Chapter 2

The Story of the *TAC* Case: The Potential and Limits of Socio-Economic Rights Litigation in South Africa

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Introduction

I gave birth to an HIV positive baby who should have been saved. That was my experience, the sad one, and I will live with it until my last day.[1]
Busisiwe Maqungo
Mfuleni, Cape Town, South Africa

When Busisiwe Maqungo walked into an antenatal clinic in Cape Town in 1999, she knew that there were medicines that could be used to reduce the risk of transmitting the human immunodeficiency virus ("HIV")—the virus that causes Acquired Immune Deficiency Syndrome ("AIDS")—from mothers to their children. She had learned this, in fact, from television. But she did not think she might be at risk of HIV infection. Not a single health care provider at the clinic said anything about an HIV test during her visit, even though at the time, more than one in five pregnant women attending public antenatal clinics in South Africa was HIV-positive.[2] Busisiwe worried when she saw the word "positive" on her antenatal chart, but a nurse explained it away: "Something to do with iron," she was told.[3]

At the age of one month, Busisiwe's daughter Nomazizi fell gravely ill with pneumonia and diarrhea. When doctors diagnosed Nomazizi with HIV, they told Busisiwe that her daughter would die, and that nothing could be done.[4] After that, her baby was always sick. Busisiwe

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[1] Affidavit of Busisiwe Maqungo, Submitted in Support of the Applicants in *Minister of Health & Others v Treatment Action Campaign & Others (No 2)* 2002 (5) SA 721 (CC) (S. Afr.) at para. 7 (Aug. 2001) [hereinafter Maqungo Aff.]. This affidavit, as well as most of the record of the *TAC* case, is available at http://www.tac.org.za/Documents/MTCTCourtCase/MTCTCourtCase.htm.

[2] *See* REPUBLIC OF S. AFR. DEP'T. OF HEALTH, NATIONAL HIV AND SYPHILIS SERO-PREVALENCE SURVEY OF WOMEN ATTENDING PUBLIC ANTENATAL CLINICS IN SOUTH AFRICA (2000), *available at* http://www.doh.gov.za/docs/reports/2000/hivreport.html (reporting that in 1999, 22.4% of all women attending public antenatal clinics in South Africa were HIV-positive).

[3] Maqungo Aff., *supra* note 1, at para. 5.

[4] Children with HIV can live long and healthy lives if they have access to antiretroviral ("ARV") treatment. In South Africa in 1999, however, children and mothers like Nomazizi and Busisiwe did not have access to the necessary treatment. *See, e.g.*, Mark Heywood, *Shaping, Making and Breaking the Law in the Campaign for a National HIV/AIDS Treatment Plan*, *in* DEMOCRATIZING DEVELOPMENT: THE POLITICS OF SOCIO-ECONOMIC RIGHTS IN SOUTH AFRICA 181, 212 (Peris Jones & Kristian Stokke eds., 2005) [hereinafter Heywood, *Shaping, Making and Breaking*].

explained: "I had to borrow money from her father's parents, to take her to hospital. . . . Sometimes my baby would be out of hospital for a week and then she would be sick again. I never had enough time with her."[5]

In time, Busisiwe would learn that she had been tested for HIV without her consent, and that no one had informed her of the results or even what the test was for. And no one, of course, had offered her a medicine called Nevirapine—which had been offered to the state at no cost. Nor had she been told that just two doses might well have prevented the transmission of HIV to her little girl.[6]

The clinic that Busisiwe attended was not unusual in this regard. At the time, the South African government had refused to commit to a public sector program to prevent mother-to-child-transmission of HIV (a "PMTCT" program). As a result, an estimated 89,000 children were born with HIV in South Africa in 1999.[7] Without access to medicines for treating HIV infection, all of these children would die. In 1999, at the age of just nine months, Nomazizi became one of them.

This would not, however, be the end of Nomazizi's story. Busisiwe became a member of a South African AIDS activist organization known as the Treatment Action Campaign ("TAC"). TAC is a community-based organization that campaigns for the health and rights of people living with HIV/AIDS in South Africa.[8] Founded in 1998, it now has approximately 12,000 members in more than 200 branches around the country.[9] The organization is perhaps best known for its high-profile campaigns seeking access to treatment for people with HIV/AIDS. Equally important, though, is TAC's lesser known work, which strives to improve HIV prevention efforts, combat discrimination, cultivate leadership of people living with HIV/AIDS, and build

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[5] Maqungo Aff., *supra* note 1, at para. 9.

[6] *See* Laura A. Guay et al., *Intrapartum and Neonatal Single-Dose Nevirapine Compared with Zidovudine for Prevention of Mother-to-Child Transmission of HIV-1 in Kampala, Uganda: HIVNET 012 Randomized Controlled Trial*, 354 LANCET 795, 799 (1999) (detailing study which found that Nevirapine lowered risk of HIV-1 transmission during first fourteen to sixteen weeks of infants' lives by nearly fifty percent in breastfeeding population) [hereinafter Guay].

[7] Affidavit of Quarraisha Abdool Karim, Submitted in Support of the Applicants in *Minister of Health & Others v Treatment Action Campaign & Others (No 2)* 2002 (5) SA 721 (CC) (S. Afr.), at paras. 37-39 (Aug. 13, 2001) [hereinafter Karim Aff.], *available at* http://www.tac.org.za/Documents/MTCTCourtCase/MTCTCourtCase.htm.

[8] For further information, see the Treatment Action Campaign website at http://www.tac.org.za/.

[9] The TAC national office is located in Cape Town. In addition to its provincial offices, located in the Western Cape, Gauteng, Eastern Cape, KwaZulu-Natal, Limpopo and Mpumalanga provinces, TAC has district offices in Lusikisiki and Queenstown (Eastern Cape), Pietermaritzburg (KwaZulu-Natal), Khayelitsha (Western Cape) and Ekhurhuleni (Gauteng). Comprised of more than 200 branches across the country, the TAC offices encompass a wide range of locales, from the poorest Eastern Cape communities (such as Lusikisiki), to wealthy institutions such as the University of Cape Town. Most TAC volunteers and staff members reside in the communities in which they work. The internal dynamics, leadership, and decision-making within the TAC organization fall outside the scope of this Chapter. For more information on these matters, see generally Steven Friedman & Shauna Mottiar, *Rewarding Engagement?: The Treatment Action Campaign and the Politics of HIV/AIDS: A Case Study for the UKZN Project Titled Globalisation, Marginalisation, and New Social Movements in South Africa* (Ctr. for Civ. Soc. and Sch. of Dev. Stud., Univ. of Kwazulu-Natal, 2004), *available at* http://www.ukzn.ac.za/ccs/files/FRIEDMAN%20MOTTIER%20A%20MORAL%20TO%20THE%20TALE%20LONG%20VERSION.PDF. *See also* Steven Friedman & Shauna Mottiar, *A Rewarding Engagement? The Treatment Action Campaign and the Politics of HIV/AIDS*, 33 POL. & SOC. 511, 513 (2005).

national and global networks of like-minded activist groups.[10] The organization's tactics range from legal filings, to civil disobedience, to community-based treatment literacy work that has educated tens of thousands of people around the country about the science of HIV prevention and treatment.[11]

In 2001, after repeated attempts over a number of years to convince the government to provide comprehensive PMTCT services had failed, TAC filed a lawsuit contending that the government was violating the South African Constitution. In an affidavit filed by TAC as an integral part of its court papers, Busisiwe—and a number of other women like her—told their stories. With the help of these women, TAC won what has become one of the most celebrated human rights cases in the world: *Minister of Health & Others v. Treatment Action Campaign & Others (No 2)* ("*TAC* case").[12] In its judgment, the Constitutional Court of South Africa held that the government's failure to develop and implement a comprehensive PMTCT program breached the express constitutional guarantee of access to health care services, in particular the state's positive obligations in respect of that right. The Court ordered the government to take a series of steps aimed at ensuring access to comprehensive PMTCT services in the public health sector, "without delay."[13]

For most commentators, the story of the *TAC* case has been a story about courts, and the role that they can or should play in socio-economic rights litigation. Scholars in South Africa, for example, have said "[t]he Court's order . . . demonstrates that socio-economic rights can offer important protections to the vulnerable against unreasonable government policies," but they have at the same time criticized the decision for not going far enough in its remedial aspect.[14] Scholars in the United States, in contrast, have marveled at the strength of the ruling and remedy in the *TAC* case, and have suggested that the result can be explained by the fact that this was an exceptionally simple and compelling case.[15]

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[10] TREATMENT ACTION CAMPAIGN, CONSTITUTION art. IV (1998), *available at* http://www.tac.org.za/Documents/Constitution/Constitution13Dec04.PDF.

[11] The "Treatment Literacy Program" is TAC's largest operation; as of this writing, the organization has trained over 300 of its members to become experts on the science of HIV prevention and treatment. Currently, about 250 of these experts provide treatment literacy services on almost a daily basis to health facilities and other institutions around the country. Consistent with the TAC's mission, the Treatment Literacy Program emphasizes the view that the provision of HIV prevention and treatment education increases the number of people with HIV who seek timely assistance from the public health system, and improves adherence to ARV and other HIV-related treatment. This information was provided by Nathan Geffen, the former head of TAC's policy, research and communications work and its recently elected Treasurer. Email from Nathan Geffen to Jonathan Berger (Sept. 1, 2008) (on file with authors).

[12] 2002 (5) SA 721 (CC) (S. Afr.) [hereinafter *TAC (No 2)*]. This and other South African Constitutional Court cases are available online at the Court's official website, http://www.constitutionalcourt.org.za.

[13] *Id.* at para.135.

[14] David Bilchitz, *Towards a Reasonable Approach to the Minimum Core: Laying the Foundations for Future Socio-Economic Rights Jurisprudence*, 19 S. AFR. J. HUM. RTS. 1, 2 (2003).

[15] Mark V. Tushnet, *New Forms of Judicial Review and the Persistence of Rights- and Democracy-Based Worries*, 38 WAKE FOREST L. REV. 813, 826 (2003) (arguing that the "case was a perfect one for exercising judicial review. The government's position was discredited and had been abandoned. The Constitutional Court could pretty much do whatever it wanted in the case.").

Little has been written about how the case came into being or the impact it has had on the life options and experiences of people living with and affected by HIV in South Africa.[16] Consider here three facts: the *TAC* case was brought only after four years of sustained lobbying and organizing efforts demanding PMTCT programs in South Africa. The suit itself was framed by carefully orchestrated advocacy work and mass demonstrations that caused dramatic change in the government's policy even during the litigation. Years after the stunning victory in the *TAC* case, and despite claims by some that the government "quickly implemented the orders of the Constitutional Court,"[17] reliable estimates indicate that only about thirty percent of women in South Africa who need medicine to prevent the transmission of HIV to their children are receiving it.[18]

These facts alone demonstrate that to describe the *TAC* case in terms that focus on courts or legal texts alone is to miss the true story of the case. That story is less about a judgment or a doctrine than it is about a movement. More specifically, it is about the power that an organized movement can have if it makes strategic use of constitutionally entrenched and justiciable human rights, lays the groundwork necessary to give those abstract guarantees meaning, and energetically builds broad public support for its cause. TAC did the political and technical work to make the Constitutional Court's judgment seem both legally obvious and morally necessary, and thereby created a precedent that helped bring real improvements in access to PMTCT services in South Africa, and that was also likely central to the establishment of a public sector HIV treatment program for the country. But the ultimate promise of the case—that all women in South Africa have access to quality medicines and services to prevent the transmission of HIV to their children—still awaits fulfillment. The judgment alone could not guarantee the result that it declared constitutionally required. For that, it needed a movement. And unfortunately, the Court very likely overestimated the work that the movement in question could do to implement the Court's judgment. That too is part of the legacy of the *TAC* case. In the end, then, the story of the *TAC* case is less a story about the power and limits of courts than it is a story about the power and limits of the Treatment Action Campaign.

