UNIVERSITY OF KWAZULU-NATAL

A MINIMUM CORE CONTENT TO THE RIGHT TO HEALTH FOR HIV-POSITIVE PERSONS UNDER SOUTH AFRICA'S TRANSFORMATIVE CONSTITUTION

By

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DECLARATION

I, **VIRASHMEE RAMDIAL**, declare that:

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ABSTRACT

This dissertation is an evaluation of the concept of a minimum core content to the constitutional right to health, with particular reference to HIV-positive persons in South Africa. The analysis involves an assessment of what the minimum core entails; whether such a formulation is necessary in the South African health context; the application of the concept in national and international law; as well as enforcement and implementation in the South African context.

An appraisal of the South African social reality reveals the extent of the suffering of HIV-positive individuals and the difficulties experienced in accessing health care, especially for the vulnerable and disempowered. The problem is exacerbated by a critical inadequacy in national jurisprudence which fails to generate certainty in respect of the minimum, basic entitlements of affected people.

Such a shortcoming maligns transformative constitutionalism, which requires the judiciary to develop a construction of human rights that accords with the canons of the Constitution. It is argued that one such course of action is the adoption of the minimum core, which prescribes a basic level of human rights that is guaranteed to all people – and which may withstand legislative challenge on the basis of resource constraints or progressive realisation.

Reference to international law, in terms of Section 39(1) of the Constitution, assists us to overcome the shortcoming in domestic legislation in this regard. Of particular relevance is covenantal guidance offered by the ICESCR, and its guidelines of interpretation, which include the CESCR General Comments and the WHO recommendations.

It is postulated that a minimum obligation to HIV-positive individuals under the right to health encompasses the duty of treatment and prevention and control in respect of the epidemic, on a non-discriminatory basis.

Enforcement and implementation of such core obligations must be strictly and timeously effected. Of crucial importance in such a process is a competent judiciary that is able to resist an undue deference to the legislature. A review of court judgments, however, reveals an inadequate judicial approach to the implementation of socio-economic rights and an appeal is made to the Constitutional Court to re-commit itself to an interpretation of the Bill of Rights that accords with Constitutional values, such as *uBuntu*.

DEDICATION

This dissertation is dedicated to my parents, Kanaye and Bindu Ramdial. I am eternally grateful to you for the values that you have instilled in me. Thank you for being the voice in my head that always motivates me to do better, to be the change that I wish to see in the world. You are my inspiration always.

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UNIVERSITY OF KWAZULU-NATAL

TABLE OF CONTENTS

CHAPTER 2:

Prescribing a minimum core content to the right to health – does National and International Law allow for the concept

CHAPTER 3:

Application of the Minimum Core concept to the right to health under Section 27 in respect of HIV-positive individuals

CHAPTER 4:

Implementation and Enforcement, and the path going forward

INTRODUCTION:

The South African Constitution[1] is premised on the recognition of the injustices of the past and establishes a society based on democratic values, social justice and fundamental human rights.[2] The Constitution has been hailed as being one of the few transformative constitutions in the world[3] - the embodiment of human rights and an instrument of democratic change. The legal culture of transformative constitutionalism engenders the commitment to transform society by creating social and political conditions that promote self-determination and human fulfillment.[4] This is especially important in respect of the constitutional right to access healthcare, and in the context of HIV/AIDS in South Africa. Human rights are also essential to addressing a disease such as HIV/AIDS that impacts marginalized groups most severely.[5]

Nearly twenty years later, South Africa is still a nascent democracy plagued by the legacy of colonialism, apartheid and patriarchy, which translate into new challenges for the state to meet in a society that has come to contend with the tragic consequences of the HIV/AIDS epidemic. In addition to the suffering that the epidemic threatens, HIV/AIDS triggers the violation of number of constitutional rights of millions HIV-positive South Africans[6], crucially the right to access health care.[7]

In order for such affected individuals to seek redress and enforcement of the right to health, judicial intervention is required and sought, by way of various court applications. Such adjudication is thus primary in the enforcement and protection of socio-economic rights and requires a competent and progressive judiciary that is strong to the task. Critical to the judicial process is the courts' interpretation of the rights entrenched in the Constitution.

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[1] The Constitution of the Republic of South Africa, 1996 (referred to as 'the Constitution').
[2] The Preamble to the Constitution; *S v Makwanyane* 1995(3) SA 391 CC; DM Davis and K Klare "Transformative Constitutionalism and the Common and Customary Law" 26 *South African Journal on Human Rights* 403 2010.
[3] S Liebenberg *Socio-Economic Rights: Adjudication under a Transformative Constitution* 1ed. (2010) Juta 25.
[4] Ibid.
[5] L Stemple 'Health and human rights in today's fight against HIV/AIDS' *AIDS* August 2008 22.
[6] Socio-economic rights are embodied in Sections 24 - Environment, 25 - Property, 26 - Housing & 27 - Access to health care, food, water and social security, of the 1996 Constitution.
[7] Section 27. Note: In this paper, this right may also be referred to as 'the right to health' interchangeably.

The purpose of this dissertation is to assess whether the South African experience has demonstrated a constitutionally viable and defensible interpretation of socio-economic right entitlements, with particular reference to the right to health of HIV-positive persons within a human rights framework. Fundamental to this assessment is the issue of what exactly is the court interpreting and enforcing? In order to judge the validity of the court's construction of the right to health, and its ensuing entitlements and obligations, and in order to properly enforce and implement such entitlements, it is imperative that the court defines and prescribes the content thereof. Guidance from international legal instruments and foreign case law, which shall be examined, is particularly helpful in this regard. In fact, it is a constitutional imperative that same be considered by the court in its interpretation of the Constitution.[8] However, it is submitted that the court has failed to do so and this omission must be addressed in order to properly enforce the right in question.

The right to healthcare is of particular importance in a society such as ours, decimated by the AIDS pandemic. The South African truth is that the systematic deprivation and discrimination that sidelined the majority of our people from accessing basic social entitlements during apartheid, still manifest after twenty years of constitutional democracy. The sad fact is that, for many, our 'dark past' is still a lived reality, especially for those living with HIV/AIDS. Poverty, discrimination, sexism, and inequality still subvert South Africa today.

It is argued that from a review of the case law that the approach of our courts has not been entirely successful in giving definition to our right to health, and certainly not in respect of HIV-positive individuals. It is also questionable whether the approach currently adopted by the Constitutional Court, that is, one of a reasonableness review, is particularly effective in the enforcement of the rights of HIV/AIDS affected individuals in the context of the catastrophic suffering and fatalities in the most infected country in the world.[9]

[8] Section 39(1), 1996 Constitution.
[9] UNAIDS Report on the Global AIDS Epidemic 2012; http://www.unicef.org/esaro/5482_HIV_AIDS.html.

Given the magnitude of the epidemic, the dire socio-economic consequences that result, and the constitutional role assigned to the judiciary[10] to alleviate the plight of the distressed, a jurisprudential strategy is required that endeavours to address the needs of millions of HIV-positive individuals, while at the same time respecting resource constraints weighing on the state – such that solutions proposed do not defeat the underlying purpose of adjudication, rendering it meaningless.

It is also important for the judiciary to be prudent in its approach so as not to trespass the constitutional parameters that safeguard the separation of powers of the different branches of government. Neither unreasonable interference with, nor undue deference to, the policy-making responsibilities of the legislature and executive shall be acceptable.

It is submitted that the solution to all the above concerns lies squarely in the prescribing of a minimum core content to the right to health[11], in respect of HIV-positive individuals, the interpretation whereof is supplemented by the reasonableness review presently advocated by the court.

The essential enquiry is whether there is a minimum core content to the right to health, with reference to HIV-positive persons, and what such a concept would involve and entail. In order to answer same, it is necessary to conduct an analysis of the constitutional and social context of the right, and the conceptual basis underlining it.

The key issues to be addressed in this dissertation are:

(1) Transformative constitutionalism requires transformative judicial adjudication in the interpretation and enforcement of constitutional rights. Has the approach of the courts, thus far, engendered same?

[10] Section 165.
[11] D Bilchitz 'Towards a Reasonable Approach to the Minimum Core' 19 *South African Journal of Human Rights* 1 2003 11; L Forman 'Ensuring Reasonable Health: Health Rights, the Judiciary and South African HIV/AIDS Policy' 33 *Journal of Law, Medicine and Ethics* 711 2005 719; Liebenberg (see note 3 above) 164.

(2) If so, can the court's approach be improved upon, and if not, how can such a critical shortcoming be remedied?

(3) Does the court prescribe substantive content of the right to health in the interpretation and enforcement of the right?
Is there a minimum core content to the right to health for HIV-positive individuals? If not, should there be?

(4) What would such minimum core obligations in respect of HIV-positive individuals include?

(5) How would such minimum core obligations be implemented and enforced in our society?

CHAPTER 1:

The conceptualization of the South African right to health and the notion of a minimum core to the right to health for HIV-positive individuals

1.1 Introduction to the constitutional recognition of the right to health in South Africa:

1.1.1 Historical background and HIV/AIDS:

The term HIV is the acronym for the "Human Immunodeficiency Virus," which causes a deterioration of the immune system rendering it unable to fight infection and other diseases.[12] AIDS is an abbreviation for "Acquired Immunodeficiency Syndrome" that indicates the advanced stages of HIV infection.[13] It is associated with the occurrence of various opportunistic infections such as pneumonia and tuberculosis (TB) or HIV-related cancers. HIV is primarily transmitted through unprotected sexual intercourse with an infected person. Other means of transmitting the disease include contact with infected blood and sharing contaminated syringes are. Infants may contract the virus from their mothers during the pregnancy or childbirth, or while breastfeeding.[14]

For South Africa, colonialism and apartheid meant subjugation and denial, and the creation of a healthcare framework that fostered exclusion and inaccess along racial and economic lines. The legal system legitimized the disenfranchisement of the black majority and institutionalized the privilege of the white minority. South Africa's history with HIV/AIDS has largely followed the same racial and economic lines as our social experience has.[15] The race-based healthcare system under apartheid was either not equipped, or not adequately prioritised to confront the disease. At the beginning of our democratic era, the new dispensation inherited the structures of the previous

[12] http://www.aids.org/topics/aids-faqs/difference-between-hiv-and-aids/; http://www.merriam-webster.com/dictionary/hiv.
[13] http://www.aids.org/topics/aids-faqs/what-is-aids-what-causes-aids/; http://www.merriam-webster.com/dictionary/aids.
[14] M de Jongh 'Corporate Social Responsibility as a Tool to Enhance the Fight Against HIV/AIDS' 5 *Vienna Journal on International Constitutional Law* 94 (2011) 109.
[15] N Brühn 'Litigating against an Epidemic: HIV/AIDS and the Promise of Socio-economic Rights in South Africa' 17 *Michigan Journal of Race & Law* 181 2011-2012 186.

regime, and this had lent difficulty to the incumbent government's approach to dealing with the disease.

