.
- 38** Parts of this letter are contained in the founding affidavit.
- 39** <http://www.africa-union.org/root/au/Documents/Treaties/Text/africancourt-humanrights.pdf>
- 40** <http://www.pict-pcti.org/courts/ACHPR.html>
- 41** Canadian AIDS Treatment Information Exchange, *AZT (zidovudine Retrovir) Fact Sheet* www.catie.ca (May 31, 2006).
- 42** Canadian HIV/AIDS Information Centre, *AIDS: Mother-to-Child Transmission*, <http://www.aidssida.cpha.ca/> (May 31, 2006).
- 43** Canadian AIDS Treatment Information Exchange, *Nevirapine (Viramune) Fact Sheet*, www.catie.ca (May 31, 2006).
- 44** http://www.usatoday.com/news/washington/2005-01-04-nih-aids_x.htm
- 45** <http://www.who.int/hiv/pub/mtct/en/NevirapineStatement072003.pdf>