Social and Medical Background

HIV is a retrovirus that attacks the human immune system. It can be transmitted through blood, semen, or other bodily fluids, for example through unsafe sex or injecting drug use with shared needles. Children can contract HIV from their mothers before they are born, during delivery, or while breastfeeding. Collectively, these forms of transmission are known in the field as "mother-to-child-transmission of HIV" ("MTCT"). Studies in South Africa show that, absent

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[16] This article draws heavily upon one of the best articles on the prelude to the case: Mark Heywood, *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*, 19 S. AFR. J. HUM. RTS. 278, 282 (2003) [hereinafter Heywood, *Preventing Mother-to-Child HIV Transmission*].

[17] Richard J. Goldstone, *A South African Perspective on Social and Economic Rights*, 13 HUM. RTS. BRIEF 4, 5 (2006) (referring to *TAC (No 2)* and "other cases where the court has ruled against [the government].").

[18] *See, e.g.*, WORLD HEALTH ORGANIZATION PROGRESS REPORT, TOWARDS UNIVERSAL ACCESS: SCALING UP PRIORITY HIV/AIDS INTERVENTIONS IN THE HEALTH SECTOR (2007), *available at* http://www.who.int/hiv/mediacentre/universal_access_progress_report_en.pdf; *see also infra* n.135.

any medical intervention, one-fifth to one-third of children will contract HIV from a mother infected with HIV.[19]

Adults infected with HIV can live for many years without any symptoms of the disease, as the immune system and the virus battle one another. The same cannot be said for children—and particularly infants—with HIV infection, who may decline much more quickly.[20] Eventually, if a person is not treated with the antiretroviral ("ARV") medicines that prevent the replication of the virus, his or her immune system will be weakened, and he or she will begin to develop illnesses characteristic of AIDS, such as tuberculosis and cryptococcal meningitis.[21] Absent treatment, AIDS is fatal.

First identified in 1981, AIDS is now the leading cause of death in many countries around the world. Approximately 33 million people around the world are living with HIV, two-thirds of them in sub-Saharan Africa.[22] Two million people died of AIDS-related illnesses in 2007, including an estimated 270,000 children under the age of fifteen.[23] During the same period, there were an estimated 2.7 million new infections, with approximately 370,000 of these in children under the age of fifteen.[24]

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[19] *See* Anna Coutsoudis et al., *Method of Feeding and Transmission of HIV-1 from Mothers to Children by 15 Months of Age: Prospective Cohort Study from Durban, South Africa*, 15 AIDS 379, 383 fig.1 (2001) (showing infection rates at 15 months of about 19% for children who were never breastfed, 24% for children who had been exclusively breastfed, and 36% for children who were fed a mix of breast milk and other food); *see also id.* at 386 (hypothesizing reasons for higher rate of transmission for children who were fed a mix rather than exclusively breastfed, e.g. that mixed feeding compromises the child's digestive system).

[20] For example, a relatively old study showed that nearly half of all children who contracted HIV from their mothers and went untreated would die by the age of two. *See* Rosemary Spira et al., *Natural History of Human Immunodeficiency Virus Type 1 Infection in Children: A Five-Year Prospective Study in Rwanda*, 104 PEDIATRICS e56, *3 (1999). With early access to ARV treatment, however, survival rates increase significantly. Interim data from a recent Children with HIV Early Antiretroviral Therapy ("CHER") study "found a significant increase in survival among infants who received immediate ARV therapy (96%) compared to infants who received therapy later (84%) based on declining immune function linked to a defined CD4+ T-cell count and/or clinical progression." NATIONAL INSTITUTES OF HEALTH, NATIONAL INSTITUTE OF ALLERGY AND INFECTIOUS DISEASES, QUESTIONS AND ANSWERS, CHILDREN WITH HIV EARLY ANTIRETROVIRAL THERAPY (CHER) STUDY: TREATING HIV-INFECTED INFANTS EARLY HELPS THEM LIVE LONGER, para. 8 (2007), *at* http://www3.niaid.nih.gov/news/QA/CHER_QA.htm (describing the results of the 2007 DSMB review of the CHER interim data regarding infant survival rates).

[21] For access to basic information on HIV/AIDS that is focused on the U.S., see http://www.thebody.com/; *see also* http://www.cdc.gov/hiv/topics/basic/index.htm. For access to information on HIV/AIDS with a focus on South Africa, see TREATMENT ACTION CAMPAIGN, HIV IN OUR LIVES: A BOOK OF INFORMATION SHEETS FOR PEOPLE LIVING WITH HIV, SUPPORT GROUPS AND CLINICS (2007), *available at* http://www.tac.org.za/community/files/file/InOurLives/HIVInOurLivesEnglish.pdf (providing a guide to living with HIV in the form of a series of worksheets); TREATMENT ACTION CAMPAIGN, ARVS IN OUR LIVES: A HANDBOOK FOR PEOPLE LIVING WITH HIV AND TREATMENT ADVOCATES IN SUPPORT GROUPS, CLINICS AND COMMUNITIES (2006), *available at* http://www.tac.org.za/documents/arvsinourlives.pdf (providing a detailed guide to antiretroviral treatment, aimed at people with advanced treatment literacy skills).

[22] *See* JOINT UNITED NATIONS PROGRAM ON HIV/AIDS ("UNAIDS"), AIDS EPIDEMIC UPDATE 32 (2008), *available at* http://www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2008/2008_Global_report.asp.

[23] *Id*. at 32, 37.

[24] *Id.* 31-31.

In South Africa alone, an estimated 11.2% of the population, approximately 5.4 million people, were living with HIV/AIDS in 2006.[25] Approximately 346,000 deaths in South Africa—out of an estimated total of 737,000 deaths from all causes, both natural and unnatural—were attributed to the epidemic in 2005.[26] Importantly, these deaths were not evenly distributed across the population as a whole. As noted by a discussion document published by the South African Presidency, "[t]he most affected in this regard are able-bodied citizens in the prime of their lives. These would most likely be parents of young children and possibly breadwinners of extended families who are also among the most skilled within the population."[27]

As far back as the mid-to-late-1990s, scientists began to make enormous progress in learning how to treat and prevent HIV with the use of ARV medicines. In 1994, for example, it was discovered that ARV medicines such as zidovudine ("AZT") could dramatically reduce the risk of MTCT.[28] ARV combination therapy emerged in 1996, and it quickly became clear that it could keep people with HIV/AIDS alive and healthy, perhaps indefinitely.[29] The subsequent development of simplified PMTCT regimens in 1998 and 1999 meant that such programs could be implemented in even the most resource-poor settings.[30]

The most important such regimen for the purpose of the *TAC* case was confirmed by a Ugandan study in 1999, in which scientists showed that just one dose of Nevirapine given to the mother during labor, and one dose given to the child directly after birth, could reduce the risk of MTCT by up to fifty percent.[31]

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[25] R.E. DORRINGTON ET AL., THE DEMOGRAPHIC IMPACT OF HIV/AIDS IN SOUTH AFRICA—NATIONAL AND PROVINCIAL INDICATORS FOR 2006 8 (Cape Town Ctr. for Actuarial Research, S. Afr. Med. Research Council and Actuarial Soc'y of S. Afr. eds., 2006) (estimating a total of 5,372,000 HIV infected persons, rounded to the nearest thousand, in a chart entitled "HIV and AIDS Indicators at mid-2006") [hereinafter Dorrington].

[26] *Id*. at 11 (estimating, in a chart entitled "Mortality Indicators, 2006," that out of a total 737,000 deaths in South Africa in 2005, 391,000 were non-AIDS related, and 346,000 were AIDS deaths).

[27] POLICY COORDINATION AND ADVISORY SERVICES ("PCAS") & THE PRESIDENCY, A NATION IN THE MAKING: A DISCUSSION DOCUMENT ON MACRO-SOCIAL TRENDS IN SOUTH AFRICA 65 (2006), *available at* http://www.thepresidency.gov.za/main.asp?include=docs/reports/microsocial/index.html.

[28] *See* Edward M. O'Connor et al., *Reduction of Maternal-Infant Transmission of Human Immunodeficiency Virus Type 1 with Zidovudine Treatment*, 331 NEW ENG. J. MED. 1173, 1173 (1994). At the time of this study, AZT as well as a small number of other ARV medicines had already received FDA marketing approval for the treatment of HIV infections.

[29] *See e.g.*, Frank J. Palella et al., *Declining Morbidity and Mortality Among Patients with Advanced Human Immunodeficiency Virus Infection*, 338 NEW ENG. J. MED. 853, 853 (1998) (showing that AIDS-related mortality dropped by about 70% in the two years after combination therapies were adopted in the United States). ARV medicines work by interfering with the replication of the virus. If they are not taken in the proper combinations and at the prescribed times, however, the virus can evolve to become resistant to the medicines.

[30] *See, e.g.*, Nancy A. Wade et al., *Abbreviated Regimens of Zidovudine Prophylaxis and Perinatal Transmission of the Human Immunodeficiency Virus*, 339 NEW ENG. J. MED. 1409, 1412 (1998) (showing that even abbreviated AZT regimens reduced the risk of MTCT).

[31] Guay, *supra* note 6, at 795. More sophisticated regimens have significantly higher success rates. *See, e.g.*, Scott Nightingale, *Evidence behind the WHO Guidelines: Hospital Care for Children: What Antiretroviral Agents and Regimens are Effective in the Prevention of Mother-to-child Transmission of HIV?*, 52 J. TROPICAL PEDIATRICS 235 (2006) (reviewing the success of more complex regimes in developing country settings).

In 1998, at least 70,000 infants in South Africa were infected with HIV as a result of MTCT.[32] A universal PMTCT program using Nevirapine thus had the potential to prevent up to 35,000 pediatric HIV infections each year, if not more. Yet the government refused to implement such a program. This refusal was not based on cost—the government's internal documents showed that the intervention was cost-effective, because the cost of the double dose of the medicine was low and the lives and medical costs saved so substantial.[33] Rather, as Mark Heywood of the TAC has written, the primary motivation behind the government refusal appears to have been the "sometimes hidden, sometimes open, relationship . . . between the President and AIDS denialists."[34]

AIDS denialists—not to be confused with those who are simply in denial about their own risk (or the implications) of HIV infection—believe that AIDS is caused not by HIV, but rather by a hodge-podge of circumstances that weaken the immune system, such as recreational drug use, malnutrition, and ARV medicines themselves. No credible medical evidence supports this position.[35] But for reasons that are still unclear, in 1999 denialism gained a powerful foothold in the ruling party in South Africa, apparently stemming from the views of President Mbeki himself.[36] As the use of ARVs caused AIDS deaths to plummet in wealthy countries and AIDS activists began to organize globally to demand the extension of HIV treatment to developing countries, the South African government seized upon denialist arguments about the toxicity of such medicines to justify delay.[37] This set the stage for a profound conflict between the TAC and the government that would eventually make its way to the South African Constitutional Court.

Legal Background

[32] Founding Affidavit Submitted in Support of the Applicants in *Minister of Health & Others v Treatment Action Campaign & Others (No 2)* 2002 (5) SA 721 (CC) (S. Afr.), at para. 22 (Aug. 21, 2001) [hereinafter Founding Aff.] *available at* http://www.tac.org.za/Documents/MTCTCourtCase/ccmfound.rtf. Estimates such as these inevitably vary somewhat, according to the presumptions and data-gathering methods used. TAC's expert estimated the number of child infections in 1999 to be 87,000. *See* Karim Aff., *supra* note 7, and accompanying text.

[33] M. Henscher, *Confidential Briefing: The Costs and Effectiveness of Using NVP or AZT for the Prevention of Mother to Child Transmission—Current Best Estimates for SA*, TAC Founding Affidavit, Annexure T at 381.

[34] Heywood, *Preventing Mother-to-Child HIV Transmission*, *supra* note 16, at 282. Heywood is also Executive Director of the AIDS Law Project, which is a sister organization to the TAC, and which serves as its legal representative in many key public interest cases. For further information, see the AIDS Law Project website at http://www.alp.org.za/.