It has been acknowledged that "the epidemic is not just a health problem requiring a 'simple' medical solution."[16] HIV/AIDS is also a social disease, one whose incidence is directly related to social and economic factors. As Brühn notes, the somewhat "measurable impact of the disease is accompanied by the immeasurable burdens that shape the experience of being HIV-positive in South Africa."[17] An effective response to the HIV/AIDS epidemic thus, is required to be directed at international and national levels, including medicine, epidemiology, infectious disease control, vaccines, and social sciences.[18] It is submitted that, with the significant medical and scientific advancements recorded especially of late,[19] it is the social dimensions of the disease that demand our focus and attention going forward.[20] The socio-economic facet of the epidemic unavoidably impacts on the success or failure of any health care strategy, and is compounded by various structural determinants, *inter alia* poverty, discrimination, and gender bias. Structural factors are described as "elements outside of individual control or knowledge that have the potential to influence the vulnerability of individuals and groups to HIV infection, which can include social (e.g. stigma, gender inequality), legal-political (e.g. laws and regulations), cultural, and economic (e.g. lack of livelihood opportunity) factors." [21]

UNAIDS[22] identifies South Africa as being the most HIV infected country in the world. The social repercussions of this dubious honour reflect the connection between the HIV/AIDS pandemic, poverty and the discrimination of infected people, and include an alarmingly growing number of orphans and child-headed households;

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[16] H Watchirs 'A Human Rights Approach to HIV/AIDS: Transforming International Obligations into National Laws' 22 *Australian Year Book of International Law* 77 2002 82.
[17] Brühn (see note 15 above) 190.
[18] Watchirs (see note 16 above) 83.
[19] S Abdool Karim 'HIV Infection and Tuberculosis in South Africa: An Urgent Need to Escalate the Public Health Response' *Lancet* (2009) September 12 374 (9693) 921; S Abdool Karim 'An AIDS-Free Generation' *Science* Vol 337 13 July 2012 133; JA Singh 'Antiretroviral Resource Allocation for HIV Prevention' *AIDS* (2013) 27 863.
[20] Abdool Karim (see note 19 above) 133; JO Parkhurst 'HIV Prevention, Structural Change and Social Values: The Need for an Explicit Normative Approach' *Journal of the International AIDS Society* 2012 15 (Suppl 1) 17367 1.
[21] *http://www.aidstarone.com/focus_areas/prevention/pkb/structural_interventions/overview_structural_approaches_hiv_prevention.*
[22] UNAIDS Report on the Global AIDS Epidemic 2012; http://www.unicef.org/esaro/5482_HIV_AIDS.html.

exploitation of the vulnerable – children, the weak, elderly and disabled; and the abuse of women.[23] The debilitating effects of co-epidemics are also evident. For example, it is reported that KwaZulu-Natal, which currently has the highest HIV infection rates in South Africa,[24] also has the highest cases of pneumonia in children under-five years in the country; and malnutrition is deemed the most severe in KwaZulu-Natal.[25] It is not particularly surprising as the province has the lowest expenditure on district health management as a percentage of its primary health care budget, of all the provinces.

HIV prevalence and incidence remain high, with five new infections for every two people placed on therapy. [26] Acute setbacks in human development are an inevitable consequence of untimely death and disability caused by AIDS – the sixth-most common cause of death worldwide.[27] As it is thus expected, the epidemic makes it difficult to achieve programmatic goals for the reduction of poverty and the acceleration of progress in other government departments such as education and social welfare.[28]

The cost of HIV/AIDS can be particularly high for individual households. It is a disease that targets the young to middle-aged predominantly – the economically viable, and breadwinners of the home who are rendered unable to contribute financially. It is estimated that within two generations, the average household income in South Africa will be a quarter of what it could have been without the impact of AIDS,[29] and the population 35% less by 2025 due to the epidemic.[30] In addition, scarce resources will be spent on medicines for those infected with the disease, and the burden of care will fall on family members, for whom such a responsibility invariably entails loss of their own employment. The result is a vicious cycle of greater poverty and loss, and the increased incidence of the disease converging into one another.[31] While poverty and

[23] World Health Organisation Fact Sheet 31 'The Right to Health' 21.
[24] The Mercury, (29 October 2013). 'HIV Rates Still the Highest in KZN' 8.
[25] Ibid.
[26] P Pronyk, et al. 'Policy and Programme Responses for Addressing the Structural Determinants of HIV' June 2013 *AIDS Support and Technical Assistance Resources* 1.
[27] Ibid.
[28] Ibid.
[29] Brühn (see note 15 above) 189.
[30] de Jongh (see note 14 above) 137.
[31] Brühn (see note 15 above) 189; N Novogrodsky 'The Duty of Treatment: Human Rights and the HIV/AIDS Pandemic' 12 *Yale Human Rights & Development Law Journal* 1 2009; J Joni 'Access To Treatment For HIV/AIDS: A Human Rights Issue In The Developing World' 17 *Connecticut Journal of*

environmental stresses are chief causes of an unhealthy life; poor health may in turn, be one of the reasons for poverty and underdevelopment.[32]

The social cost of HIV/AIDS inescapably impacts on the South African healthcare system which is unable to cope with the strain of the consequences of the disease – loss of healthcare workers; the death of patients; and the high cost of healthcare. It erodes government's ability to maintain essential services,[33] and further diminishes rights access.

It has been acknowledged that the relationship between HIV/AIDS and human rights has developed in response to the epidemic, not just in South Africa, but in all developing countries. [34] And it is here that the potential to overcome the tragic situation presents itself – by recognising that the way forward lies at the intersection of AIDS and human rights. The answer lies in access to medicines and health care for people living with HIV/AIDS – where, as previous successful campaigns have shown, treatment of infected and affected individuals can expand the implementation of economic and social rights; and the recognition of rights in turn, enables treatment of and care for people living with HIV/AIDS.[35] It is also about re-affirming the individual's rights to human dignity, equality and freedom,[36] which increased access to HIV medicines can assure.

The Constitution, to this end, recognises that the health and well-being of an individual is determined by various factors – medical, environmental and societal, by entrenching various "socio-economic rights" in the Bill of Rights.[37] Section 27 of the Constitution, in particular provides for the right of everyone to access health care, food, water and social security.

International Law 273 2001-2002 275.
[32] IR Pavone 'The HIV/AIDS Pandemic and International and Human Rights Law' 2009 *Lawasia Journal* 96 2009 97.
[33] Brühn (see note 15 above) 183.
[34] Novogrodsky (see note 31 above) 7.
[35] WHO Fact Sheet 31 (see note 23 above) 20; Joni (see note 31 above).
[36] Section 7(1), 1996 Constitution.
[37] See constitutional socio-economic rights at note 6 above.

1.1.2 The constitutional recognition of socio-economic rights, such as the right to access health care:

1.1.2.1 The justiciability of socio-economic rights:

In order to properly understand the rights accorded to HIV-positive individuals, it is important to make reference to the constitutional framework of socio-economic rights that impact on the well-being of such persons.

The late Dullah Omar, the esteemed former Minister of Justice and Constitutional Development, said on the inclusion of socio-economic rights in the Constitution, that "the failure to do so would not only make social and economic transformation impossible, but in reality, it would be nullifying first generation rights, *inter alia*, equality and democracy for the vast majority of South Africans."[38] He further identified two major objectives that a future constitutional framework for South Africa should promote – firstly, it should not prevent social and economic transformation; and secondly, it must create mechanisms and structures that will empower South Africans to achieve and defend such rights through the Constitution.[39] It is submitted that it is in the context of HIV/AIDS, perhaps, that the prophetic value of the aforementioned objectives may be seen most clearly.

(i) The Certification process:

The inclusion of socio-economic rights in the Constitution thus proved essential to the promotion of such progressive constitutional aims. The Constitutional certification process[40], however, demonstrated the divergence of views regarding such inclusion, and to an extent, reflects the current ambivalence in the judicial enforcement of such rights.[41]

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[38] D Omar 'Enforcement of Social and Economic Rights' in *A Bill of Rights for a Democratic South Africa* (1991) 106-114.
[39] Ibid.
[40] *Ex Parte Chairperson of the Constitutional Assembly: In Re Certification of the Constitution of the Republic of South Africa* 1996 (4) SA 744 (CC).
[41] DM Davis 'Adjudicating the Socio-Economic Rights in the South African Constitution: Towards 'Deference Lite'?' 22 *South African Journal on Human Rights* 301 2006 303.

Proponents of inclusion argued that the constitutional presence of socio-economic rights was fundamental to social transformation (as envisaged by Omar above), as it gave a voice and a platform to the poor and the marginalised of society – purely by virtue of their entitlement to a better life guaranteed in the Constitution. It would serve as a mechanism of rights enforcement and state accountability in the event of rights deprivation.[42] Pieterse [43] perceives justiciable socio-economic rights as "tools with which to bridge the disconnection" between the ideal of social justice espoused by socio-economic rights contained in the Constitution and the lived experiences of South Africans. Ultimately, it is a means of redressing the legacy of apartheid while securing the democratic path forward.

(ii) The Separation of Powers doctrine:

The arguments advanced by opponents to the inclusion of socio-economic rights in the Constitution are echoed in the judgments delivered in the post-constitutional adjudication of socio-economic rights cases – predominantly that the enforcement of these rights would be inconsistent with the doctrine of the separation of powers, which seeks to keep distinct the roles of the judiciary, the legislature and the executive. The concern was primarily founded on the belief that the judiciary may trespass on the territory, and interfere with the duties of the legislature and executive, by directing how policy should be framed, by issuing directives as to how the legislature is to act, and how state budgets should be allocated.[44] The separation of powers doctrine instead sees the legislature and executive as best placed to pronounce on how socio-economic rights entitlements may most effectively be claimed and enforced – this in light of purported legislative capacity and proficiency, and resources at its disposal in this regard.[45]

The certification process acknowledged that the judiciary may pronounce on socio-economic matters with budgetary implications, but recognised that this was also true in

[42] Liebenberg (see note 3 above) 18.
[43] M Pieterse 'Legislative and Executive Translation' 14 Law *Democracy & Development* 231 2010.
[44] M Pieterse 'Coming To Terms With Judicial Enforcement Of Socio-Economic Rights' 20 *South African Journal on Human Rights* 383 2004; C Mubangizi 'The Constitutional Protection of Socio-Economic Rights' 2 *African Journal of Legal Studies* 1 2006-200; Liebenberg (see note 3 above) 20; Davis (see note 41 above) 304.
[45] Pieterse (see note 43 above) 232.

the adjudication of civil-political rights, which carried no censure in respect of a breach of the separation of powers.[46] The Constitutional Court thus confirmed the place of socio-economic rights in the Constitution, as well as the justiciability of such rights.[47] It also recognised the interdependence of all rights,[48] which are co-existent and require a purposive interpretation that gives credence to the founding values and aims of the Constitution in a democratic dispensation. As such, in the judicial enforcement of socio-economic rights, the tenets of the Constitution must be applied holistically and in the context of the South African reality.

1.1.2.2 Transformative constitutionalism and adjudication:

As a society safeguarded by the Constitution, the goal, inter alia, is to "heal the divisions of the past and establish a society based on democratic values, social justice and fundamental human rights," as well as to "improve the quality of life of all citizens and free the potential of each person."[49] In this context, the judicial enforcement of human rights must occur within the constitutional mandate, as provided for in the Preamble. In essence, what is envisaged is an endeavour in transformative constitutionalism that engenders social change for the benefit of all South Africans.

Karl Klare[50] defines transformative constitutionalism as a "long-term project of constitutional enactment, interpretation and enforcement, committed to transforming a country's political and social institutions and power relationships in a democratic, participatory and egalitarian direction." It is submitted that this is especially important in respect of the constitutional right to access healthcare, and in the context of HIV/AIDS in South Africa.

If we are to address individual and public inequities that inhere as a result of the epidemic, it is vital to recognise the importance of socio-economic rights, such as the right to access health care, and the significance of transformative constitutionalism in our social context.

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[46] The *Certification* case (see note 40 above) at paragraph 77.
[47] Ibid at paragraph 78.
[48] Ibid at paragraph 37.
[49] Preamble, 1996 Constitution.
[50] K Klare 'Legal Culture and Transformative Constitutionalism' 14 *South African Journal on Human Rights* 146 (1998) 150.

By requiring an openness to recognising and responding to both existing and new forms of disadvantage and marginalization[51] that have emerged in post-apartheid South Africa, including the AIDS epidemic,[52] transformative constitutionalism provides the means to address the social dimension of the disease[53] - underdevelopment, inequality and poverty – by foregrounding these issues in judicial decisions.

It is submitted that the inclusion in the Constitution, and justiciability of, socio-economic rights ought to be exploited to ensure that the rights of HIV-positive individuals to health care are realised beneficially, and not relegated to the status of "background norms".[54] In holding that socio-economic rights are subject to judicial enforcement,[55] the Constitutional Court significantly ensured that the transformation of the lives of many South Africans was a legal possibility.