[35] For documents reviewing the scientific evidence that the HIV virus causes AIDS, see NATIONAL INSTITUTES OF HEALTH, THE EVIDENCE THAT HIV CAUSES AIDS, *at* http://www.niaid.nih.gov/factsheets/evidhiv.htm. *See also* http://www.aidstruth.org (website developed by HIV/AIDS research scientists and community advocates to counter AIDS denialists and promote use of ARVs). Also notable is the decision of the Supreme Court of South Australia in *R v. Parenzee* (2007) SASC 143 (S. Austl.) where, in dismissing the "evidence" of prominent AIDS denialists, Justice Sulan holds as follows: "I am satisfied that no jury would conclude that there is any doubt that the virus HIV exists. I consider no jury would be left in any doubt that HIV is the cause of AIDS . . . ." *Id.* at 372.

[36] Mbeki, for example, invited prominent denialists to join a Presidential AIDS Advisory Panel to "debate" the causes of AIDS. *See* Heywood, *Preventing Mother-to-Child HIV Transmission, supra* note 16, at 281. For further discussion of AIDS denialism in South Africa, see EDWIN CAMERON, WITNESS TO AIDS 97-100 (2005); Edwin Cameron & Jonathan Berger, *Patents and Public Health: Principle, Politics and Paradox*, 131 PROC. BRIT. ACAD. 331, 361 (2005).

[37] Heywood, *Preventing Mother-to-Child HIV Transmission*, *supra* note 16, at 282-83, n.26.

The South African Constitution is widely hailed as one of the most progressive constitutions in the world. It was adopted in 1996,[38] after a long debate over the proper scope of constitutional rights in a new democracy and the feasibility of judicial enforcement of socio-economic rights.[39] The debates were resolved in favor of the view that political and civil rights and social and economic rights go hand in hand. The Constitution thus includes some of the strongest socio-economic rights protections in the world. For example, section 27—which draws much inspiration from Article 12 of the International Covenant on Economic, Social and Cultural Rights ("ICESCR")[40]—provides as follows:

> (1) Everyone has the right to have access to—
> (a) health care services, including reproductive health care;
> (b) sufficient food and water; and
> (c) social security, including, if they are unable to support themselves and their dependents, appropriate social assistance.
> (2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of these rights.
> (3) No one may be refused emergency medical treatment.[41]

In many constitutional systems, rights to health care services, food, or social security are non-existent, non-justiciable, or subject to only very minimal judicial review. One prominent school of jurisprudential thought contends that courts simply do not have the resources, expertise, and wherewithal to interpret and enforce such rights. Typically, the argument goes, such matters involve technical expertise that courts simply do not have, and require decisions about resource allocation that are better suited to the legislative branch.[42] This issue marks a critical fault line in the theory and law of human rights. If socio-economic rights cannot be litigated, one important tool for their realization is eliminated. The argument against the

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[38] S. AFR. CONST. 1996, *available at* http://www.info.gov.za/documents/constitution/index.htm. South Africa's transitional constitution, which governed the region's first democratic elections on April 27, 1994, included a provision for a post-apartheid Parliament to draft a "final" Constitution. Interestingly, the Interim Constitution, which was negotiated prior to the 1994 elections and later adopted by the apartheid Parliament, largely did not recognize socio-economic rights. *See* S. AFR. (Interim) CONST. 1993 ch. 3 s. 7–35 ("Fundamental Rights") *available at* http://www.constitutionalcourt.org.za/site/constitution/english-web/interim/ch3.html.

[39] *See, e.g.*, Dennis M. Davis, *The Case Against the Inclusion of Socio-Economic Demands in a Bill of Rights Except as Directive Principles*, 8 S. AFR. J. HUM. RTS. 475 (1992); Nicholas Haysom, *Constitutionalism, Majoritarianism, and Socio-Economic Rights*, 8 S. AFR. J. HUM. RTS. 451 (1992); Etienne Mureinik, *Beyond a Charter of Luxuries: Economic Rights in the Constitution*, 8 S. AFR. J. HUM. RTS. 464 (1992).

[40] International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200A (XXI), art. 2(1), U.N. Doc. A/6316 (Dec. 16, 1966), *available at* http://www.unesco.org/education/pdf/SOCIAL_E.PDF [hereinafter ICESCR]. One important distinction should be noted between the two documents. Whereas Section 27 of the South African Constitution of 1996 guarantees a right to have access to health care services, Article 12 of the ICESCR entrenches a right "to the enjoyment of the highest attainable standard of physical and mental health." (ICESCR art. 12(1)). This distinction is evident in the manner in which the Constitutional Court understands minimum core obligations—an integral part of the ICESCR—as "possibly being relevant to reasonableness under Section 26(2) [of the South African Constitution], and not as a self-standing right conferred on everyone under Section 26(1)." *TAC (No 2)* 2002 (5) SA 721 (CC) at para. 34 (S. Afr.) (citing Justice Yacoob in *Government of the Republic of South Africa & Others v Grootboom & Others* 2001 (1) SA 46 (CC) (S. Afr.)). Further, the ICESCR has yet to be ratified by South Africa's Parliament.

[41] S. AFR. CONST., *supra* note 39, ch. 2, s. 27.

[42] *See, e.g.*, Davis, *supra* note 39.

justiciability of such rights also often implicitly works to reinforce the notion that civil and political rights are more fundamental than socio-economic rights.

The South African Constitutional Court (along with the U.N. Committee on Economic, Social and Cultural Rights as well as supreme courts in countries such as India) has firmly rejected the argument that socio-economic rights are categorically non-justiciable, and insisted on the interdependence between social, economic, political, and civil rights. In a series of cases that have become milestones in the global debate over socio-economic rights, the Constitutional Court has declared that such rights, as they are enshrined in the South African Constitution, are fully justiciable, and in fact that South African courts are *obliged* to test the constitutional adequacy of the government's programs against these guarantees and to provide adequate remedies for all constitutional violations. Few courts have done as much to interpret and enforce socio-economic rights, and as a result, "South Africa's role in the social rights adjudication debate is seen as revolutionary and heroic by proponents of justiciability and as irresponsible and doomed by its detractors."[43]

Two foundational cases structure the basic framework of socio-economic rights litigation in South Africa, forming the backdrop to the decision in the *TAC* case. *Soobramoney v Minister of Health, KwaZulu-Natal* was the first socio-economic rights case to come before the Constitutional Court.[44] It was brought by a man with late-stage kidney failure who was in urgent need of dialysis, but who had been rejected from his local hospital because he did not satisfy the strict medical criteria being used to ration scarce time available on the hospital's limited number of dialysis machines.

The Court in *Soobramoney* ruled that the hospital's guidelines limiting access were reasonable and non-discriminatory,[45] and that it would "be slow to interfere with rational decisions taken in good faith by the political organs and medical authorities."[46] Further, the Court held that the reality of limited resources will at times require the state to "adopt a holistic approach to the larger needs of society rather than to focus on the specific needs of particular individuals within society."[47]

In the second foundational case, *Government of the Republic of South Africa and Others v Grootboom and Others*,[48] members of an informal ("squatter") settlement who were facing eviction sued the government under, *inter alia*, Section 26 of the Constitution, which provides that "everyone has the right to have access to adequate housing," and that the state must "take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of this right." The Court unanimously ruled against the government, established that the socio-economic rights in the South African Constitution are clearly judicially

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[43] Eric C. Christiansen, *Adjudicating Non-Justiciable Rights: Socio-Economic Rights and the South African Constitutional Court*, 38 COLUM. HUM. RTS. L. REV. 321, 321 (2007).
[44] 1998 (1) SA 765 (CC) (S. Afr.).
[45] *Id*. at para. 25.
[46] *Id*. at para. 29.
[47] *Id*. at para. 31.
[48] 2001 (1) SA 46 (CC) (S. Afr.).

enforceable,[49] and set forth the basic inquiry in socio-economic rights cases, instructing courts to determine simply "whether the measures taken by the state to realize the right . . . are reasonable" in the circumstances.[50]

"Reasonableness" is obviously a malleable concept, and *Grootboom* established the case-by-case approach that has come to characterize the Constitutional Court's review of socio-economic rights issues generally. But it also established several principles that courts must use when assessing the reasonableness of a government plan, including the notion that the needs of the poor "require special attention,"[51] and the requirement that such plans must be "capable of facilitating the realization of the right," must allocate appropriate financial resources for the program, and must seek to achieve their goal "expeditiously."[52]

Applying those standards to the facts in the case, *Grootboom* held that the government's housing program was not reasonable because it failed "to recognize that the state must provide for relief for those in desperate need."[53] The Court then ordered the government to "devise and implement within its available resources a comprehensive and coordinated program progressively to realize the right of access to adequate housing."[54]

Because the court ordered the government to produce a plan, but specified very little about the precise parameters of that plan and did not make it automatically subject to further judicial oversight, scholars from traditions characterized by a presumption against the justiciability of socio-economic rights have hailed the decision as invoking a new form of judicial review that is democratically experimental,[55] or that adopts a flexible "administrative law model of socioeconomic rights."[56] Within South Africa, however, the decision has been routinely criticized for the weakness of its remedy. Ultimately, while *Grootboom* did lead to some limited relief for the individual plaintiffs, it has resulted in few meaningful improvements in housing for the poor.[57] As a result, the years leading up to the decision in the *TAC* case were characterized by significant academic debate within South Africa over the role of the Constitutional Court and in particular the remedial adequacy of the order in *Grootboom*.[58]

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[49] *Id*. at para. 20 ("The question is . . . not whether socio-economic rights are justiciable under our Constitution, but how to enforce them in a given case. This is a very difficult issue which must be carefully explored on a case-by-case basis.").
[50] *Id*. at para. 33.
[51] *Id*. at para. 36.
[52] *Id*. at paras. 39, 41, 46.
[53] *Id*. at para. 66.
[54] *Id*. at para. 99.
[55] *See, e.g.*, Tushnet, *supra* note 15, at 822 (suggesting that *Grootboom* "can be seen as a version of a broader type of weak-form judicial review that Michael Dorf and Charles Sabel identify with what they call democratic experimentalism").
[56] *See* CASS R. SUNSTEIN, DESIGNING DEMOCRACY: WHAT CONSTITUTIONS DO 234 (Oxford University Press, 2001) (italics omitted).
[57] *See, e.g.*, Kameshni Pillay, *Implementing* Grootboom*: Supervision Needed*, 3 ESR REV. 16, 17(2002) *available at* http://www.escr-net.org/caselaw_more/caselaw_more_show.htm?parent_id=401409 (noting that after a year of inaction, the government's response was "limited to putting together a plan to deal with the permanent resettlement of the Wallacedene Community. There is a clear lack of understanding that the judgment requires systemic changes to national, provincial and local housing programmes to cater for people in desperate and crisis situations.").
[58] *See, e.g.*, David Bilchitz, *Giving Socio-Economic Rights Teeth: The Minimum Core and its Importance*, 119 S. AFR. L. J. 484 (2002); Pillay, *supra* note 56.