The central role of the judiciary in such an interpretive process is apparent. Courts must support the development of substantive judicial standards that give meaning to such rights and entitlements, and serve, as such, as vital mechanisms of transformative adjudication that advance the tenets of transformative constitutionalism. [56] Transformative adjudication involves facilitating democratic transformation via a forum at which the State response to poverty, especially, can be evaluated in terms of constitutional values.

The role of such public interest litigation in advancing transformative constitutionalism is critical. Gloppen[57] suggests that various factors determine the relative success of such action –

- marginalized groups must be placed to effectively "voice" their claims or have representatives argue on their behalf;

[51] P Langa 'Transformative Constitutionalism' (2006) 17 (3) *Stellenbosch Law Review* 351 354.
[52] Liebenberg (see note 3 above) 28.
[53] Ibid.
[54] Pieterse (see note 43 above) 232.
[55] *Certification* case (see note 40 above) at paragraph 78.
[56] It is suggested that one such mechanism is the recognition of a minimum core content to socio-economic rights, particularly in respect of Section 27, as discussed further below.
[57] S Gloppen 'Social Rights Litigation as Transformation: South African Perspectives' Bergen: *Chr. Michelsen Institute CMI Working Paper* WP 2005: 3.

- the effective and meaningful "responsiveness of the court" to respond to such claims;
- "judicial capability" to enforce rights significantly and effectually; and
- eventual "compliance" with judgments by the executive and legislature by way of legislation and policy.

1.2 Defining the "right to access health care" for South Africans in the context of transformative constitutionalism:

1.2.1 Giving definition and content to the right to health:

The preamble of the World Health Organisation's (WHO) constitution defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity."[58] The United Nations Committee on Economic, Social and Cultural Rights (UN-CESCR) has defined the right to health in Article 12 (1) of the International Covenant on Economic, Social and Cultural Rights (ICESCR),[59] as "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." It has been suggested that the definition given in Article 12 (1) of the ICESCR is more reasonable and less ambitious than that of the WHO,[60] taking into account difficulties that may arise in the realisation of the right.

The "right to health care," on the other hand, can specifically be defined as "the prevention, treatment and management of illness and the preservation of mental and physical well-being through the services offered by the medical and allied health professions."[61] People are entitled to freely control their health and have the right to a health care system that provides the opportunity equally for everyone to attain the highest attainable standard of health.

The constitutional right to the right to health care[62] is located at Section 27 of the

[58] Constitution of the World Health Organization. Geneva: World Health Organization; 1948.
[59] UN General Assembly, *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966.
[60] de Jongh (see note 14 above) 94.
[61] Mubangizi, JC (2010) 'The Right to Health Care in the Specific Context of Access to HIV/AIDS Medicines: What can South Africa and Uganda Learn from Each Other?' 10 *African Human Rights Law Journal* 105 2010 109
[62] Section 27 of the Constitution provides:

Constitution, and as with other constitutional socio-economic rights, may be said to have been molded in terms of the ICESCR.[63] It provides for "the right to have access to health care services."

The divergence of definition, or perhaps, wide contortions of what "health" and "health care" actually mean, as well as the social dimension of the concept, demonstrate that the right to (access) health or health care is a broad notion that entails an interdependency of all human rights[64] – it is closely related to the right to food and water, and housing, for example. In itself, it involves a range of rights that rely on socio-economic factors necessary in order to promote a healthy life, in addition to the factors that ensure good physical and medical health.

Transformative constitutionalism and adjudication mandate the judiciary with the task of interpreting and giving meaning to constitutional rights and entitlements,[65] developing the law to make it more socially relevant and responsive, and to provide a forum at which State action may be measured in terms of the Constitution. The judicial impact of such judgments must of necessity, be far-reaching, persuasive and influential, empowering indigent and vulnerable claimants who face difficulties accessing the law in the first place.[66] This is further underscored by the requirements of Section 39 (1) of the Constitution which requires the courts to develop an interpretation of the Bill of Rights which promote the values that underlie an open and democratic society based on human dignity, equality and freedom.

The court's approach in ***Government of the RSA and others v Grootboom and others ("Grootboom")***,[67] demonstrates that consideration of both the context of the rights (the Constitution) and the circumstances in which the violation of the rights is alleged (the

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1. Everyone has the right to have access to -
   (a) health care services, including reproductive health care; sufficient food and water; and
   (b) 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 realisation of each of these rights.
3. No one may be refused emergency medical treatment.

[63] K.McLean 'Constitutional Deference, Courts and Socio-Economic Rights in South Africa' (2009) Pretoria University Law Press 15; available at: *http://www.pulp.up.ac.za/pdf/2009_13/2009_13.pdf.*
[64] De Jongh (see note 14 above) 96
[65] Section 172
[66] Gloppen (see note 57 above) 7
[67] 2001 (1) SA 46 (CC).

political, historical, economic and social context), is required.[68] Transformative adjudication thus implies a willingness to explore new approaches to the interpretation of rights that promote the values of human dignity, equality and freedom, and an inclination to adopt novel interpretive methods. Such openness implies consideration of International and foreign jurisprudence on socio-economic rights as well.

In light of the diversity of people of various socio-economic dispositions that rely on the right, the importance of prescribing more than just a definition but actual substantive content to the right to health thus becomes apparent. This is especially so for HIV-positive individuals, against a background of abject poverty and the stark deprivation of basic human needs; and in light of a need for valid enforcement mechanisms ensuring that basic needs, at a minimum, are guaranteed. This accords with the suggestion by Henry Shue that human rights concern the "lower limits on tolerable human conduct" rather than "great aspirations and exalted ideals."[69] Human rights are therefore basic standards that are more intent on "avoiding the terrible than with achieving the best."[70] The aim is to provide a minimum good for a maximum number, if not all, of the people.[71]

It is submitted that in this context, ascribing minimum core obligations to human rights play a valuable role in socio-economic rights litigation, achieving that modest standard for the majority of people, and ensuring that the urgent material needs of vulnerable and disadvantaged groups receive immediate attention.[72] Failure to do so risks betraying the hope promised by the Constitution.

1.2.2 A minimum core content to the Constitutional right to health:

Young defines the concept of a minimum core as "a minimalist strategy whereby maximum gains are made by minimizing goals",[73] in that "the minimum core standard

[68] Ibid at paragraph 22.
[69] Henry Shue '*Basic Rights*' 2 ed. Princeton University Press (1980) 74.
[70] Ibid.
[71] J. Nickel '*Making Sense of Human Rights*' 2 ed. Malden, MA: Blackwell Publishing 2007.
[72] Liebenberg (see note 3 above) 172.
[73] KG Young 'The Minimum Core of Economic and Social Rights: A Concept in search of Content' *Yale Journal of International Law* (33) 113 2008
113.

seeks to confer a minimum, predetermined legal content to economic and social rights."[74] It is submitted that the transformative adjudication of a socio-economic rights dispute necessitates invoking such a concept; and entails a process whereby courts give specified content to these rights, which are usually outlined very vaguely.[75] In this way, it is believed that the executive is placed with a greater understanding of what obligations arise from the right in question, and the individual is placed in a better position to be able to hold the executive responsible for not meeting the guaranteed minimum of that right.

1.2.2.1 The development of a 'minimum core' concept:

(i) The Limburg Principles on the Implementation of the ICESCR, 1987 ("the Limburg Principles"):

The Limburg Principles[76] were formulated when international law experts met in Maastricht in June 1986 to consider the nature and scope of the obligations of States Parties to the ICESCR.[77] The principles proposed, in respect of a minimum level of obligation, that State Parties be *obligated to ensure respect for minimum subsistence rights for all regardless of their level of economic development*.[78]

(ii) The Maastricht Guidelines on Violations of Economic, Social and Cultural Rights, 1997 ("the Maastricht Guidelines"):

The Maastricht Guidelines[79] were adopted in Maastricht in January 1997, to elaborate on the Limburg Principles as regards the nature and scope of violations of economic, social and cultural rights and appropriate responses and remedies.[80] The Guidelines

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[74] Ibid.
[75] J Chowdhury 'Judicial Adherence to a Minimum Core Approach to Socio-Economic Rights – A Comparative Perspective' (2009) *Cornell Law School Inter-University Graduate Student Conference Papers*, *Paper 27* 2.
[76] UN Commission on Human Rights, *Note verbale dated 86/12/05 from the Permanent Mission of the Netherlands to the United Nations Office at Geneva addressed to the Centre for Human Rights ("Limburg Principles")*, 8 January 1987.
[77] *http://www.maastrichtuniversity.nl/web/file?uuid=de124f6f-3388.*
[78] Limburg Principles at paragraphs 25-28.
[79] International Commission of Jurists (ICJ), *Maastricht Guidelines on Violations of Economic, Social and Cultural Rights*, 26 January 1997.
[80] *http://www1.umn.edu/humanrts/instree/Maastrichtguidelines_.html.*

expand on the Limburg Principles on a minimum obligation, stating that *failures to satisfy minimum core obligations violate the ICESCR and that States had such obligations irrespective of the national availability of resources or other factors or difficulties*.[81]

1.2.2.2 A conceptual basis for the minimum core:

Conceptually, the "minimum core" is said to be derived from German Basic Law[82], where the "'core' or 'essential content' of certain constitutional rights may not be limited or violated".[83] Bilchitz notes that the core suggests that "there are different levels to the realisation of a right, some of which are more 'essential than others'." [84] It thereby confers a minimum legal content for socio-economic rights – "a basic floor of social provisioning". [85] It is argued that the core protects people's urgent interests in survival, [86] as "the inability to survive wipes out all possibility for realising the source values of a being."[87]

1.2.2.3 Defining the content of the 'minimum core' to the right to health:

As will be elaborated on in Chapter 3 below,[88] General Comments 3 and 14 of the UN-CESCR to the ICESCR, provide specific definition to the concept of a minimum core. Paragraph 10 of UN-CESCR General Comment 3[89] provides that "a minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of

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[81] Maastricht Guidelines at paragraph 9.
[82] Young (see note 73 above) 124.
[83] Ibid.
[84] D Bilchitz *Poverty and Fundamental Rights*: *The Justification and Enforcement of Socio-Economic Rights* 1 ed. (2007) Oxford University Press 186.
[85] S Liebenberg 'South Africa's Evolving Jurisprudence on Socio-Economic Rights: An Effective Tool in Challenging Poverty' (2002) 6 *LDD* 159: 169, available at *http://www.saflii.org/za/journals/LDD/2002/2.pdf*; D Petherbridge 'South Africa's Pending Ratification of the International Covenant on Economic, Social and Cultural Rights: What are the implications?' (2012) 2, available at: *http://blogs.sun.ac.za/seraj/files/2012/11/South-Africas-pending-ratification-of-the-ICESCR.pdf.*
[86] Bilchitz (see note 84 above) 187.
[87] Ibid.
[88] Space constraints and context preclude a more detailed account of the CESCR General Comments beyond that which is discussed in this Chapter 1. In Chapter 3, a detailed application of these Comments is made to the right to health.
[89] UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 3: The Nature of States Parties' Obligations (Art. 2, Para. 1, of the Covenant)*, 14 December 1990.

each of the rights (in the ICESCR) is incumbent upon every State party … (and that) 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".

UN-CESCR General Comment 14[90] serves as the definitive instrument guiding interpretation of a minimum core to the right to health, which it locates at paragraph 43,[91] and further obligations of comparable priority in paragraph 44.[92] It is submitted that these provisions provide the guidance necessary in the assessment of the basic rights of HIV-positive individuals, or the 'floor of social provisioning'[93] below which a State may not legitimately permit the deprivation of rights. Of particular relevance are the obligations to:

"(a) To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;

(d) To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;

(e) To ensure equitable distribution of all health facilities, goods and services" (at paragraph 43),

and

"(c) To take measures to prevent, treat and control epidemic and endemic diseases" (at paragraph 44).

1.2.2.4 The minimum core controversy:

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[90] UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*, 11 August 2000.

[91] In the Committee's view, these core obligations include at least the following obligations –
(a) To ensure the right of access to health facilities, goods and services on a non- discriminatory basis, especially for vulnerable or marginalized groups;
(b) To ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone;
(c) To ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;
(d) To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;
(e) To ensure equitable distribution of all health facilities, goods and services;
(f) To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include methods, such as right to health indicators and benchmarks, by which progress can be closely monitored; the process by which the strategy and plan of action are devised, as well as their content, shall give particular attention to all vulnerable or marginalized groups.

[92] The Committee considers the following obligations to be of comparable priority –
(a) To ensure reproductive, maternal (pre-natal as well as post-natal) and child health care;
(b) To provide immunization against the major infectious diseases occurring in the community;
(c) To take measures to prevent, treat and control epidemic and endemic diseases;
(d) To provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them;
(e) To provide appropriate training for health personnel, including education on health and human rights.

[93] Liebenberg (see note 85 above); Petherbridge (see note 85 above).

The concept is by no means free of controversy, and does give rise to conceptual complexities with courts differing in their approach and academics in disagreement in respect of clarifying the concrete content of entitlements of rights.[94] Lehmann[95] is of the view that the advocated minimum core approach is "both conceptually and pragmatically misconceived", and considers the court's reasonableness approach jurisprudentially sounder than the proposed minimum core alternative. The basis for her argument is that the process of according a minimum core to human rights is "utilitarian rather than principled", which renders the minimum core approach inappropriate in the context of human rights enforcement. [96] She contends that the judicial focus should rather be on addressing any purported squandering of public funds, so that funds are spent appropriately on the public good.[97]

In addition to the debate relating to the separation of powers, discussed above, concerns also arise in respect of the counter-majoritarianism argument. This condemns the role of the judiciary, who are unelected individuals, in mandating the executive, who are democratically elected by the majority of the electorate, in matters concerning such a majority. Such an act is considered undemocratic and arbitrary. Further unease exists in respect of the capacity of the judiciary, both in terms of competence and faculty.

It is however, submitted that it is by virtue of the relative independence of the judiciary, that the checks and balances intended by the separation of powers doctrine can be implemented. It is suggested that the judicial role is not to impede or replace legislative function, but rather to monitor same. This is essential for a democracy and the meeting of constitutional guarantees.

It is arguable that without meeting the minimum essential needs which people require to survive, the state's obligation to progressively achieve the full realisation of the

[94] M Pieterse 'Resuscitating Socio-economic Rights: Constitutional Entitlements to Health Care Services' 22 *South African Journal of Human Rights* 473 2006; K Lehmann 'In defence of the Constitutional Court: Litigating Socio-Economic Rights and the Myth of the Minimum Core' 22 *American University International Law Review* 163 (2006-2007); Young (see note 73 above).
[95] Lehmann (see note 94 above) 165.
[96] Ibid 166.
[97] Ibid 165.

rights become meaningless.

According to Forman,[98] the minimum core "reflects the fundamental human rights idea that certain individual interests, including the basic health needs of the poor, should be prioritised at any cost." Further, that the core suggests that social rights, and the interests they reflect, "should place reasonable limits on political and economic actions that intrude so far into basic needs as to render human dignity and equal worth meaningless."[99]

The 'core' requires that States should provide the basics of a functional public health and health care system, including essential drugs, hospitals, clinics, and personnel.[100] The core is not defined in terms of specific health care services, but rather provides guidelines for policy-making. As such, content may vary from country to country, but its normative content is to protect the right from resource constraints that render it empty and meaningless. It is said, "the core is intended to ensure that States prioritise the maximum decencies of citizenship in the modern world."[101]

1.2.2.5 Minimum core obligations in the context of *uBuntu* advance transformative constitutionalism:

1.2.2.5.1 The Constitutional value of *uBuntu*:

The minimum core primarily seeks to provide a basic blueprint of the needs of a people in particular circumstances that allow the dignity of such individuals to be maintained – whether such dignity manifests in ensuring such people's survival or basic necessities of life. It accords in either way with the concept of being human.

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[98] L Forman 'What Future for the Minimum Core? Contextualizing the Implications of South African Socioeconomic Rights Jurisprudence for the International Human Right to Health,' in J Harrington and M Stuttaford (eds), *Global Health and Human Rights: Legal and Philosophical Perspectives* Routledge 2009 62.
[99] Ibid.
[100] Forman (see note 98 above) 69.
[101] A Sachs 'The Judicial Enforcement of Socio-Economic Rights – The *Grootboom* case' 2006 56 *Current Legal Problems* 579.

Given the emphasis placed on the constitutional values of human dignity, equality and freedom, as well as the importance of transformative constitutionalism and adjudication in the meeting of constitutional guarantees, it is worth exploring the relationship that may exist between the minimum core and the constitutional value of *uBuntu*.

The South African Constitutional Court has advanced that constitutional values contained in the Constitution do not constitute a *numerus clausus*, and that other values can also be elevated to this status. *uBuntu,* or group or shared solidarity, has been recognised by the Constitutional Court as such a constitutional value.[102] The shared struggle of a people, first linked by oppression and thereafter by a rampant epidemic, provides the basis for such a value to inform our jurisprudence.

In ***S v Makwanyane***, *uBuntu* was described as follows –

"It is a culture which places some emphasis on communality and on the interdependence of the members of a community. It recognises a person's status as a human being, entitled to unconditional respect, dignity, value and acceptance from the members of the community such person happens to be part of. It also entails the converse, however. The person has a corresponding duty to give the same respect, dignity, value and acceptance to each member of that community. More importantly, it regulates the exercise of rights by the emphasis it lays on sharing and co-responsibility and the mutual enjoyment of rights by all"

Mokgoro J further elaborated that –

"Generally, *uBuntu* translates as 'humanness'. In its most fundamental sense it translates as personhood and "morality". Metaphorically, it expresses itself in *umuntu ngumuntu ngabantu,* describing the significance of group solidarity on survival issues so central to the survival of communities. While it envelops the key values of group solidarity, compassion, respect, human dignity, conformity to the basic norms and collective unity, in its fundamental sense it denotes humanity and morality. Its spirit emphasises respect for human dignity, marking a shift from confrontation to conciliation. In South Africa *uBuntu* has become a notion with particular resonance in the building of a democracy".[103]

This concept has also been alluded to in the White Paper for Social Welfare[104] as a value permeating the social security context as well,[105] that –

[102] *S v Makwanyane* (see note 2 above) at paragraph 224.
[103] *S v Makwanyane* (see note 2 above) at paragraph 308.
[104] The White Paper for Social Welfare (GN 1108 in GG 18166 of 8 August 1997).
[105] Ibid Chapter 2, paragraph 24.

"the principle for caring for each other's well-being will be promoted, and a spirit of mutual support fostered. Each individual's humanity is ideally expressed through his or her relationship with others and theirs in turn through a recognition of the individual's humanity. *uBuntu* means that people are people through other people".

In, ***City of Johannesburg v Rand Properties (Pty) Limited and Others***[106] ***("City of Johannesburg"),*** Jajbhay J held that **"**our Constitution requires a court to weave the elements of humanity and compassion within the fabric of the formal structures of the law. It calls upon us to balance competing interests in a principled way and to promote the constitutional vision of a caring society based on good neighbourliness and shared concern (referring to ***Port Elizabeth Municipality v Various Occupiers***[107] ***("Port Elizabeth Municipality")*** at paragraph 37). Our Constitution retains from the past only what is defensible and represents a decisive break from, and a ringing rejection of that part of the past which is disgracefully racist, authoritarian, insular and repressive, and vigorous identification of and commitment to a democratic, universalistic, caring and aspirationally egalitarian ethos (referring to Mahomed J in ***Makwanyane***)."

The crucial importance of this approach by the court is evident. It translates into an obligation on the State to mobilise sufficient social resources towards overcoming poverty and extreme inequalities. It follows that the respect for and promotion of the principle of *uBuntu* can in fact contribute to the success of a comprehensive human rights system and other measures aimed at the alleviation of poverty and social exclusion in South Africa. To this end, it can enable the realisation of health rights, especially for HIV-positive individuals, by the recognition of human worth.

1.2.2.5.2 The minimum core, *uBuntu* and HIV-positive individuals:

(i) *uBuntu* and Transformative Constitutionalism:

Thomas is of the opinion that there are two important factors in transformative constitutionalism – "a constitution that recognises social and economic rights, and a

[106] *City of Johannesburg v Rand Properties (Pty) Limited and Others* 2007 (6) SA 417 (SCA) at paragraph 62.
[107] 2005 (1) SA 217 (CC).

reformed courts system."[108] He considers the concept of *uBuntu* a jurisprudential principle that ought to be informing courts in such a process,[109] to enable a value-based recognition of rights – especially in light of our social context and history.

A minimum core content to the right to health, it has been said, would encompass the constitutional value of human dignity. As highlighted in the ***Minister of Health & Others v Treatment Action Campaign & Others ('TAC')*** case "the minimum core might not be easy to define, but includes at least the minimum decencies of life consistent with human dignity."[110] In this vein, by ensuring that the basic essential levels of existence are secured so as to guarantee the survival of a people – and in so doing, maintaining human dignity – the minimum core resonates with the tenets of *uBuntu.*

Himonga[111] argues for the importance of the concept of *uBuntu* in the implementation of human rights, as a response to the challenges presented in rights enforcement in Africa – mainly an apparent lack of lawfulness and acceptance of such rights among the people who are supposed to benefit from them. An inherent fear of Anglophone influences festers among indigenous people, who are suspicious of foreign support – for example, in the form of medical aid. While such an outlook might be expected, given colonial coercion and abuse, it may be detrimental to those in need of treatment provided by such powers. *uBuntu* serves to bridge this gap, and enable a communal acceptance of assistance.

(ii) *uBuntu* and the African Charter:

In light of the Preamble to the African Charter, which sets out the concept of "duty and people's rights," the Charter's provisions on the right to health may be said to be directly related to *uBuntu,* and the realisation of the right. For example, attributes of

[108] CG Thomas 'Ubuntu. The missing link in the rights discourse in post-apartheid transformation in South Africa' *International Journal of African Renaissance Studies* 3:2 39: 40.
[109] Ibid.
[110] *Minister of Health & Others v Treatment Action Campaign & Others (No.2)* 2002 (5) SA 721 (CC) at paragraph 28.
[111] C Himonga 'The Right to Health in an African Cultural Context: The Role of *Ubuntu* in the Realisation of the Right to Health with Special Reference to South Africa' *Journal of African Law First View* article August 2013 1.

uBuntu such as communitarianism, interdependence and group-solidarity are particularly relevant for the purposes of effective HIV prevention and treatment campaigns. According to Mutua,[112] "solidarity between the individual and the greater society safeguards collective rights, without which individual rights would be unattainable." It is further held that by giving duties to individuals, the Charter emphasises the central feature of *uBuntu*, which is "group-centred individualism."

(iii) *uBuntu* and the ICESCR:

uBuntu is further in line with the provisions of General Comment 14 to the ICESCR, which holds that the realisation of the right to health is open to various approaches – including policy and judicial action. This would allow social action, which may be more effective. It has been said that the ***TAC*** case "exemplifies how *uBuntu's* attribute of solidarity may play a role in the enforcement of court decisions on health rights."[113]

(iv) *uBuntu* and Children's rights:

uBuntu is also seen as especially relevant in respect of AIDS-orphans "for such children are heavily dependent on society for their very survival."[114] The high number of abandoned and AIDS-infected children in South Africa bears testament to the failure of the social welfare system to adequately protect and support such children. Many children, especially orphans, street children and children in child-headed households are often simply treated as statistics – ignored by the government. It is submitted that this represents the real tragedy of the HIV/AIDS epidemic – the death of the country's future. It has been proposed that the Constitutional Court enforce minimum core entitlements for such children without support.[115] This would help ensure the protection of orphans and other vulnerable children - and would be consistent with children's constitutional rights as well as the overarching philosophy of *uBuntu.*

[112] M wa Mutua 'The Banjul Charter and the African Cultural Fingerprint' (1994) 35 *Virginia Journal of International Law* 339.
[113] Himonga (see note 111 above) 25.
[114] JD Bessler 'In the Spirit of *Ubuntu:* Enforcing the Rights of Orphans and Vulnerable Children Affected by HIV/AIDS in South Africa' 31 *Hastings International and Comparative Law Review* 33 2008 46.
[115] Ibid.