The Story of the Case

The current situation, in which women with HIV are unable to take appropriate measures to protect their health and that of their infants, has a devastating impact on their lives. That situation is avoidable.[59]
Siphokazi Mthathi
Mowbray, Cape Town, South Africa

Prelude

The efforts that led to the *TAC* case began in 1997, four years before the litigation papers were drawn up. A coalition including the AIDS Law Project, the AIDS Consortium and the Perinatal HIV Research Unit at the University of Witwatersrand, Johannesburg, began lobbying the government to urge the creation of a national policy and program for PMTCT.[60] In 1998, results of the trials that demonstrated the viability of short-course AZT therapy for PMTCT were released, making a comprehensive national program seem significantly more feasible. Around the same time, TAC itself was created, and "one of its primary objectives [was] a demand that government implement a programme to prevent MTCT."[61]

In its initial response to the TAC demands regarding PMTCT, the government seemed cooperative, with the high price of AZT appearing to be the main obstacle. The medicine was under patent in South Africa, meaning that the company Glaxo Wellcome possessed the exclusive right to make, sell, or import it into the country. As a result, the company could effectively charge whatever price it liked, and the medicine was priced exorbitantly. In an April 1999 meeting, TAC and the government agreed that the "government would name an affordable price for the implementation of AZT to pregnant mothers and report within six weeks on the price and other issues pertaining to the prevention of mother-to-child transmission," and that TAC and other civil society organizations would call on Glaxo Wellcome to "unconditionally lower the price of all HIV/AIDS medications to an affordable price for poor people and countries."[62]

Over the next year, TAC focused significant energy on securing affordable prices for AZT and other HIV-related medicines. Its members marched, protested, met with drug companies, and intervened on the side of the government in a lawsuit brought by patent-based drug companies that challenged a law designed to reduce the prices of medicines in South Africa. These efforts met with significant success. Facing an avalanche of pressure, patent-holding companies began reluctantly to reduce their prices. They also withdrew their lawsuit against the South African government, in significant part due to a worldwide campaign urging them to do so and to TAC's intervention in the case.[63]

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[59] Founding Aff., *supra* note 32 at para. 238.
[60] Heywood, *Preventing Mother-to-Child HIV Transmission*, *supra* note 16, at 280.
[61] *Id*. at 281.
[62] Founding Aff., *supra* note 32, at para. 233.
[63] Mark Heywood, *Drug Access, Patents and Global Health: "Chaffed and Waxed Sufficient,"* 23 THIRD WORLD Q. 217 (2002).

But at the same time that this advocacy was creating the conditions for comprehensive PMTCT and ARV treatment programs in South Africa, AIDS denialism was taking hold at the highest levels of government. The first signs came shortly after the April 1999 meeting, which just preceded national and provincial elections and the inauguration of a new president. In September, the new Health Minister, Dr. Mantombazana ("Manto") Tshabalala-Msimang, told TAC that the government was committed to a PMTCT program, but that there were concerns about the safety and efficacy of Nevirapine.[64] Despite mounting evidence to the contrary, Tshabalala-Msimang told Parliament in November of that year: "we simply do not have enough information, either on the affordability or on the appropriateness of [using] the [ARV] drugs [for PMTCT] to make any decisions that might have long term health effects on the lives of children born to HIV positive mothers."[65]

In November 1999, President Mbeki publicly questioned whether AZT was too toxic to be of medical benefit, and announced that he had ordered an inquiry into the matter.[66] When the South African Medicines Control Council ("MCC") completed its review and concluded that AZT's health benefits outweighed the risks, the report was first rejected and then ignored.[67] When the results of the South African Intra-partum Nevirapine Trial ("SAINT") began to emerge in early 2000, and showed Nevirapine to be as safe and efficacious as indicated in an earlier Ugandan PMTCT study, the South African government continued to stall.[68] Around the same time, the government also declined to take up an offer from the drug company Boehringer Ingelheim for a five-year free supply of Nevirapine for PMTCT.[69]

In July 2000, the Thirteenth International AIDS Conference was held in Durban, South Africa, creating a platform for TAC and other AIDS activist groups to stage the first global march for treatment access. Thousands strong, the marchers demanded, among other things, that

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[64] Nevirapine was known to cause, in a very small number of cases, serious and life-threatening side effects when used in continuous, long-term ARV treatment. These side-effects were considered rare enough, and the benefits significant enough, that the drug had been registered for treatment in South Africa in 1996. Furthermore, a Ugandan PMTCT trial found only two adverse events that were "possibly, but unlikely to be" attributable to the drug, out of 310 women studied. Guay, *supra* note 6. Nevertheless, TAC was aware at the time that there were some uncertainties about the possible long-term effects of single-dose Nevirapine on women who later wished to begin ARV treatment, as well as about the efficacy of Nevirapine in cases where it is not feasible to use baby formula ("formula feed"). A careful review of the medical evidence demonstrated that Nevirapine's benefits outweighed its risks in settings where more efficacious medical regimens for PMTCT were not available. Founding Aff., *supra* note 32, at paras. 83-91, 92-107 and 117-119 respectively.

[65] Dr. M.E. Tshabalala-Msimang MP, Minister of Health, *Statement to the National Assembly on HIV/AIDS and Related Issues* (Nov. 16, 1999), *at* http://www.info.gov.za/speeches/1999/0001131124a1002.htm.

[66] Heywood, *Preventing Mother-to-Child HIV Transmission*, *supra* note 16, at 282.

[67] *Id*. at 283.

[68] *See id*. at 285; Founding Aff., *supra* note 32 at para. 233; *see also* D. Moodley 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*, 187 J. INFECTIOUS DISEASES 725 (2003).

[69] *See* Press Release, Boehringer Ingelheim, Boehringer Ingelheim Offers VIRAMUNE® (nevirapine) Free of Charge to Developing Economies for the Prevention of HIV-1 Mother-to-child Transmission (July 7, 2000), *available at* http://www.boehringer-ingelheim.com/hiv/news/ndetail.asp?ID=101; *see also* Pat Sidley, *Drug Firm is to Supply AIDS Drug Free in South Africa*, 323 BRIT. MED. J. 7311, 7311 (2001) (noting the government's initial failure to take up the offer).

the South African government "immediately implement a country-wide program to reduce the risk of mother-to-child transmission of HIV using AZT or Nevirapine."[70] But President Mbeki's opening speech for the conference did not highlight AIDS as a specific problem for Africa, and offered no indication that the government would move forward with PMTCT programs.[71]

In August 2000, the health minister and her nine provincial counterparts announced that the government would continue to avoid the use of AZT for PMTCT, and that Nevirapine-based PMTCT programs would not be considered until the drug was registered for the purpose in South Africa, and then used for two years at a limited number of "pilot sites" around the country.[72]

This was a clear signal that the government had no intention of moving forward with a comprehensive PMTCT program with any speed. But it would still be more than a year before TAC filed its suit. As Mark Heywood of the TAC describes:

> At the International AIDS Conference, TAC seriously considered bringing an urgent High Court application for access to Nevirapine on behalf of several women in the late stages of pregnancy. However, despite scientific consensus on its safety and efficacy, the medicine was not yet registered in South Africa for the prevention of MTCT. AZT was registered, but it was felt that with the greater cost of the medicine, together with the more complicated drug regimen (AZT must be taken daily from 36 weeks of pregnancy) made successful litigation more difficult. TAC's legal counsel cautioned against commencing litigation before Nevirapine was registered.[73]

TAC could have relied upon the fact that Nevirapine was registered for other uses in the country, and that "off label" prescribing (where a doctor prescribes a medicine for uses other than those for which the drug is registered) is widely accepted, but the organization believed that this was asking the court to "invit[e] compromise in the system of medicine registration." Heywood continues: "There was no option for TAC but to continue the campaign, but delay the litigation. Pressure was now turned to the MCC to speed up registration of the drug and on government to clarify its programme."[74]

Neither task proved simple. There were numerous delays in establishing the pilot sites, and continued acrimony between the Health Minister and advocacy groups.[75] After inexplicable

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[70] TAC & HealthGAP Coalition, *Global Manifesto* (July 9, 2000), *available at* http://www.actupny.org/reports/durban-access.html. The manifesto included numerous additional demands, for instance, that drug companies reduce their prices, that wealthy countries support HIV treatment and prevention programs in the South, that all trade pressures being exerted on developing countries seeking to override patents and use generic AIDS medicines be halted, and that international agencies such as UNAIDS and WHO "proceed rapidly with viable programs to increase medication access." *Id.*

[71] Heywood, *Preventing Mother-to-Child HIV Transmission, supra* note 16, at 285-86.

[72] *Id*. at 286. TAC later learned, through leaked minutes, that the health Member of the Executive Council came to this conclusion despite the fact that the country's Chief Director for HIV/AIDS had recommended the immediate implementation of a country-wide PMTCT program, and pointed out the ethical importance of providing to women immediately. *Id.* at 288.

[73] *Id*. at 286.

[74] *Id*.

[75] *Id*. at 290.

delays, Nevirapine was expressly approved for PMTCT use in April 2001.[76] With thousands of preventable infant HIV-infections taking place each month and the necessary registration for Nevirapine in place, TAC recruited some of the country's leading constitutional lawyers, and prepared a comprehensive letter of demand to the Minister of Health and the political heads of the nine provincial health departments. It requested that the government immediately permit doctors—where capacity existed—to prescribe Nevirapine in the public sector and expand beyond the pilot sites to create a national PMTCT program.[77] The Health Minister refused both requests, citing resource constraints, anticipated problems with Nevirapine-induced viral resistance to HIV medicines, concerns about the lack of safe alternatives to breastfeeding, and questions about sustainability.[78] The Campaign had finally exhausted all options, and so commenced a constitutional suit.

Litigation and Rulings

On August 21, 2001, TAC filed suit in the Pretoria High Court, along with two other plaintiffs: the Children's Rights Centre in Durban and a coalition of concerned pediatricians known as "Save Our Babies." Some external groups and allies, such as the Congress of South African Trade Unions, were quietly supportive, but "reluctant publicly to endorse taking 'our' government to court."[79] TAC members were not so reticent. Here it is worth reflecting on another precondition of a successful lawsuit. Before a court can enforce a right, it needs a willing plaintiff. In post-apartheid South Africa, many organizations have been reluctant to challenge directly the overwhelmingly popular African National Congress government, and unwilling to use the courts and the Constitution in their struggle for social change.

In their pleadings, TAC and its co-applicants contended that the government's refusal to extend PMTCT programs beyond the pilot sites and its refusal to permit doctors—where capacity existed—to prescribe Nevirapine for PMTCT in the public health sector violated sections 27(1) and (2) of the Constitution, as well as other constitutional provisions dealing with rights to life, equality, dignity, bodily and psychological integrity, and children's rights.[80] The application also argued that the government's policy violated the Universal Declaration on Human Rights (which South Africa recognized as forming part of customary international law), as well as several human rights treaties that had been signed and ratified by South Africa: the International Covenant on Civil and Political Rights, the African Charter on Human and People's Rights, the Convention on the Elimination of All Forms of Discrimination Against Women, the Convention on the Rights of the Child and the International Convention on the Elimination of All Forms of Racial Discrimination.[81]

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[76] TAC learned through documents obtained in litigation that the internal MCC decision that the drug was safe and effective had occurred in November 2000. *Id*. at 289.
[77] *Id.* at 289-91.
[78] *Id.* at 291.
[79] *Id.* at 300.
[80] Founding Aff., supra note 32, at paras. 268-75.
[81] *Id.* at paras. 284-91. The founding affidavit also referred to the ICESCR, which South Africa has signed but not yet ratified. Interestingly, the only reference to international human rights law in the Constitutional Court's decision is its refusal to adopt the concept of minimum core obligations arising out of various interpretations of the ICESCR.

In the months before the case was filed, TAC had paved the road by recruiting various experts who could show that PMTCT programs were effective and affordable. For example, a professor of economics presented data that she had prepared demonstrating the cost-effectiveness of a Nevirapine-based regime compared with the costs of treating the children who would otherwise contract HIV.[82] A professor of medicine and Principal Medical Specialist for the Provincial Administration of the Western Cape reviewed the existing evidence to demonstrate that Nevirapine was a cheap, effective, safe, and internationally recommended intervention for PMTCT.[83] A former National Director of the HIV/AIDS and Sexually Transmitted Diseases program in South Africa submitted an affidavit providing evidence about rates of HIV infection in the country.[84]

TAC also ensured that the case addressed the human consequences of the government's failure to act by including affidavits from women such as Busisiwe Maqungo, nurses who worked in antenatal clinics and cared for children with HIV, and doctors who were unable to prescribe Nevirapine to their patients and who spoke of the untenable ethical position which they consequently faced.