1.2.2.6 Concluding thoughts:

Following on the reasoning of Sachs J in ***Port Elizabeth Municipality***, that "in all determinations about the reach of constitutionally protected rights, the starting and ending point of the analysis must be to affirm the values of human dignity, equality and freedom,"[116] *uBuntu* would influence the reach of the right to health from a communitarian perspective[117] as it is profoundly based on the concept of humanity and respect for one another. *uBuntu* requires focus on the human dimension of judgments, rather than just on the position of the State and the financial. This, it is submitted, may prove more beneficial for a large number of people in the enforcement of core obligations, especially in the South African social context.

The value of prescribing a minimum core content to the right to health in respect of HIV-positive individuals is thus evident on various levels. Firstly, the core is seen to guarantee such individuals minimum levels of healthcare that are immediately realizable. Such a guarantee has the potential of saving thousands of lives, and preserving many more. Further, the core would help ensure that the dignity of the sick and debilitated is maintained. In essence, the core advances the tenets of transformative constitutionalism, and constitutional values such as *uBuntu*, primarily meeting the canons of the Constitution.

[116] *Port Elizabeth Municipality* (see note 107 above) at paragraph 15.
[117] Himonga (see note 111 above) 17

CHAPTER 2:

Prescribing a minimum core content to the right to health – does National and International Law allow for the concept?

2.1 Introduction:

It is submitted that the effective transformative adjudication of socio-economic rights, such as the right to health care, would be invalidated if the realisation of the right does not successfully reach the indigent and make a difference to their lives. Accordingly, transformative adjudication requires constitutionally defensible judgments, enforcing and effectively realising the constitutional guarantee at stake. As such, the court's use of definitive standards and tests in the interpretation of rights impacts acutely on the realisation of entitlements.[118] Judgments must resist opposition and satisfy the requirements of transparency and accountability. Chowdhury makes a valid observation that "if courts wish to meaningfully adjudicate socio-economic rights, then rights must be given content, … and to this extent, there must be a minimum core approach."[119]

2.2 The South African law governing the right to health:

2.2.1 The Constitution - Section 27:

The South African Bill of Rights is believed to be among "the most progressive in the world."[120] It locates the right to access health care at Section 27 of the Constitution, which provides that everyone has the right to have access to health care services;[121] that the state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of the right;[122] and that no one may be

[118] Chowdhury (see note 75 above) 2.
[119] Ibid 18.
[120] JC Mubangizi 'HIV/AIDS and the South African Bill of Rights, with Specific Reference to the Approach and Role of the Courts' *African Journal of AIDS Research* (2004) 3 (2) 113: 115.
[121] Section 27(1).
[122] Section 27(2).

refused emergency medical treatment.[123]

As mentioned in Chapter 1 above, the constitutional right to health must be appreciated and interpreted in terms of its social context[124] – the legacy of apartheid and an inequitable and discriminatory health system. The situation of the right to health amongst the socio-economic determinants of health in Section 27 facilitates transformative constitutionalism by laying the foundation for an interpretation that attempts to redress the gross inequalities of the past and establish an egalitarian health care system.

Despite the transformative potential of the right, considerable difficulty lies in the implementation of the right. There is very little to indicate what the scope and nature of the entitlement is, or the extent to which resource limitations and progressive realisation may permissibly limit this right to 'access health care services.'

2.2.2 Case Law:

Transformative adjudication is intended to advance and give meaning to constitutional principles in the spirit that the Constitution intends.[125] In this way, one should be able to rely on the jurisprudence of the Constitutional Court to provide the interpretation sought and to give the content required to legislative provisions. It would be instructive at this juncture to consider current South African jurisprudence, with particular reference to the approach adopted by the court in socio-economic rights litigation, as well as any recognition by the courts of a minimum core content to the right at issue. The following analysis assesses the prevailing position of the courts. A further critique of the Constitutional Court's approach - the suitability thereof, and whether an amended approach is required, follows at Chapter 4 below.

2.2.2.1 Judicial use of the reasonableness standard of review:

[123] Section 27(3).
[124] *Grootboom* (see note 67 above) at paragraph 22.
[125] Preamble, 1996 Constitution.

The Constitutional Court has had opportunities to assess the content of various socio-economic rights, with litigation primarily in respect of the right to emergency medical treatment health care,[126] access to health care,[127] and social assistance in Section 27,[128] the right to access housing in Section 26,[129] and the right to access water in Section 25[130] - and has revealed the court's adoption of the reasonableness paradigm as its preferred model of review for assessing compliance with the Constitution. The court has, in fact, been unwavering in its refusal to adopt a minimum core content to the rights at issue, and to develop the substantive content thereof. This has been attributed to the Constitutional Court's wariness to be seen as trespassing on the duties of another branch of government, should it draw on issues of policy-making in its judgments or make decisions that have budgetary implications for the polity.

In an effort to retain a separation in duties and constitutional propriety, the court has advanced the reasonableness standard of review in respect of State action. The central question that the court asks is whether the means chosen are reasonably capable of facilitating the realisation of the socio-economic right in question.

Soobramoney v Minister of Health, KwaZulu Natal ('Soobramoney')[131] involved a determination in respect of treatment being made available at a public hospital, to a patient in the final stages of chronic renal failure. The patient was also a diabetic, and suffered from ischaemic heart disease and cerebro-vascular disease. Dialysis treatment would have prolonged the patient's life indeterminately, with no hope for a cure. Further such treatment was costly and weighed heavily on the already over-burdened institution. Faced with such serious resource constraints, and difficult decisions to make prioritising which patients to admit, the institution devised and followed a strict admission policy. In respect of dialysis patients, in particular, admission was limited to patients who faced a reasonable prospect of being cured in a short-term, and who were eligible for a kidney transplant. The applicant, Soobramoney, did not qualify.

Soobramoney applied to the Durban High Court claiming a right to receive dialysis

[126] *Soobramoney v Minister of Health (KwaZulu Natal)* 1998 (1) SA 765 (CC).
[127] *Minister of Health & Others v Treatment Action Campaign & Others (No.2)* 2002 (5) SA 721 (CC).
[128] *Khosa & Others v Minister of Social Development and Others* 2004 (6) BCLR 569 (CC).
[129] *Grootboom* (see note 67 above).
[130] *Mazibuko & Others v City of Johannesburg & Others* 2010 (4) SA 1 (CC).
[131] *Soobramoney* (see note 126 above).

treatment, in terms of the constitutional right to life[132] and the right to receive emergency medial treatment.[133] The High Court dismissed the application.

On appeal, the Constitutional Court defined 'emergency' to mean "a dramatic, sudden situation or event which is of a passing nature in terms of time".[134] The court held that in the given circumstances, Soobramoney's condition did not amount to an emergency which warranted for emergency medical treatment as envisaged by Section 27(3). It also held that the right not to be refused emergency medical treatment is independent from the right to life.

The court then considered whether Soobramoney qualified in terms of Section 27, to have access to health care services provided by the state. The Court noted that the state has a constitutional obligation *within its available resources* to provide health care, and observed the precarious financial position of the Department of Health. The court held–

"The provincial administration which is responsible for health services in KwaZulu-Natal has to make decisions about the funding that should be made available for health care and how such funds should be spent. These choices involve difficult decisions to be taken at the political level in fixing the health budget, and at the functional level in deciding upon the priorities to be met. A court will be slow to interfere with rational decisions taken in good faith by the political organs and medical authorities whose responsibility it is to deal with such matters." [135]

The Court accordingly concluded that it had not been shown that the state's failure to provide renal dialysis facilities for all persons suffering from chronic renal failure constitutes a breach of its constitutional obligations.

Drawing on subsequent case law (discussed below), Liebenberg notes that a reasonable government programme in the context of socio-economic rights is deemed to have the following attributes:[136]

" A reasonable programme must –

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[132] Section 11, 1996 Constitution.
[133] Section 27(3), 1996 Constitution.
[134] *Soobramoney* (see note 126 above), at paragraph 38.
[135] Ibid at paragraph 29.
[136] Liebenberg (see note 3 above) 152; The court in *Khosa* (see note 128 above) has noted that these factors are not a closed list, and all relevant factors particular to a case must be considered, for what is relevant may vary from case to case.

- be capable of facilitating the realisation of the right;
- be comprehensive, coherent and co-ordinated;
- have appropriate financial and human resources available for the programme;
- be balanced and flexible, make appropriate provision for short, medium and long-term needs;
- be reasonably conceived and implemented;
- be transparent, and its contents must be known effectively to the public; and
- make short-term provision for those whose needs are urgent and who are living in intolerable conditions."

Fortunately, other Constitutional Court judgments revealed a more substantive basis for their enquiry into the reasonableness of state action by having considered the aforementioned factors.

The ***Grootboom*** case[137] dealt with a challenge to the state's housing program under section 26 of the Constitution.[138] Section 26 is also subject to the qualification that the state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of this right.

Grootboom and the other applicants were forcibly evicted from land they were occupying. They approached the court for an order directing the state to provide them with adequate shelter in the interim while houses were allocated to them in terms of the state's housing program.

The court affirmed that the question in socio-economic rights litigation is not whether such rights are justiciable (as this is already established), but how to enforce them in a given case.[139] This requires an assessment of the appropriate approach to interpretation, guided by the provisions of the right in question (in this case Section 26) – which obliges the state, not dissimilarly to Section 27, to (a) to take *reasonable legislative and other measures*; (b) within its available resources; and (c) to achieve the progressive realisation of this right;[140] as well as provisions of the Constitution as a whole.

[137] *Grootboom* (see note 67 above).
[138] Section 26 guarantees that "everyone has the right to have access to adequate housing"
[139] *Grootboom* (see note 67 above) at paragraph 20.
[140] Ibid at paragraph 21.

It held further that, in such an interpretive process, rights must be understood in their textual setting and within their social and historical context.[141] The court confirmed that all rights in the Bill of Rights are interdependent and mutually supporting.[142]

Applying the reasonableness standard of review the court held that "a reasonable programme therefore must clearly allocate responsibilities and tasks to the different spheres of government and ensure that the appropriate financial and human resources are available,"[143] and that "a court considering reasonableness will not enquire whether other more desirable or favourable measures could have been adopted, or whether public money could have been better spent."[144] Further, the court held that the reasonableness of State action is impacted on by the factors of progressive realisation of a right and the availability of resources.[145]

The court found the state's housing program unconstitutional, as the program in question was held to be unreasonable because it addressed only medium- and long-term housing needs and excluded a significant segment of society.[146]

The court held -

"The issues here remind us of the intolerable conditions under which many of our people are still living. The respondents are but a fraction of them. It is also a reminder that, unless the plight of these communities is alleviated, people may be tempted to take the law into their own hands in order to escape these conditions. The case brings home the harsh reality that the Constitution's promise of dignity and equality for all remains for many a distant dream. People should not be impelled by intolerable living conditions to resort to land invasions. Self-help of this kind cannot be tolerated, for the unavailability of land suitable for housing development is a key factor in the fight against the country's housing shortage."[147]

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[141] Ibid at paragraph 22.
[142] Ibid at paragraph 23.
[143] Ibid at paragraph 39.
[144] Ibid at paragraph 41.
[145] Ibid at paragraphs 45 – 46.
[146] Ibid at paragraph 43; Importantly, the court held that - "**Reasonableness must also be understood in the context of the Bill of Rights as a whole**... **A society must seek to ensure that the basic necessities of life are provided to all if it is to be a society based on human dignity, freedom and equality.** To be reasonable, measures cannot leave out of account the degree and extent of the denial of the right they endeavour to realise. **Those whose needs are the most urgent and whose ability to enjoy all rights therefore is most in peril, must not be ignored by the measures aimed at achieving realisation of the right…**Furthermore, the Constitution requires that everyone must be treated with care and concern. **If the measures, though statistically successful, fail to respond to the needs of those most desperate, they may not pass the test**".
[147] Ibid at paragraph 53.