The government offered a response of more than a thousand pages justifying its policy. First, it argued that a comprehensive PMTCT program was unaffordable, in part because of the cost of Nevirapine, but also because of the costs of counseling, testing, and training healthcare providers.[85] While it admitted that Nevirapine had been registered for PMTCT, the government also suggested that its use could nonetheless be "catastrophic for public health" because it could lead to widespread resistance to ARV medicines.[86] Further, the government stressed that even if Nevirapine were used, some of the drug's effect would be undone through breastfeeding, for example, where women were not able to use baby formula ("formula feed") because of lack of access to clean water.[87]

TAC enlisted support from a variety of experts to counter each of these points in its replying papers. For example, it relied upon the Director of the Centre for Health Policy at the University of the Witwatersrand to identify the capacity that did exist within the healthcare system to provide PMTCT services.[88] The claim was substantially helped by the fact that one

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[82] Affidavit of Professor Nicoli Jean Nattrass, Submitted in Support of the Applicants in *Minister of Health & Others v Treatment Action Campaign & Others (No 2)* 2002 (5) SA 721 (CC) (S. Afr.), at paras. 7-23 (Aug. 15, 2001)**,** *available at* http://www.tac.org.za/Documents/MTCTCourtCase/MTCTCourtCase.htm.

[83] Affidavit of Professor Robin Wood, Submitted in Support of the Applicants in *Minister of Health & Others v Treatment Action Campaign & Others (No 2)* 2002 (5) SA 721 (CC) (S. Afr.), at paras. 17-50 (Aug. 16, 2001), *available at* http://www.tac.org.za/Documents/MTCTCourtCase/MTCTCourtCase.htm.

[84] Karim Aff., *supra* note 7.

[85] *TAC v Minister of Health* 2002 (4) BCLR 356 (T) (High Court judgment describing submission of Dr. Ntsaluba). *See also* Heywood, *Preventing Mother-to-Child HIV Transmission, supra* note 16, at 297.

[86] Answering Affidavit Submitted in Support of the Respondents in *Minister of Health & Others v Treatment Action Campaign & Others (No 2)* 2002 (5) SA 721 (CC) (S. Afr.), at para. 816 (Oct. 20, 2001), *available at* http://www.tac.org.za/Documents/MTCTCourtCase/MTCTCourtCase.htm.

[87] Heywood, *Preventing Mother-to-Child HIV Transmission*, *supra* note 16, at 296.

[88] Affidavit of Helen Schneider, Submitted in Support of the Applicants in *Minister of Health & Others v Treatment Action Campaign & Others (No 2)* 2002 (5) SA 721 (CC) (S. Afr.), at paras. 6-23 (Nov. 4, 2001) , *available at* available at http://www.tac.org.za/Documents/MTCTCourtCase/MTCTCourtCase.htm. ; *see also* Heywood, *Preventing Mother-to-Child HIV Transmission, supra* note 16, at 299.

"rogue" province, the Western Cape, had already submitted an affidavit detailing its plans to create a comprehensive PMTCT program that would reach 90% of the population in need in 2002, and 100% of that population by 2003.[89]

TAC did not limit its enlisted support to South African experts. As Heywood also recounts,

> [C]ontact was made with Dr. Mark Wainberg, one of the world's leading virologists, based in the United States, who agreed to depose to an affidavit countering the selective quotation of one of his own articles by [Director-General of the Department of Health] Ntsaluba around the issue of Nevirapine resistance. Similarly, Dr. Laura Guay, the principle investigator on the [Ugandan Nevirapine] trial, was contacted and supplied an affidavit countering a number of distortions made with regard to this clinical trial.[90]

It was these efforts, along with the affidavits accompanying the initial filing, that made a complicated set of disputes about medical evidence, programmatic structure, and cost-benefit calculation seem simple. Importantly, the successful mobilization by TAC of political sentiment against the government's policy also framed the case in profound ways. Throughout the period that the suit was pending, TAC continued to advocate for a national PMTCT program as well as a comprehensive national ARV treatment program. It held workshops with its volunteers to explain the case, and organized a national treatment summit that took place several days before the High Court hearing, bringing together more than 600 people from civil society, government, and the health care sector.[91] Rallies and marches were held throughout the country. The night before the hearing, 600 TAC supporters stood vigil outside the courthouse.[92]

The ruling issued by High Court Judge Chris Botha on December 14, 2001 did not disappoint. It rejected the government's suggestion that Nevirapine was too toxic or would cause long-term resistance for women, concluded that breastfeeding would not fully negate the benefits of Nevirapine, found that there was "incontrovertible evidence that there is a residual or latent capacity in the public sector outside the eighteen pilot sites to prescribe Nevirapine," and asserted that the cost of the drug was not a concern because it was "minimal."[93] Justice Botha concluded that the government's policy in "prohibiting the use of Nevirapine outside the pilot sites in the public health sector [was] not reasonable and that it [was] an unjustifiable barrier to the progressive realization of the right to health care."[94]

Justice Botha ordered the government to make Nevirapine available in the public health system, and to "plan an effective comprehensive national programme to prevent or reduce mother-to-child transmission for HIV" that included voluntary testing and counseling services, access to Nevirapine and formula feed.[95] In addition, he instructed the respondents to lodge

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[89] Heywood, *Preventing Mother-to-Child HIV Transmission, supra* note 16, at 295. In response to this affidavit, the plaintiffs no longer sought any order against that province.
[90] *Id*. at 298-99.
[91] Heywood, *Shaping, Making and Breaking*, *supra* note 4, at 188-89.
[92] *Id.*
[93] *TAC v. Minister of Health* 2002 (4) BCLR 356, 384 (T).
[94] *Id*.
[95] *Id.* at 387.

plans detailing the steps that they had taken—and planned to take—to implement his order. Such plans were to be lodged with the court by the end of the first quarter of 2002, with the TAC and its allies being given an opportunity thereafter to comment on them and the state a further opportunity to reply.[96]

The government quickly indicated its intent to appeal, effectively putting the order on ice. For most of the next four months, a fierce battle over whether the government had to provide Nevirapine—but not implement a comprehensive PMTCT program—pending that appeal ensued. In response to an application to compel interim implementation notwithstanding the government's application for leave to appeal, the High Court ordered the government to permit state doctors to provide the medicine where it was medically indicated. In so doing, Judge Botha noted that the plaintiffs had shown the "irreparable harm" required for interim implementation because ten children a day would needlessly contract HIV in the absence of the intervention, with the "harm" to the state of implementing pending an appeal being essentially an inconvenience if anything at all.[97] The government sought to appeal this interim order too, but was several times denied leave—including by the Constitutional Court itself a little less than a month before the merits of the appeal were argued.[98]

Yet at the same time, the government seemed publicly to signal a change in its approach to PMTCT. Gauteng province started to expand its PMTCT program beyond the two pilot sites, and despite criticism from the Health Minister, quietly continued.[99] And just over two weeks before the main appeal was argued before the Constitutional Court, Mbeki's Cabinet officially shifted gear, stating, in an official Cabinet press statement:

> Where there is capacity to provide the package of care that is needed, and where the demands of research dictate, sites are being extended. Towards the end of the year, tests will be done on the babies and mothers being monitored, for us to then consider moving to universal access of Nevirapine. A Universal Roll-out Plan in this regard is being worked on and will be released in due course.[100]

But the appeal in the *TAC* case continued, as did TAC mobilization. The group organized protests in several South African cities in the days before the hearing in Constitutional Court, including a march in Johannesburg on the first day of the hearing that drew 5000 people.[101] On that day, activists waited on long lines and filled the courtroom, many wearing the "HIV-positive" t-shirts that had come to be the hallmark of TAC.

On July 5, 2002, the Constitutional Court unanimously found in favor of TAC, squarely rejecting each of the government's arguments about efficacy, safety, resistance, and capacity. The Court's findings and arguments merit close consideration because they point to TAC's

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[96] *Id*..
[97] *TAC v Minister of Health,* TPD Case No 21182/2001 (Mar. 8, 2002) 12-13 (on file with authors).
[98] Heywood, *Preventing Mother-to-Child HIV Transmission, supra* note 16, at 304.
[99] *Id*.
[100] *Summary on Government's Position on HIV/AIDS* (Apr. 17, 2002), *available at* http://www.info.gov.za/issues/hiv/govposition02.htm.
[101] Heywood, *Preventing Mother-to-Child HIV Transmission*, *supra* note 16, at 310.

success in defining the contours of reasonable debate about PMTCT, and the government's approach to the issue. Importantly, the judgment relied on the factual evidence provided by TAC, and, wherever it could, on the government's own admissions and actions—many of which had been prompted by pressure from TAC and its co-plaintiffs. The Court noted, for example, that the "decision of the government to provide Nevirapine to mothers and infants at the research and training sites is consistent only with government itself being satisfied as to the efficacy and safety of the drug."[102]

The Court carefully skirted the resource-allocation issue in similar fashion, pointing out that the government admitted that the cost of Nevirapine was "within the resources of the state,"[103] and that it had admitted "at the hearing of the appeal that the government has made substantial additional funds available for the treatment of HIV, including the reduction of mother-to-child transmission. . . . This means that the budgetary constraints referred to in the affidavits are no longer an impediment."[104] Thus, despite a well-documented history of state inaction, the Court portrayed the limited PMTCT program as one that had been freely chosen by the state. This made the court's jurisprudential job considerably easier, and was made possible by the comprehensive campaigning of TAC.

In its legal analysis, the Court forcefully rejected the government's argument that the right to have access to health services is not justiciable.[105] But, it also declined expressly to adopt the jurisprudential approach taken by the U.N. Committee on Social, Economic and Cultural Rights in interpreting the ICESCR. This so-called "minimum core" approach—designed to make socio-economic rights easier to apply—posits that states must respect an essential "core" of social and economic rights, despite the broad caveat in the ICESCR (Article 2) that obliges a state party to respect such rights to "the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized." As described by the Committee:

> The concept of progressive realization constitutes a recognition of the fact that full realization of all economic, social and cultural rights will generally not be able to be achieved in a short period of time. In this sense the obligation differs significantly from that contained in article 2 of the International Covenant on Civil and Political Rights which embodies an immediate obligation to respect and ensure all of the relevant rights. Nevertheless, the fact that realization over time, or in other words progressively, is foreseen under the Covenant should not be misinterpreted as depriving the obligation of all meaningful content. [106]

To ensure this, the Committee went on to conclude that the treaty imposes a "minimum core obligation" on all states to ensure "minimum essential levels of each of the rights."[107] As a

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[102] *TAC (No 2)* 2002 (5) SA 721 (CC) at para. 62 (S. Afr.).
[103] *Id*. at para. 71.
[104] *Id*. at para. 120.
[105] *Id.* at para. 106.
[106] U.N. Committee on Economic, Social and Cultural Rights [CESCR], *General Comment 3: The Nature of States Parties Obligations (Article 2(1))*, para. 9, U.N. Doc. E/1991/23 (Dec. 14, 1990).
[107] *Id*. at para 10.

result, "a State party in which any significant number of individuals is deprived of essential foodstuffs, of essential primary health care, of basic shelter and housing, or of the most basic forms of education is, prima facie, failing to discharge its obligations under the Covenant," even if the state argues that it lacks resources or is working towards this goal in progressive fashion.[108]

An *amicus curiae* in the *TAC* appeal urged the Constitutional Court to read section 27(1) of the South African Constitution to create its own "minimum core" to which individuals are entitled without regard to the "progressive realization" and "available resources" qualifications of section 27(2).[109] In declining to do so, the Court relied on the text of section 27 and its worry that "courts are not institutionally equipped to make the wide-ranging factual and political enquiries necessary for determining what the minimum core standards . . . should be."[110] Importantly, the Court did not abandon the concept of minimum core entitlements completely. Instead, it reaffirmed the position stated in *Grootboom* that the idea of minimum core is potentially relevant "in determining whether measures adopted by the State are reasonable."[111] In other words, the failure to provide a minimum set of benefits in a particular context may indeed constitute unreasonable—and thus unconstitutional—conduct.[112]