According to Liebenberg,[148] the Constitutional Court in ***Grootboom*** established a higher standard of reasonableness for state compliance with constitutional duties, and extensively interpreted the State's obligation to take measures to progressively realise access to services within available resources in respect of the rights guaranteed in Sections 26 and Section 27.

In the ***TAC*** case,[149] various organizations challenged the government's refusal to provide the anti-retroviral drug, Nevirapine, to HIV-positive pregnant women at all public health institutions. In light of concerns about the safety of Nevirapine, only a limited number of designated test sites were allowed to dispense Nevirapine, while the efficacy of the drug was being monitored. Doctors at other public facilities were prohibited from dispensing Nevirapine. However, government failed to provide a time-frame within which national roll-out of the drug would occur.

The court found that the government's refusal to permit the provision of Nevirapine at all public health facilities was unconstitutional. Following its jurisprudence in ***Grootboom,*** the court only examined the reasonableness of the government's program. The court found that it was unreasonable for the state not to dispense Nevirapine country-wide, since it could be provided within available resources and its efficacy had been reasonably established.

The court ordered the court government to formulate and implement a comprehensive Nevirapine roll-out program nationwide as soon as possible, as well as the removal of all restrictions preventing doctors at public hospitals from dispensing Nevirapine. Further, the court instructed the government to provide Nevirapine at public hospitals and clinics, and to provide testing and counseling at such facilities.

2.2.3 Shortcoming in national jurisprudence - guidance from International law:

Much criticism has been leveled against the Constitutional Court for having failed to provide normative clarity to the content of the different socio-economic rights, and examining instead the obligations on government, by enquiring into the reasonableness

[148] Liebenberg (see note 3 above) 134.
[149] *TAC* (see note 110 above).

of the measures.[150] A critique of the Constitutional Court's approach follows at Chapter 4 below.

It is submitted that in order to address the jurisprudential difficulty identified above, Section 39 of the Constitution directs us to seek guidance from international and comparative foreign law on the issue. Ideally, the answer may lie in supplementing the reasonableness review with the minimum core approach, such that a new standard of review may be developed ensuring a more substantive engagement with the purposes and underlying values of socio-economic rights.

2.3 International law in respect of the right to health:

There has been wide-ranging entrenchment of the right to health in international and regional human rights treaties, as discussed below.[151] Aids in the interpretation of the right to health especially, assist in providing clarity in respect of the entitlements and duties that this right imposes.[152] In respect of the minimum core, the pivotal instruments of analysis are the UN-CESCR General Comments 3 and 14.

2.3.1 An overview of international instruments that have a bearing on the right to health and the minimum core obligations on States in respect of the right to health:

2.3.1.1 Regional:

(i) The African Charter on Human and Peoples' Rights (the African Charter):[153]

The African Charter is the primary African human rights instrument.[154] Article 16

[150] L Stewart 'Adjudicating Socio-Economic Rights Under A Transformative Constitution' *Pennsylvania State International Law Review* Vol. 28:3 (2010) 487 492; Bilchitz (see note 11 above) 8; Pieterse (see note 44 above) 383.
[151] S Gruskin 'Health and Human Rights' accessed at *www.phr.org.il/uploaded/HEALTH-HR.pdf;* Mubangizi (see note 120 above) 114.
[152] Forman (see note 98 above) 65.
[153] Organization of African Unity (OAU), African Charter on Human and Peoples' Rights ('Banjul Charter'), 27 June 1981.
[154] S Gumedze 'HIV/AIDS and Human Rights: The role of the African Commission on Human and

provides that state parties "shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick". The right is not subject to progressive realisation or the availability of resources.

Article 30 establishes the African Commission on Human and People's Rights, as well as a complaints mechanism for State violations of human rights contained in the Charter. The Commission's Resolution on the HIV/AIDS Pandemic is of particular relevance – it declares HIV/AIDS a human rights issue and a threat against humanity. The Resolution "calls upon African governments to allocate national resources in a way that reflects a determination to fight the spread of HIV/AIDS."[155]

It may inferred that as South Africa has ratified the African Charter, which reiterates many of the socio-economic rights contained in the ICESCR, South Africa has tacitly acquiesced to the provisions of the ICESCR. This further enjoins our courts to defer to such instruments in the interpretation of socio-economic rights.

(ii) The Constitutive Act of the African Union (2000):[156]

The Act, which establishes the African Union, states as one of its objectives at Article 3 (n) "to work with relevant international partners in the eradication of preventable diseases and the promotion of good health on the continent".

(iii) Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (2003):[157]

In addition to various provisions which regulate a woman's right to dignity, equality and non-discrimination, Article 14 provides specifically for the health and reproductive

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People's Rights' 4 *African Human Rights Law Journal* 181 2004 182.

[155] Resolution on the HIV/AIDS Pandemic –Threat Against Human Rights and Humanity Number 53, 29th Ordinary Session of the ACHPR –
1. **Declares** that the HIV/AIDS pandemic is a human rights issue which is a threat against humanity;
2. **Calls upon** African Governments, State Parties to the Charter to allocate national resources that reflect a determination to fight the spread of HIV/AIDS, ensure human rights protection of those living with HIV/AIDS against discrimination, provide support to families for the care of those dying of AIDS, devise public health care programmes of education and carry out public awareness especially in view of free and voluntary HIV testing, as well as appropriate medical interventions;
3. **Calls upon** the international pharmaceutical industries to make affordable and comprehensive health care available to African governments for urgent action against HIV/AIDS and invites international aid agencies to provide vastly increased donor partnership programmes for Africa including funding of research and development projects.

[156] Available at: *http://www.africa-union.org/root/au/AboutAu/Constitutive_Act_en.htm.*

[157] Available at: *http://www.achpr.org/files/instruments/women-protocol/achpr_instr_proto_women_eng.pdf.*

rights of women, and includes the obligations of States to provide adequate, affordable and accessible health services.

(iv) The African Charter on the Rights and Welfare of the Child (1990):[158]

The Charter prioritises the best interests of the child and accords children the right to the best attainable state of physical, mental and spiritual health.

2.3.1.2 Sub-regional:

(i) Southern Africa Development Community (SADC):

- **SADC HIV and AIDS Strategic Framework (2010-2015):[159]**
  The framework establishes objectives and actions of operation to provide guidance to the response to HIV and AIDS, particularly to move towards Millennium Development Goal (MDG) 6[160] and its targets.

- **SADC Protocol on Health (1999):[161]**
  Provisions of relevance include – Article 10, which regulates HIV/AIDS and Sexually Transmitted Diseases; Article 19 requires Member States to develop effective strategies for the procurement and allocation of adequate resources for health care; and Article 29, which provides for the production, procurement and distribution of effective drugs.

2.3.1.3 International:

(i) The Universal Declaration of Human Rights (1948):[162]

In terms of Article 11: "everyone has the right to a standard of living adequate for the

[158] African Charter on the Rights and Welfare of the Child, OAU Doc. CAB/LEG/24.9/49 (1990), entered into force Nov. 29, 1999. Available at: *http://www1.umn.edu/humanrts/africa/afchild.htm*.
[159] Available at: *www.sadc.int/files/4213/5435/8109/SADCHIVandAIDSStrategyFramework2010-2015.pdf.*
[160] Millennium Development Goal 6 aims to combat HIV and AIDS and other diseases by 2015.
[161] Available at: *http://www.sadc.int/documents-publications/show/Protocol_on_Health1999.pdf*
[162] UN General Assembly, Universal Declaration of Human Rights, 10 December 1948.

health and well-being of himself and his family including … medical care and necessary social services."

(ii) The United Nations International Covenant on Economic, Social and Cultural Rights (ICESCR) (1966):[163]

The primary Covenant protecting socio-economic rights is the ICESCR, and it is particularly relevant to the interpretation of Sections 26, 27 and 29 of the Constitution (although it has not been ratified by South Africa), as it was a major source of reference for the drafting of these provisions.[164] The ICESCR came into force on 3 January 1976 and currently has 161 state parties. The right to health is provided for in in Article 12.[165]

Article 12(2) also lays down broad guidelines regarding the necessary steps to be taken by the member states in order to achieve the full realisation of this right, including the duty at Article 12 (2)(c) to take steps necessary for *the prevention, treatment and control of epidemic, endemic, occupational and other diseases.*

Various guidelines have been formulated to aid in the interpretation of the provisions of the ICESCR, and to render a normative enforceable standard in respect of the entitlements and obligations that flow from this right. These include International Legal Expert Principles, Conferences, Declarations, and the UN-CESCR General Comments, which in particular, define the scope of the entitlement under Article 12[166] - the right to the highest attainable standard of health, and the duties that progressive realisation within available resources places on States.

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[163] UN General Assembly, *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966.

[164] Liebenberg (see note 3 above) 106; J Fitzpatrick 'Economic and Social Rights – South Africa' (2003) 97 *American Journal of International Law* 669.

[165] Article 12 provides -

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
(b) The improvement of all aspects of environmental and industrial hygiene;
(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

[166] Forman (see note 98 above) 66.

(iii) Convention on the Elimination of All Forms of Discrimination against Women (CEDAW):[167]

Article 12 of CEDAW provides that –

> States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health-care services, including those related to family planning.
>
> Notwithstanding the provisions of paragraph 1 of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

CEDAW and the ICESCR recognise that women are affected by many of the same health conditions as men, but women experience them differently.[168] The WHO identifies the following factors that have an adverse effect on the health of women, specifically – "the prevalence of poverty and economic dependence among women; their experience of violence; gender bias in the health system and society at large; discrimination on the grounds of race or other factors; the limited power many women have over their sexual and reproductive lives; and their lack of influence in decision-making are social realities which have an adverse impact on their health"[169]

Both the ICESCR and CEDAW require the elimination of discrimination against women in health care as well as guarantees of equal access for women and men to health-care services. Redressing discrimination in all its forms, including in the provision of health care, and ensuring equality between men and women are fundamental objectives of treating health as a human right. In this respect, CEDAW specifically calls upon States to ensure that "women in rural areas... participate in and benefit from rural development" and "have access to adequate health-care facilities... counselling and services in family planning."[170]

It is submitted that the above provisions are especially relevant in a country such as South Africa, where gender abuse and inequality demands our attention. Health care must be prioritised especially for indigent rural women infected and affected by the

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[167] UN Committee on the Elimination of Discrimination Against Women (CEDAW), 1992, A/47/38, available at: *http://www.refworld.org/docid/453882a422.html*.
[168] WHO Fact Sheet 31 (see note 23 above) 12.
[169] Ibid.
[170] CEDAW, Article 14.

epidemic, who face particular discrimination and hardship.

(iv) Convention on the Rights of the Child (CRC):[171]

According to the WHO, children are particularly vulnerable to health challenges, which make them especially susceptible to malnutrition and infectious diseases, as well as sexual and reproductive problems at adolescence.[172]

In this regard, the CRC[173] recognizes the obligation on States "to reduce infant and child mortality, and to combat disease and malnutrition," especially as children are at risk of HIV infections through mother-to-child transmission. It is noted that a baby born to an HIV-positive mother has a 25 to 35 per cent chance of becoming infected during pregnancy, childbirth or breastfeeding.[174] Accordingly, States should take measures to prevent such transmission through, inter alia, education in respect of transmission of HIV and infant care, testing, and the provision of adequate medical and health care for women, infants and children.

In terms of Section 28 of the Constitution, children are accorded the right "to basic nutrition, shelter, basic health care services and social services".[175] The right is not subject to the qualifications of resource availability, nor the progressive realisation of human rights. Recognising the non-derogable status of children's entitlement to good health care, it is imperative that the core elements of the right to health, as recognised by the CESCR are realised and enforced with due urgency and without unjustified interference by State. South Africa is placed to safeguard this right by mandating the provision of free basic health care to all children under-six years,[176] and by conferring vital importance to primary health care as directed by the Declaration of Alma Ata. This, it is submitted, extends to the provision of ART, HIV testing, care and counselling, and education.

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[171] UN General Assembly, *Convention on the Rights of the Child*, 20 November 1989, United Nations, Treaty Series, vol. 1577, available at: *http://www.refworld.org/docid/3ae6b38f0.html.*
[172] WHO Fact Sheet 31 (see note 23 above) 14.
[173] Convention on the Rights of the Child (see note 171 above) Article 24.
[174] WHO Fact Sheet 31 (see note 23 above) 14.
[175] 1996 Constitution
[176] National Health Act 61 of 2003.

It is further submitted that this also places a weighty obligation on the State to address the social dimension of the pandemic experienced by the large number of child-headed households and orphans, as a result of the AIDS pandemic. The minimum core, of necessity, entails that the State reviews or introduces social welfare schemes that would adequately ensure the well-being of such vulnerable children in our society.

(v) Declaration of Alma-Ata, 1978:[177]

Numerous conferences and declarations, such as the International Conference on Primary Health Care (resulting in the Declaration of Alma-Ata), have also helped clarify various aspects of public health relevant to the right to health and have reaffirmed commitments to its realization.

The Declaration confirms that primary health care is essential as "it forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community".[178] The prominence given to primary health care highlights that the main health problems in the community will be addressed by "providing promotive, preventive, curative and rehabilitative services accordingly".[179]

(vi) United Nations Millennium Declaration and Millennium Development Goals ("MDGs"):[180]

The MDGs, agreed to by Member States at the 2000 UN Millennium Summit, are aimed at reducing global poverty by half, by 2015, by way of a series of specific goals.[181] It has served to highlight the plight of the global poor, by mobilising donor involvement and aid, and contributions to health care, such as ARVs. It has facilitated

[177] Declaration of Alma-Ata, International Conference on Primary Health Care, Alma-Ata, USSR, September 1978.
[178] Ibid.
[179] Ibid.
[180] See *http://www.un.org/millenniumgoals/*.
[181] The MDGs include: eradicate extreme poverty and hunger; achieve universal primary education; promote gender equality and empower women; reduce child mortality; improve maternal health; combat HIV/AIDS, malaria, and other diseases; ensure environmental sustainability; and global partnership for development.

the co-operation of governments, corporations and non-governmental organisations.[182]

Significant MDG success has been realised in respect of the US President's Emergency Plan for AIDS Relief (PEPFAR) launched in 2003. It has improved access to AIDS treatment in the developing world significantly. The MDG Health Alliance, founded in 2011, is comprised of business and NGO leaders around the world working toward the MDG health targets, including the elimination of mother-to-child HIV transmission. As at 2011 more than eight million people worldwide were receiving AIDS treatment.[183]

(vii) UN Declaration of Commitment on HIV/AIDS:[184]

The UN Declaration of Commitment on HIV/AIDS acknowledges that "prevention of HIV infection must be the mainstay of the national, regional and international response to the epidemic".[185] It further recognises that "all countries must continue to emphasize widespread and effective prevention, including awareness-raising campaigns through education, nutrition, information and health-care services".[186] Pavone interprets this undertaking to include ensuring a wide range of prevention programmes in all countries that must be "culturally sensitive and available in local languages which aim to reduce risky behaviour; encourage responsible sexual behaviour; reduce harm related to drug use; treatment for sexually transmitted infections, and voluntary and confidential counselling and testing."[187]

Paragraph 15 of the Declaration, in particular, states "access to medication is a fundamental element for achieving progressively the right of everyone to the highest possible standard of physical and mental health."

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[182] McArthur, JW 'What the Millennium Development Goals Have Accomplished' 92 *Foreign Affairs* 152 2013.
[183] Ibid.
[184] General Assembly resolution S-26/2 of 27 July 2001.
[185] Ibid at paragraph 17, which proceeds to confirm that "prevention, care, support and treatment for those infected and affected by HIV/AIDS are mutually reinforcing elements of an effective response and must be integrated in a comprehensive approach to combat the epidemic".
[186] Ibid at paragraph 18.
[187] Pavone (see note 32 above) 97.

2.4 Foreign law:

Section 39 (1) (c) of the Constitution provides that regard may be had to foreign jurisprudence in the interpretation of the Bill of Rights. The following jurisdictions have proven influential in respect of the enactment of health rights in domestic law and policy, and/or their ratification and incorporation of the ICESCR in domestic law; and with regard to the expansion of these provisions to the rights of people living with AIDS. Uganda demonstrates the effectiveness of grass-roots policy implementation, and provides a useful reference as to how the minimum core (in respect of HIV-positive individuals) may be incorporated in domestic legislation. Colombia has shown the success of progressive judicial mechanisms that are available to the masses of people who ordinarily would not be able to access justice. Both countries encompass aspects of how implementation of the minimum core would prove beneficial for individuals in greatest need.

2.4.1 Uganda:

Uganda acceded to the ICESCR on 21 January 1987,[188] and is considered to be example of how an African country, believed to be more resource-challenged than South Africa, has achieved success at combatting the AIDS epidemic. [189] It is submitted, however, that while Uganda is a model of how effective policy implementation may lead to successes at combating the epidemic, it is also an example of how weak policy execution in turn leads to rising infection rates. Further, it demonstrates that effective AIDS policy cannot be successful if the State endorses discriminatory practices, such as legislating against homosexuality.

The Ugandan constitution[190] contains no distinct provisions for the right to access health care. Instead, it comprises various National Objectives and Directive Principles incorporating Social and Economic Objectives,[191] which include health services, and

[188] Accession to the ICESCR occurs if ratification of the Covenant occurs without it being signed first.
[189] Mubangizi (see note 61 above) 106; Forman (see note 11 above) 717; Watchirs (see note 16 above) 81.
[190] Constitution of the Republic of Uganda, 1995.
[191] National Objective XIV.

Medical Services,[192] that guide the state in interpreting the law and implementing any policy decisions.

At the peak of HIV infection in the country in 1992, the government initiated aggressive prevention and treatment strategies by way of national programmes[193] involving civil society to better improve policy implementation. This paved the way for infection levels to fall to Uganda's lowest rate of 6.4% in 2006,[194] and has been attributed to strong leadership, an "open approach to combating the epidemic" and "a strong multi-sectoral, decentralized and community response."[195]

Civil society in Uganda has also been praised in the implementation of HIV policies.[196] Civil Society Organisations (CSOs) are said to have contributed fundamentally in providing care and support to the infected and affected, via effective communication approaches. CSOs are believed to be successful in their mandate because of their flexibility and ability to reach marginalised populations in remote areas.[197] South Africa has achieved similar success in respect of our own CSOs, such as the highly dynamic Treatment Action Campaign.[198] The value of community-based support in the fight against AIDS cannot be over-emphasised, and must be stimulated in order to ensure that people on the fringe of society and at grassroots level are not neglected.

Current records, unfortunately, indicate that HIV prevalence in Uganda has risen from 6.4% to 7.3% over the last few years.[199] Tumwesigye, et al,[200] acknowledge that the

[192] National Objective XX.
[193] For example – (1) the Poverty Eradication Action Plan (PEAP) identifies HIV/AIDS as one of the priority areas to be addressed by, inter alia, the provision of ARVs; (2) the Health Sector Strategic Plan, which identify specific targets for the prevention and control of HIV/ AIDS, including the scale up of voluntary counselling and testing and the prevention of mother-to-child transmission (PMTCT) services, and increasing the offering of HIV/AIDS care with anti-retroviral therapy; and (3) the ARV Policy, which aims at universal access to anti-retroviral treatment to all that are clinically eligible for it, and a strategic plan on HIV/AIDS, which provides for care and treatment.
[194] *www.avert.org/hiv-aids-uganda.htm*; accessed 11/11/13.
[195] Ibid; Global AIDS Response Progress Report: Uganda Jan 2010-Dec 2012:1
[196] Mubangizi (see note 61 above) 127.
[197] Ibid.
[198] M Heywood 'South Africa's Treatment Action Campaign: Combining Law and Social Mobilization to Realize the Right to Health' available at *http://www.section27.org.za/wp-content/uploads/2010/04/journal-HR-practice-heywood.pdf.*
[199] Ibid; UNAIDS Global Report 2012; *www.irinnews.org/report/97651/uganda-government-under-pressure-to-boost-arv-funding*, accessed 12/11/2013.
[200] Tumwesigye et al. 'Policy development, implementation and evaluation by the AIDS control program in Uganda: a review of the processes' *Health Research Policy and Systems* 2013, 11:7,

response to the HIV/AIDS epidemic in Uganda had led to an overall reduction in HIV prevalence from 18% in the early 1980s to 7.3% in 2011. The writers attribute Uganda's success mainly to its AIDS Control Program (ACP), which has developed and revised several HIV/AIDS prevention, care and treatment policies to improve the lives of people living with HIV/AIDS. However, concerns have developed regarding the delays experienced currently in policy development and revision processes. These delays subsequently affect timely implementation of critical evidence-based interventions, and it is said, "may partly explain the current stagnation of HIV prevalence".[201]

Valuable statistical information, such as the above, is procured via Uganda's "Country Progress Report," submitted to the UN-CESCR, as part of the mandatory reporting obligations of member States.[202] It is submitted that Uganda provides a useful example of the significance of ratification of (or accession to) the ICESCR, in this regard – as Member States are obliged to provide such reports. In this way, States are better monitored and held accountable for their actions and inactions.

Uganda is in the process of enacting the HIV/AIDS Prevention and Control Bill of 2009, which although controversial in respect of its criminalisation of HIV provisions, specifically provides for State responsibilities in respect of HIV control. The Bill mandates the obligation to **"** devise measures to –

- ensure the right of access and equitable distribution of health facilities, goods and services including essential medicines on a non-discriminatory basis;
- provide universal HIV treatment to all persons on a non-discriminatory basis;
- process, adopt and implement a national public health strategy and plan of action for HIV and AIDS;
- prevent and control of HIV transmission;
- take measures to develop and promote awareness rights and duties imposed on persons under this Act;
- take measures to develop and implement programmes in order to promote the rights of persons;

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available at: *http://www.health-policy-systems.com/content/11/1/7.*
[201] Ibid.
[202] Global AIDS Response Progress Report: Uganda January 2010 - December 2012.

- promote and ensure involvement of people living with HIV in participating in government programmes;
- mainstream HIV in all government sectors; and
- provide care and support to persons living with HIV."[203]

It is submitted that the afore-mentioned provision enforces the minimum core obligations as set out in the ICESCR, with specific reference to HIV-positive individuals.

The East African Community HIV/AIDS Regional Bill of 2010, which seeks to prevent and manage the spread of HIV/Aids and to promote human rights of persons living with the disease, has been assented to by Ugandan President Yoweri Museveni. The Bill is aimed at mandating partner states to play a key role in controlling and managing the disease, by providing HIV/AIDS related services, guaranteeing the right to privacy of people living with HIV/AIDS and prohibiting HIV-related discrimination, and ensuring the provision of quality health care and social services for persons living with HIV and their care-givers. The Bill is awaiting signature by other East African heads of state to become a binding law in the region.