Relief Granted

With these preliminary interpretive issues decided, the Constitutional Court was now in a position to answer the two key legal questions of the case. First, was the state entitled to limit the provision of Nevirapine for PMTCT to eighteen identified sites, "even where it was medically indicated and adequate facilities existed for the testing and counseling of the pregnant women concerned"? Second, had the state "devise[d] and implement[ed] within its available resources a comprehensive and coordinated programme to realise progressively the rights of pregnant women and their newborn children to have access to health services to combat . . . [MTCT]?"[113] Applying the reasonableness test set forth in *Grootboom*, the Court held in favor of the TAC on both issues.[114] Its analysis was highly case-specific, eschewing any broad statements about the nature of the constitutional right to health services and simply concluding that—absent any real resource constraints or safety issues, and given the existing capacity in the health sector—the government's position was unreasonable.[115]

What remedy should follow? The Court stated the general principle that "[w]here a breach of any right has taken place, including a socio-economic right, a court is under a duty to

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[108] *Id.*
[109] *TAC (No 2)* (5) SA at para. 26. *See also Government of the Republic of South Africa & Others v Grootboom & Others* 2001 (1) SA 46 (CC) at paras. 27-33 (S. Afr.) [hereinafter *Grootboom*].
[110] *TAC (No 2)* (5) SA at para. 37.
[111] *Grootboom* (1) SA at para. 33; *see also TAC (No 2)* (5) SA at para. 34 (suggesting that the minimum core is "relevant to reasonableness under section 26(2)").
[112] In this regard, see *N v Government of Republic of South Africa (No 1)* 2006 (6) SA 543 (D), in which the failure to provide prisoners at a particular facility with access to ARV treatment was held to be unreasonable, and therefore unconstitutional.
[113] *TAC (No 2)* (5) SA at para. 135.
[114] For further discussion of the *TAC* case, see Heywood, *Preventing Mother-to-Child HIV Transmission, supra* note 16. *See also* Mark Heywood, *Contempt or Compliance? The* TAC *case after the Constitutional Court Judgment*, 4 ESR REV. 7 (2003) [hereinafter Heywood, *Contempt*].
[115] *TAC (No 2)* (5) SA at para. 80.

ensure that effective relief is granted,"[116] and noted the courts' obligations to be flexible and creative in crafting effective remedies, because "'[p]articularly in a country where so few have the means to enforce their rights through the courts, it is essential that on those occasions when the legal process does establish that an infringement of an entrenched right has occurred, it be effectively vindicated.'"[117]

The Court then ordered the government "without delay" to permit doctors to prescribe Nevirapine in state clinics and hospitals; to "facilitate" the use of Nevirapine for PMTCT; and to take "reasonable measures" to expand testing and counseling programs in the state sector to facilitate the use of Nevirapine.[118] But it also vacated the lower court's order that the government return to court to submit its new plan. Part of the Court's reluctance to grant the supervisory order plaintiffs had sought appears rooted in the fact that by the time the case was argued, the state's official position had changed. As we have already mentioned, the government had already—albeit reluctantly—expressly committed itself to the universal rollout of PMTCT services, and certain provinces had started to implement such programs.[119] The Court wrote:

> Government policy is now evolving. Additional sites where Nevirapine is provided with a full package to combat mother-to-child transmission of HIV are being added. In the Western Cape, Gauteng and KwaZulu-Natal, programmes have been adopted to extend the supply of Nevirapine for such purpose throughout the province. What now remains is for the other provinces to follow suit. The order that we make will facilitate this.[120]

Formally, the Court justified its decision by holding that supervisory orders should issue only when "necessary," and by noting that "the government has always respected and executed orders of this Court. There is no reason to believe that it will not do so in the present case."[121]

This statement is notably incongruous with the history of denialism and obstructionism within the South African government that initially led to the *TAC* case. The Court's expressed confidence was clearly in part intended as a performative statement, to produce the compliance that the Court desired. But it also hints at an implicit delegation of the enforcement of the decision—to civil society, and specifically to the TAC itself. If the government did not comply with the decision, or stalled in its implementation, the Court may have presumed that TAC would simply return to court, judgment in hand, and demand its enforcement. If so, the presumption overstated the capacity of the TAC, as we will see.

Outcome and Impact

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[116] *Id.* at para. 106.
[117] *Id*. at para. 102 (citing *Fose v Minister of Safety and Security* 1997 (3) SA 786 (CC) at para. 69 (S. Afr.)).
[118] *Id*. at para. 135.
[119] *See* Jonathan Michael Berger, *Litigation Strategies to Gain Access to Treatment for HIV/AIDS: The Case of South Africa's Treatment Action Campaign*, 20 WIS. INT'L. L. J. 595, 601-03 (2002).
[120] *TAC (No 2)* (5) SA at para. 132.
[121] *Id.* at para. 129 (footnote omitted). Interestingly, the Court relied in part on the decision of the Nova Scotia Court of Appeals in *Doucet-Boudreau v. Nova Scotia (Dep't of Educ.)* (2001) NSCA 104, 128, stating: "Canadian courts have also tended to be wary of using the structural injunction," *TAC (No 2)* (5) SA at para. 110. The *Doucet-Boudreau* decision has since been overruled by the Supreme Court of Canada ("SCC"). *See Doucet-Boudreau v Nova Scotia (Minister of Educ.)*, (2003) 3 S.C.R. 3.

Since the Constitutional Court judgment, tens of thousands of mothers and children have received the single-dose Nevirapine regimen in South Africa. It is beyond rational question that thousands of young lives and immeasurable suffering have been spared.[122]
Justice Edwin Cameron
Bloemfontein, South Africa

Analysis and Response

Activists responded to the ruling with immediate elation, singing and dancing outside of the Court and the TAC's Johannesburg offices.[123] The Health Minister's response was more equivocal. In an interview she gave at the Fourteenth International AIDS Conference in Barcelona, Tshabalala-Msimang was reported to have "described drugs used to prevent transmission of HIV from mother to child as poison."[124] But in another interview, the Minister declared that the government would accept the ruling of the Court, and even insisted that its ruling in fact "'confirmed the approach of her department in planning to extend the availability of Nevirapine."[125] The reality seems to be that the ruling was, as the *Financial Times* noted, "a crushing defeat for the government."[126]

Since it was handed down, the decision in the *TAC* case has been widely hailed as a deeply significant judgment and as a symbol of the power that courts can have on the terrain of socio-economic rights. One TAC lawyer, for example, declared that the case "shows that the Constitution creates a powerful tool in the hands of civil society, to ensure that the government gives proper attention to the fundamental needs of the poor, the vulnerable and the marginalised."[127] Other legal commentators agreed that the ruling demonstrated conclusively the importance of socio-economic rights, but criticized the Court for failing to retain supervisory jurisdiction, effectively leaving it up to TAC to ensure government compliance. In addition, they criticized the decision's failure to adopt the minimum core approach, as described above.[128]

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[122] Cameron, *supra* note 36, at 117.
[123] *See, e.g.*, *Court Ruling on Supply of Aids Drugs Welcomed*, BBC NEWS, July 5, 2002. *See also* Nicol Degli Innocenti & Geoff Dyer, *Court Victory for Aids Campaigners*, FIN. TIMES (LONDON), July 6, 2002, at 8 (citing TAC leader Zackie Achmat's statement: "We are elated by the ruling. . . [b]ut there is an element of sadness too, because we had to fight government for five years and it was a totally unnecessary battle.") [hereinafter Innocenti & Dyer].
[124] *See*, *e.g.*, Laurie Garrett, *Anti-HIV Drug Poison, Summit Told*, THE AGE, July 9, 2002, *available at* http://www.theage.com.au/articles/2002/07/08/1025667115671.html. Unsurprisingly, this comment was later denied.
[125] Carmel Rickard, *Human Rights Triumph As State Loses AIDS Battle*, SUNDAY TIMES (JOHANNESBURG), July 7, 2002, *available at* http://www.aegis.com/news/suntimes/2002/ST020701.html.
[126] Innocenti & Dyer, *supra* note 122, at 8.
[127] Geoff Budlender, *A Paper Dog with Real Teeth*, MAIL & GUARDIAN (S. AFR.), July 12, 2002, *available at* http://www.tac.org.za/Documents/Other/geoff_budlender.txt.
[128] *See, e.g.*, Sandra Liebenberg, *Enforcing Basic Rights*, FINANCIAL MAIL (S. AFR.), July 12, 2002, *available at* http://www.queensu.ca/msp/pages/In_The_News/2002/July/basic.htm; Bilchitz, *supra* note 14; Marius Pieterse, *Resuscitating Socio-Economic Rights: Constitutional Entitlements to Health Care Services*, 22 S. AFR. J. HUM. RTS. 473, 474 (2006).

Another group instead found remarkable how strong the court's order and judgment in fact were, especially when compared to the order in *Grootboom*.[129] *Grootboom*, after all, ordered the government only to develop a *plan* to address the housing needs of the poorest and most vulnerable people; the decision in the *TAC* case instead ordered the government to provide Nevirapine "without delay" in the public health sector, and to build the counseling and testing services needed to make the PMTCT program effective.[130] Several commentators have offered the same explanation of the difference between the two results: The *TAC* case, they state, was much easier. As one wrote:

> The crucial factor that separates *TAC* from *Grootboom* is not greater assertiveness on the part of the Court, but the fact that extending an entitlement to Nevirapine—where the drug is medically indicated and where, if necessary, testing and counseling are available—had only limited cost-implications and did not involve issues involving great expertise.[131]

But, it seems just as odd to present the *TAC* case as an inherently "easy case" as it is to present the judgment as the result of a sudden assertiveness on the part of the Constitutional Court. The issue of PMTCT services in South Africa did not start out as a simple one. The pre-history of the *TAC* case demonstrates that the result relied crucially on concerted and savvy advocacy that made an initially difficult issue appear simple, and morally imperative. And the Court must have been attuned to the very real possibility that such a decision would have significant financial implications beyond PMTCT, in particular regarding government policy on ARV treatment and access to other HIV-related services.

As the narrative above demonstrates, the case for these programs was built by a large coalition over many years. It involved not only legal expertise, but also scientific, medical, and economic expertise, and a broad public consensus in favor of PMTCT. It also required recognition of the AIDS denialism that had taken hold in the government. Had TAC brought its case several years earlier, before it had, for example, worked to ensure the timely registration of Nevirapine for PMTCT, and to mobilize healthcare providers and women to demand PMTCT services, the case would not have been an easy one at all.

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[129] Jonathan Klaaren, *A Remedial Interpretation of TAC*, 20 S. AFR. J. HUM. RTS. 455, 460-61 (2004) (stating "[T]he judges took their role of evaluation very seriously. Governmental objections were assessed against evidence and found wanting. . . . The case was an example of a willingness to closely scrutinize the government's decisions with respect to access to socio-economic rights. In administrative law terms, TAC was a hard-look case."); Mark Tushnet, *Social Welfare Rights and the Forms of Judicial Review*, 82 TEX. L. REV. 1895, 1906 (2004) (calling *TAC* an example of enforcement of a "strong social welfare right," i.e., one that "courts will enforce . . . fully, without giving substantial deference to legislative judgments, whenever they conclude that the legislature has failed to provide what the constitution requires").

[130] *TAC (No 2)* 2002 (5) SA 721 (CC) at para. 135 (S. Afr.).

[131] Murray Wesson, Grootboom *and Beyond: Reassessing the Socio-Economic Jurisprudence of the South African Constitutional Court*, 20 S. AFR. J. HUM. RTS. 284, 296 (2004). *See also* Tushnet, *supra* note 15, at 826 (crediting the decision to the fact that "South African legal elites knew that the government's policy was motivated in large measure by President Thabo Mbeki's expressed view that AIDS was not caused by HIV," as well as to the fact that Nevirapine had been approved "through the ordinary processes for the approval of drugs," the government's concession that Nevirapine was affordable, and the government's decision to "make Nevirapine generally available by the time the Constitutional Court decided the case").

Immediate and Practical Impact on PMTCT

The importance of reading *TAC*—the case—through the lens of TAC—the movement—becomes even more evident when we look to the aftermath of the decision. The political and symbolic significance of the decision in the *TAC* case cannot be overemphasized. It dealt a decisive blow to denialism within the government, and ensured that the Ministry of Health could no longer simply refuse to provide comprehensive PMTCT services in the public sector.[132] But, in terms of its immediate and practical impact on the provision of PMTCT services, the record is significantly less spectacular.

Since the Court's decision in July 2002, implementation of the PMTCT program has been patchy at best. Although the government insisted that it was complying with the ruling, it also refused to give TAC information about its plans and progress. Only after TAC threatened further legal action did the government provide it with information about what had been done to comply.[133] In general, "TAC found that . . . in provinces where there was already a commitment to establishing a comprehensive PMTCT program . . . the judgment unshackled health departments and politicians and opened the door to implementation."[134] In other provinces, the result was decidedly otherwise. In Mpumalanga province, for example, implementation only began after the TAC held a public demonstration and filed contempt of court proceedings.[135]

Most disturbing is that six years later, the PMTCT program in South Africa still has a long way to go to reach universal coverage. While the state claims relatively high levels of coverage,[136] a sizeable disconnect between the estimated numbers of pregnant women in South Africa with HIV and those actually accessing the full PMTCT package of services appears to remain.[137] As the South African Health Review 2006 explains:

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[132] As late as October 24, 2000, the Minister of Health stated: "[t]here is a narrow view again that continues to associate prevention of mother to child transmission of HIV with the use of antiretrovirals only. . . . We know there are other medical interventions. . . . We know . . . [ARV medicines] are toxic." *See* Steven Swindells, *South Africa Limits Role of Key Drugs in AIDS Fight*, REUTERS NEWS MEDIA, Oct. 24, 2000, *available at* http://www.aegis.com/news/re/2000/RE001017.html. A day later, UNAIDS recommended that PMTCT programs constitute a base level of care for pregnant women with HIV and their children. *See* Press Release, UNAIDS, Preventing Mother-to-Child HIV Transmission: Technical Experts Recommend Use of Antiretroviral Regimens Beyond Pilot Projects (Oct. 25, 2000), *available at* http://www.thebody.com/content/treat/art651.html.

[133] Heywood, *Contempt, supra* note 112, at 9.

[134] *Id.*

[135] *Id*. at 10.

[136] *See* REPUBLIC OF S. AFR., PROGRESS REPORT ON DECLARATION OF COMMITMENT ON HIV/AIDS (REPORTING PERIOD JAN. 2006 TO DEC. 2007) (PREPARED FOR THE U.N. SPECIAL SESSION ON HIV AND AIDS) 24-25 (Mar. 4, 2008) [hereinafter S. AFR. PROGRESS REPORT 2006-07], *available at* http://data.unaids.org/pub/Report/2008/south_africa_2008_country_progress_report_en.pdf.

[137] The South African Country Progress Report for the U.N. Special Session on HIV and AIDS appears to misrepresent the data. For example, the report claims that "[t]he total number of HIV-positive pregnant women identified and enrolled into the PMTCT programme in 2006 was 186,646 (72.7%)"—out of an estimated 256,700 HIV-positive pregnant women who attended antenatal services in the public health sector that year. However, an earlier draft of the country report (on file with the authors) indicated that only 69,952 HIV-positive women accessed ARV medicines for PMTCT in 2006. Using that number, coverage of comprehensive PMTCT services in 2006 was below 30%. It appears as if the state is using the wrong numerator in its calculations. S. AFR. PROGRESS REPORT 2006-07, *supra* note 134, at 24.

> PMTCT data from the 53 health districts in [South Africa] for 2004 indicated that a relatively low proportion of mothers actually got tested for HIV, resulting in many deliveries of women of unknown HIV serostatus and missed opportunities to prevent MTCT.[138]

In other words, the programs that do exist are not reaching many of the women who need them, apparently in significant part because women either are not being offered HIV tests or because they are not agreeing to be tested. This need not be the case, however. For instance, 95% of women who attend the Cape Town Médecins Sans Frontières PMTCT program in Khayelitsha agree to be tested, in part because of the quality of the counseling offered.[139] The result of a substandard regimen,[140] the lack of testing uptake, the low rates of ARV access, and the persistence of breastfeeding as a mode of transmission, is that an estimated 64,000 children contracted HIV from their mothers in 2006.[141]

It has also long been clear that PMTCT interventions are far more successful if they use several ARVs than if they use only one. More drugs means more expensive—and potentially more complicated—programs, but a consensus has emerged since the *TAC* case that simple multi-drug regimens are sufficiently cost effective and should now be the standard in developing countries, many of which are already implementing significantly more complex ARV treatment programs. World Health Organization ("WHO") guidelines now officially recommend such regimens.[142] But until relatively recently, all but one province in South Africa—the Western Cape—still relied upon a single-dose Nevirapine regimen.

The new national *HIV & AIDS and STI Strategic Plan for South Africa, 2007-2011* ("National Strategic Plan") recognizes the centrality of improving the PMTCT program, and the importance of moving to more efficacious drug regimens.[143] Once again, however, the presence

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[138] Arthi Ramkissoon et al, *Options for HIV Positive Women*, *in* SOUTH AFRICAN HEALTH REVIEW 2006, 315, 323(P. Ijumba & A. Padarath eds., Health Systems Trust 2006).

[139] Médicins Sans Frontièrs, Activity Report, *Providing HIV Services Including Antiretroviral Therapy at Primary Health Care Clinics in Resource-Poor Settings: The Experience from Khayelitsha* 14 (2003) (showing an over 95% acceptance rate for 2002 and 2003), *available at* www.msf.org/source/countries/africa/southafrica/2004/1000/khayelitsha1000.pdf.

[140] The new PMTCT protocol, adopted on February 11, 2008, is much improved. While it still falls short of international good practice, early indications suggest that it will result in a significant reduction in HIV incidence amongst infants. In this regard, see Louise Flanagan, *Gauteng sees progress in mom-and-baby programme*, INDEPENDENT ONLINE (JOHANNESBURG), Sept. 2, 2008, *available at* http://www.iolhivaids.co.za/index.php?fSectionId=1591&fArticleId=4589806. To view the 2008 protocol, see The National Department of Health, *Policy and Guidelines for the Implementation of the PMTCT Programme* (Feb. 11, 2008) *available at* http://www.doh.gov.za/docs/policy/pmtct.pdf.

[141] *See* Dorrington, *supra* note 25, at ii.

[142] WORLD HEALTH ORGANIZATION, ANTIRETROVIRAL DRUGS FOR TREATING PREGNANT WOMEN AND PREVENTING HIV-INFECTIONS IN INFANTS: TOWARDS UNIVERSAL ACCESS, RECOMMENDATIONS FOR A PUBLIC HEALTH APPROACH, 27 (2006), *available at* http://www.who.int/hiv/pub/guidelines/pmtctguidelines3.pdf.

[143] SOUTH AFRICAN NATIONAL AIDS COUNCIL, HIV & AIDS AND STI STRATEGIC PLAN FOR SOUTH AFRICA, 2007-2011 (2007) [hereinafter NATIONAL STRATEGIC PLAN 2007], *available at* http://www.info.gov.za/otherdocs/2007/aidsplan2007/khomanani_HIV_plan.pdf. The National Strategic Plan was adopted by the newly constituted South African National AIDS Council ("SANAC") on April 30, 2007, and by Mbeki's Cabinet two days later, was developed under the leadership of Deputy President Phumzile Mlambo-

and activity of a movement to hold the government accountable has been critical. In August 2007, the AIDS Law Project wrote to the health minister on behalf of a group of concerned health care workers, the Southern African HIV/AIDS Clinicians' Society and TAC, demanding that the PMTCT regimen be updated. The minister did not respond. Instead, her department informed the South African National AIDS Council ("SANAC") some three months later that "dual therapy"[144] would become the minimum PMTCT regimen in the country.[145] Despite promising to finalize the amended protocol within two weeks, the process took a further three months.[146]

Despite the Constitutional Court's somewhat misplaced trust in government's willingness to comply with its judgment, as well as its apparent faith in the TAC's tenacity and ability to hold the state to account, the state's failure properly to implement a comprehensive PMTCT program has shown how important it is for courts to be mindful of the fact that even the strongest of civil society organizations do not have unlimited resources and capacity. In retrospect, the Court's order in the *TAC* case did not "ensure that the rights enshrined in the Constitution are protected and enforced,"[147] and was thus not an "appropriate" remedy for the constitutional harm.[148]

As an organization that has used the law, advocacy campaigns and public mobilization effectively to compel the state to invest billions of rands into the provision of health care services, even the TAC was not able to ensure proper implementation of the Court's judgment. In part, its "failure" to hold the state to account lies in its focus on the broader campaign for comprehensive HIV treatment services. Had the organization not been fighting the government on a range of other fronts, it would have been able to work with the Court's decision to ensure proper implementation—just as it has been able to use the national treatment plan to ensure that ARV treatment is provided to greater numbers of people in the public sector.

Ngcuka, former Deputy Minister of Health Nozizwe Madlala-Routledge, and Dr Nomonde Xundu, chief director of HIV and AIDS, TB and STIs in the national Department of Health. The plan states: "[e]xtending prevention programmes and getting them to work . . . is critical [to] reducing long-term morbidity and costs. A simple example is PMTCT. If this programme was functioning properly, it would radically reduce paediatric AIDS cases. . . ." NATIONAL STRATEGIC PLAN 2007 at 122. Goals 3.1 and 3.2 include the following: "Broaden existing mother to child transmission services to include other related services and target groups" and "Scale up coverage and improve quality of PMTCT to reduce MTCT to less than 5%." *Id*. at 73-74.

[144] Although technically incorrect, the term "dual therapy" is widely used in South Africa to refer to a two-drug regimen – ordinarily AZT and nevirapine – for PMTCT. Such a regimen is not therapy, but rather prophylaxis.

[145] Telephonic communication from Mark Heywood, Deputy Chairperson, SANAC, to Jonathan Berger (Nov. 28, 2007).

[146] Media communiqué issued by the Government Communications and Information Service (GCIS) on behalf of SANAC (Nov. 29, 2007) (on file with authors). At the same time, the KwaZulu-Natal Department of Health started to take disciplinary action against Colin Pfaff—a public sector doctor—for providing better PMTCT services at Manguzi Hospital in the rural north of the province. Manguzi Hospital was able to do so because it had received donor funds from a UK-based organization. The charges against Pfaff were later dropped. *See* Kerry Cullinan, *Doctor in Trouble for His Attempt to Reverse 'Miserable Lives' of HIV Babies*, HEALTH-E NEWS SERVICE, Feb. 16, 2008, *available at* http://www.health-e.org.za/news/article.php?uid=20031882; Kerry Cullinan, *KZN Drops Misconduct Charges Against Doctor*, HEALTH-E NEWS SERVICE, Feb. 21, 2008, *available at* http://www.health-e.org.za/news/article.php?uid=20031889.

[147] *Fose v Minister of Safety and Security,* 1997 (3) SA 786 (CC) at para. 19 (S. Afr.).

[148] For more on what constitutes appropriate relief, see Kent Roach & Geoff Budlender, *Mandatory Relief and Supervisory Jurisdiction: When is it Appropriate, Just and Equitable?*, 122 S. AFR. L. J. 325 (2005).

The *TAC* case shows why socio-economic rights claimants have to ensure that sufficient evidence is placed before courts regarding the broader social and political context within which their decisions are made. Had the Constitutional Court been more attuned to the broader campaign for access to ARV treatment, or more responsive to the clear history of obstruction within the government, it may well have realized that TAC was not in a position to do what was expected of it. Even if it was wary of granting supervisory jurisdiction in circumstances which had witnessed a significant government retreat in relation to PMTCT policy, the Court should—at a bare minimum—have required the state to report publicly on its progress in implementing the order. In the absence of such information, the TAC was unable to expend the necessary resources to ensure compliance.

Impact on Broader HIV/AIDS Policy

It is no accident that the decisive legal victory in the *TAC* case was used to support the organization's campaign to compel a reluctant state to develop and implement a comprehensive public sector ARV treatment program. Simply put, the case was conceptualized—from the very beginning—as an integral part of the broader treatment access campaign. While the issue of PMTCT was—and remains—of paramount importance, the TAC always conceived of the case as a stepping stone towards the provision—at state expense—of comprehensive HIV treatment services.[149]

Subsequent developments have vindicated the TAC approach, with the case arguably providing the kick-start that was needed to shift the state into action. The first breakthrough came in the Cabinet statement of April 17, 2002 where, in addition to a commitment to implement a comprehensive PMTCT program, the government pledged to ensure the availability of post-exposure prophylaxis services in the public health sector.[150] For the first time, government publicly recognized the utility of ARV medicines in treating HIV infection, acknowledging that they "can improve the quality of life of People Living with AIDS, if administered at certain stages in the progression of the condition and in accordance with international guidelines and protocols."[151]

The skeptic may argue that this action, coming just short of two weeks before the hearing of the appeal in the *TAC* case, was a transparent—and apparently successful—attempt to influence the Constitutional Court. But regardless of intention, the commitment was indeed followed by further action. Shortly after the Court handed down its decision, the government established a Joint Health and Treasury Task Team charged with "examining treatment options to supplement comprehensive care for HIV and AIDS in the public health sector."[152] In an apparent reference to the work of the Task Team, another Cabinet statement issued some three

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[149] *See* Heywood, *Shaping, Making and Breaking*, *supra* note 4.

[150] Post-exposure prophylaxis uses ARV medicines to reduce the risk of HIV transmission following rape and other forms of sexual assault.

[151] Government Communications and Information Service, *Statement of Cabinet on HIV/AIDS*, Apr. 17, 2002, *available at* http://www.tac.org.za/newsletter/2002/ns18_04_2002.txt

[152] *Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa* at 13 [hereinafter OPERATIONAL PLAN 2003], *available at* http://www.info.gov.za/issues/hiv/careplan.htm.

months later on October 9, 2002 claimed that the government was working "to create the conditions that would make it feasible and effective to use antiretrovirals in the public health sector."[153]

But, as has unfortunately been the hallmark of the South African government's response to HIV/AIDS for some time, progress from this point to the adoption of the national treatment plan some thirteen months later was hardly smooth—or inevitable. Among other events that formed part of the TAC intensified program of action, two stand out: a powerful march of 20,000 people on the opening of Parliament in February 2003, and a nationwide campaign of civil disobedience that began little more than a month later on the eve of Human Rights Day. Drawing on a repertoire of protest that evoked the struggle against apartheid, protesters marched on government buildings, staged sit-ins, peacefully provoked arrest, and laid charges of culpable homicide against two government ministers—one for failing to take lawful action to override patents and bring the prices of HIV medicines down, and the other for failing to prevent loss of life through the development and implementation of a treatment program.[154]

The campaign produced results. The Cabinet called a special meeting in which it was decided that "the Department of Health should, as a matter of urgency, develop a detailed operational plan" that would provide ARV treatment in the public sector.[155] On November 19, 2003, Cabinet adopted such a plan, officially committing the government to provide ARV treatment in the public healthcare system.[156] This too was part of the legacy of the *TAC* case. As government experts themselves recognized, the *TAC* case and its predecessors, such as *Grootboom*, helped to inform the government's sense that it was obliged to provide such treatment.[157]

Broader Impact

While it is difficult to measure with precision the extent to which the decision in the *TAC* case was responsible for the development, adoption and subsequent implementation of South Africa's national treatment plan, the evidence points in the direction of significant influence. In addition to strengthening the public campaign of TAC, and assisting the state to think through its

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[153] Government Communications, *Update on Cabinet's Statement of 17 April 2002 on Fighting HIV/AIDS*, (Oct. 9, 2002) *available at* http://www.info.gov.za/issues/hiv/updateoct02.htm.

[154] The decision to make March 21 Human Rights Day was a deliberate one. Formerly known as Sharpeville Day, the date marks the anniversary of a particularly bloody attack in 1960 by police officers on peaceful protesters of the apartheid regime. In Gauteng province, the TAC civil disobedience campaign involved a march to the local Sharpeville police station to lodge the culpable homicide charges.

[155] Government Communications, *Statement on Special Cabinet Meeting: Enhanced Programme Against HIV and AIDS* (Aug. 8, 2003), *available at* http://www.info.gov.za/speeches/2003/03081109461001.htm.

[156] Operational Plan, *supra* note 152, at 246.

[157] Government of the Republic of South Africa, *Rep. of the Joint Health and Treasury Task Team Charged with Examining Treatment Options to Supplement Comprehensive Care for HIV/AIDS in the Public Health Sector*, (Aug. 1, 2003) [hereinafter *Task Team Rep.*], *available at* http://www.info.gov.za/otherdocs/2003/treatment.pdf. Other noteworthy cases in this regard are *Soobramoney v Minister of Health (KwaZulu-Natal)* 1998 (1) SA 765 (CC) (S. Afr.), and *Government of the Republic of South Africa & Others v Grootboom & Others* 2001 (1) SA 46 (CC) (S. Afr.). An Appendix of the *Task Team Report* indicated that these cases "outlined some principles which are relevant to the question of whether and in what manner antiretroviral drugs should be supplied in the public health sector." See *Task Team Rep.* App. at 2 (internal citation omitted)

constitutional obligations in respect of the treatment of HIV infection, the case was instrumental in solidifying the foundation for further litigation, advocacy, mobilization and campaign work that were necessary for the country to reach the point where the new National Strategic Plan could be developed in a truly consultative manner.

The emerging health rights jurisprudence—to which the *TAC* case makes a significant contribution—has been used successfully by the TAC in at least three further matters relating to access to treatment for HIV infection: *Hazel Tau v GlaxoSmithKline South Africa (Pty) Ltd. and Boehringer Ingelheim (Pty) Ltd.*;[158] litigation threatened in March 2004 to compel the state to procure an interim supply of ARV medicines pending the finalization of a formal state tender for the national treatment program; and *N v Government of Republic of South Africa (No 1)*, *N v Government of Republic of South Africa (No 2)*, and *N v Government of Republic of South Africa (No 3).*[159]

The first case, brought by the TAC and others, sought to use competition law to challenge the pricing practices of two multinational pharmaceutical companies, and directly resulted in increasing access to a sustainable supply of affordable ARV medicines. In the second matter, the TAC succeeded in compelling the Minister of Health to procure an interim supply of ARV medicines, and this gave provinces with existing capacity the space to implement the national treatment plan with urgency, saving many lives that would have been lost in the year that it took the government to procure ARV medicines through a formal state tender.[160] The last cases were brought by TAC lawyers on behalf of prisoners living with HIV who needed access to ARVs. As a result of these cases, there has been a significant—although still insufficient—increase in the number of prisoners accessing ARV treatment.[161]

Thus, much of the broader impact of the *TAC* case was not determined until well after the ink was dry on the opinion. Once again, that impact has been significantly shaped by the existence of a strong social movement that has been able to weave the judgment—and the South African Constitution—into a series of ongoing advocacy efforts to improve the lives of people living with, or at risk of being infected by, HIV. Indeed, because AIDS is still an everyday catastrophe in South Africa, and because that movement is stronger than ever, much of the history of the *TAC* case undoubtedly remains to be written.

Conclusion

One of the greatest health and social challenges our country faces is the HIV/AIDS epidemic. Former President Nelson Mandela said, "AIDS is no longer (just) a health issue, it is a human rights issue" . . . . It is a human rights issue that babies continue to be infected by their HIV

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[158] Complaint before the Competition Commission of South Africa, case no. 2002Sep226.

[159] 2006 (6) SA 543 (D) (S. Afr.); 2006 (6) SA 568 (D) (S. Afr.); 2006 (6) SA 575 (D) (S. Afr.).

[160] For example, Gauteng province began to provide ARV treatment only days after the Minister's capitulation on the issue. Other provinces followed shortly thereafter.

[161] For further detail on *N*'s case, see Lukas Muntingh & Christopher Mbazira, *Prisoners' Right of Access to Anti-Retroviral Treatment*, 7(2) ESR REV. 14, 16 (2006); *see also* Adila Hassim & Jonathan Berger, *Case Review: Prisoners' Right of Access to Anti-Retroviral Treatment*, 7(4) ESR REV. 18, 21 (2006); Adila Hassim, *The '5 Star' Prison Hotel? The Right of Access to ARV Treatment for HIV Positive Prisoners in South Africa*, 2 INT'L J. PRISONER HEALTH 157 (2006).

positive mothers because the clinic sister has neglected to tell the pregnant mother about how she could reduce the risk of her baby being infected.[162]
Former Deputy Minister of Health Nozizwe Madlala-Routledge
Cape Town, South Africa

Much of what the *TAC* case has to offer, both in terms of lessons learned and a possible way forward, lies beyond the academic debates that ordinarily focus narrowly on legal doctrine and ideology. Considering it in its totality—from the initial advocacy before the TAC was even established, through the recent adoption of South Africa's National Strategic Plan (which includes a renewed focus on PMTCT)—shows the *TAC* case as a tool in a broader campaign, rather than simply a case.

For lawyers working in the field of human rights and social justice litigation, the *TAC* case merely reinforces what many have long realized—that, while law and legal institutions have the potential to be used as tools of social change, their impact in large part depends on how and by whom they are used. As much work as is needed to prepare for litigation, much more is needed to ensure that a successful court decision translates into successful societal outcomes. And regardless of how far courts are prepared to go in fashioning their orders, those fighting to create change can rely only on themselves to ensure that jurisprudential victories put bread on the table, or pills in mouths, or roofs over people's heads. While courts may make the job of civil society much easier through the use of creative remedies, ultimately enforcement requires active participation from an organized and mobilized populace.

For economists, scientists, researchers and academics, to name but a few relevant professions, the *TAC* case shows how knowledge needn't—and shouldn't—be produced in a vacuum. Instead, valuable research can and must be used to benefit society more broadly, and to ensure that public policy is well-informed, evidence-based and responsive to real needs. But perhaps more important, the *TAC* case shows that we cannot take science and scientific thought for granted and that, on their own, they are highly vulnerable to the raw muscle of politics.

For poor people, the *TAC* case shows the power of organization, mobilization and voice. In the context of South Africa in particular, it demonstrates the crucial link between civil and political rights on the one hand, and socio-economic ones on the other. Without the political space to assemble, express views contrary to unreasonable state policy, and popularize and clarify demands through a free press, the socio-economic demands of TAC regarding access to state resources for addressing people's health needs would most likely not have been realized. And without giving expression to the voices of people like Busisiwe Maqungo, the real impact of the impugned policy may not have been clearly understood.

For all of us, the *TAC* case shows that successful struggles for social justice are interrelated. While Irene Grootboom—the first applicant in the landmark housing rights case discussed above who passed away in August 2008—may not have seen any significant improvement in her living conditions, her case has proved an indispensable part of ensuring that

[162] Nozizwe Madlala-Routledge, foreword, *Health & Democracy: A Guide to Human Rights, Health Law and Policy in Post-Apartheid South Africa* (Adila Hassim et al. eds., 2007). A transcript of the former Deputy Minister's speech at the formal launch of the book can be found at http://www.doh.gov.za/docs/sp/2006/sp1027.html.

the South African state begins taking its responsibilities in respect of health care services seriously. In just six years, the *TAC* case has played an instrumental role in helping to catalyze fundamental shifts in state policy, resource allocation and the balance of power between the state and those in whose name and on whose behalf it exists.

Yet the story of the *TAC* case is far from complete. It will remain so for as long as hundreds of thousands of people each year in South Africa are infected with HIV and die from AIDS-related illnesses, and access to comprehensive health care services remains a luxury enjoyed primarily by the rich. The *TAC* case is thus at once a victory, a tool for future activism to protect basic human rights, and a promise waiting to be redeemed.