It is submitted that legislation such as the above, which sets out the obligations of the State, are in line with ICESCR, and provide a clear mandate to government in respect of its responsibilities to those living with HIV/AIDS. It also serves to clarify for affected individuals what they may expect from their leaders, and hold them accountable should obligations not be met. This would be pivotal in South Africa, especially in the event of "legislative and executive lethargy"[204] or inaction by the State in providing for basic needs.

In summary, the above analysis indicates that Uganda provides a useful measure of comparison for South Africa. It is a developing African country plagued by resource constraints, and embattled by the AIDS epidemic. Effective policy implementation is key, as well as engaging with community structures to activate the response. Uganda reinforces the value of ratification of the ICESCR in terms of its reporting mechanism,

[203] Section 27 – State Obligations.
[204] Liebenberg (see note 3 above) 40.

and the means to hold government accountable to its people.

2.4.2 South America – Republic of Colombia

The Republic of Colombia signed the ICESCR on 21 December 1966, and ratified the Covenant on 29 October 1969.

The Colombian Constitution of 1991 entrenches the justiciability of socio-economic rights in certain circumstances,[205] and establishes the Colombian Constitutional Court. The right to health is constitutionally protected in Article 49 of the Colombian Constitution,[206] and is supported by the *tutela* action,[207] which is enshrined in Article 86 of the Constitution.[208]

Young records that the *tutela* action may be presented before any judge "for the immediate protection of a fundamental human right."[209] In light of the urgent nature of the action, *locus standi* and the court's powers are deemed very generous in tutelage action. The court may issue specific directives to the State in respect of measures to be taken in order to address the right violation.[210] Further, the action "imposes strict time limitations for judges, and sanctions for public officials, including jail for contempt of court if they fail to comply."[211] A large number of *tutela* actions have been directed at the right to health.

In 2003, the Constitutional Court[212] entrenched a "minimum core" approach with a view to clarify the right to health, by specifying core obligations. The Constitutional

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[205] KG Young 'The Comparative Fortunes of the Right to Health' 26 *Harvard Human Rights Journal* 179 (2013) 180.

[206] Article 49 of the Constitución Politica de Colombia provides –

Attention to health and environmental sanitation are public services of the responsibility of the State. **The access to services of promotion, protection and recovery of health are guaranteed to all persons.** It corresponds to the State to organize, direct and regulate the provision of health services . . . in accordance with the principles of efficiency, universality and solidarity. It corresponds to the State, to establish policies for the provision of health services by private entities, and to exercise supervision and control over them. Likewise, to establish the competences of the Nation, the territorial entities and individuals and to determine the contributions of their responsibility in the terms and conditions specified in the law. Health services shall be organized in a decentralized manner, by level of care and with participation of the community. The law shall specify the terms under which basic care for all inhabitants will be gratuitous and obligatory. Every person has the duty to provide for comprehensive attention to their health and to that of their community.

[207] Young (see note 205 above) 183.

[208] Ibid 185.

[209] Ibid.

[210] Liebenberg (see note 3 above) 129.

[211] Young (see note 205 above) 185.

[212] Colombian Constitutional Court Judgment T-859, 2003.

Court's judgment in ***Decision T-760***[213] was the first ruling "to adopt structural guidelines to specifically order the government to address the major problems in the healthcare system"[214]; notably the Court adopted the right to health framework set out by the ICESCR.[215]

In its judgment, the Court established state obligations generated by the right to health, and emphasised the importance of judicial supervision in implementing the right, and for executive accountability. It also reaffirmed the responsibility of the state to adopt measured programmes towards the progressive realization of the right to health; and stressed that "the right to health calls for transparency and access to information, as well as for evidence-based planning and coverage decisions based on participatory processes."[216] Further, the Court established an essential minimum core to the right to health that was immediately enforceable.[217]

There are important lessons to be learnt from the Colombian experience. Liebenberg submits that the scope of the Preamble to the Constitution[218] allows for this principle of "social justice,"[219] which may prove highly beneficial for the indigent. For one, a *tutela*-like court action would be particularly relevant and helpful to the destitute and disempowered who seek to enforce their rights. The Colombian Constitutional Court is evidence of how greater access to the judicial system may offer better protection of the rights of thousands of people. Further, it is apparent that the Colombian Constitutional Court has wielded strong control over health policies and programmes. This illustrates the value of court oversight of State action, so as to promote accountability and the meeting of health goals timeously.

[213] Colombian Constitutional Court Judgment T-760, 2008.
[214] Young (see note 205 above) 191.
[215] AE Yamin 'How do Courts set Health Policy' *Plos Medicine* Vol 6 Feb (2009) Issue 2 147; Chowdhury (see note 75 above) 8.
[216] Ibid 149.
[217] Ibid.
[218] 1996 Constitution.
[219] Liebenberg (see note 3 above) 129.

CHAPTER 3:

Application of the Minimum Core concept to the right to health under Section 27 in respect of HIV-positive persons

3.1 The need to defer to International Law:

In the cases discussed above, the Constitutional court is criticised for not providing normative clarity on the particular socio-economic right at stake[220] – for it is expected to be well-suited to provide content to social rights and the standards of compliance that they impose.[221] A further view is that all policies of the state must be evaluated and that this too falls to the courts. It is not expected to entail the judicial rewriting of policy or the prescription of specific measures; however, the court is required to set a universal standard, such that the content of the right provides the gauge against which legislative measures should be examined.[222]

It may be said that the court in ***Grootboom*** and ***TAC*** provided *some* content to the rights in question in its judgments.[223] This approach must be developed, and it is suggested that the court's rejection of the minimum core be re-assessed and reconciled with international law and theory so that "the work of the Constitutional Court is not seen to reinforce indefensible objections to social rights,"[224] such as the right to health being "conceptually amorphous as to be meaningless", and making "zero-sum claims on budgets that would irrationally distort resource allocations to the detriment of the public good."[225]

According to Mubangizi,[226] certain provisions in international instruments are intrinsic to the enforcement of rights in national legal systems. This is especially so, it is submitted, in the light of conflict and difficulties in constitutional interpretation; so

[220] Stewart (see note 150 above) 508.
[221] Pieterse (see note 43 above) 232.
[222] Stewart (see note 150 above) 509.
[223] Bilchitz (see note 11 above) 8; Davis (see note 41 above) 313.
[224] Forman (see note 98) 62.
[225] Ibid 63.
[226] Mubangizi (see note 120 above) 114.

much so, that Section 39(1)(b) of the Constitution mandates the consideration of international jurisprudence in its interpretation.[227]

This is the case despite the fact that certain international human rights instruments are not directly applicable to South Africa, and notwithstanding that South Africa may not have ratified or even signed the instrument in question.[228] By virtue of Section 39(1)(b), which obliges "any court, tribunal or forum to consider International law when interpreting the Bill of Rights", courts are required to consider all International law, not only that which is binding.[229] Further guidance in this regard is obtained from the Constitutional Court judgment in ***S v Makwanyane,***[230] which provides in respect of Section 35 of the Interim Constitution[231] (the equivalent of Section 39 of the Constitution), that public International law would include non-binding as well as binding law.

It is also important to bear in mind that the Constitution requires that when interpreting any legislation, every court must prefer any reasonable interpretation of the legislation that is consistent with International law to any alternative interpretation that is inconsistent with International law.[232]

Liebenberg[233] is of the opinion that this recognition of international law is also necessary to recognise the constitutional receptiveness to the norms and values of the international community; that, it "resonates with the reciprocal way in which international law and institutions supported the struggle against apartheid, and were in turn, influenced by this struggle." It likewise, gives effect to the constitutional commitment in the Preamble "to build a united and democratic South Africa able to take its rightful place as a sovereign state in the family of nations (by contributing) to

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[227] Section 39 – Interpretation of the Bill of Rights provides:
1. When interpreting the Bill of Rights, a court, tribunal or forum -
   (a) must promote the values that underlie an open and democratic society based on human dignity, equality and freedom;
   (b) must consider international law; and
   (c) may consider foreign law.

[228] As is the case with South Africa and the ICESCR – see discussion below at Paragraph 3.2.

[229] Mubangizi (see note 120 above) 114; M Oliver 'Constitutional Perspectives on the Enforcement of Socio-Economic Rights' 2002 33 *Victoria University of Wellington Law Review* 117.

[230] (1995) 3 SA 391 (CC).

[231] The Constitution of the Republic of South Africa, Act 200 of 1993

[232] Section 233 - Application of international law.

[233] Liebenberg (see note 3 above) 101.

the development of international law based on our domestic experiences of human rights and democratic transformation."[234]

3.2 Ratification of the ICESCR by South Africa:

The ICESCR was signed by our then President, the revered Nelson Mandela on 03 October 1994, auspiciously, at the advent of our new democracy, heralding South Africa's intention to become bound by the provisions of the Covenant, and signifying hope for the realisation of the rights of the poor and those disenfranchised by the previous regime. However, the Covenant has, to date, not been ratified.[235] In terms of section 231(2) of the Constitution, the ICESCR must be approved by Parliament by way of a resolution of ratification before it becomes legally binding upon the Republic.

As a result, the ICESCR is not yet binding on South Africa, but is persuasive. South Africa has for a while subscribed to the norms and standards contained in the ICESCR as it has ratified the African Charter, which carries forward many of the socio-economic rights contained in the ICESCR.[236] It has also included justiciable socio-economic rights in the Bill of Rights in the South African Constitution, that are premised on the provisions of the ICESCR.

Cabinet announced, however, on 10 October 2012, its decision to ratify the Covenant by tabling it before Parliament for approval[237] – a decision that had been welcomed by civil society organisations and the South African Human Rights Commission. This is, unfortunately, still pending.

The People's Health Movement of South Africa (PHM) highlights that the importance of South Africa's ratification of the ICESCR, is the link forged between socio-economic rights and meeting the UN MDGs.[238] It is deemed essential for enforcing the

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[234] Ibid; In *Kaunda v President of the Republic of South Africa* (2005) (4) SA 325 (CC), the Constitutional Court held that our Constitution recognises and asserts that after decades of isolation, South Africa is now a member of the community of nations, and a bearer of obligations and responsibilities in terms of international law.

[235] Anecdotally, this has prompted the Black Sash to refer to the scenario as one where "South Africa is engaged but not married" in respect of the ICESCR; *http://www.blacksash.org.za/files/icescropinion.pdf.*

[236] See discussion at Chapter 2 above.

[237] *http://www.gcis.gov.za/content/newsroom/media-releases/cabstatements/11Ict2012.*

[238] *http://phm-sa.org/icescr-ratification-campaign/.*

rights of those living in poverty, and has particular relevance to South Africa in light of the majority of communities who do not have access to the most basic human rights, nor to justice.

Petherbridge[239] notes that through its ratification of the ICESCR, South Africa will –

- bind itself to the standards of the ICESCR, thereby necessitating domestic legislation and policies in line with the obligations contained the ICESCR;
- be subject to the reporting procedures carried out by the UN-CESCR in terms of which the implementation of the rights are monitored through the assessment of State reports;
- be accountable if implementation is not properly carried out; and
- be assisted, if necessary in improving the implementation of the rights protected in the Covenant.

In particular, the ratification of the ICESCR would also require that South African courts "align their jurisprudence with the obligations set out in the ICESCR".[240] This would require recognition and protection of the "minimum core obligation" imposed by the Covenant. Petherbridge further submits that ratification would therefore see that courts develop the reasonableness test so as to incorporate a requirement that the government accord priority protection to basic socio-economic needs.

3.3 Application of the ICESCR to the South African right to health:

3.3.1 Interpretation of the Article 12 Right to Health:

3.3.1.1 UN-CESCR General Comments:

The main sources for interpreting the ICESCR are the General Comments adopted by the UN-CESCR, the primary supervisory organ in terms of the ICESCR. Although not legally binding, they carry persuasive weight as indications of how the UN-CESCR

[239] Petherbridge (see note 85 above) 1.
[240] Ibid.

interprets the provisions of the ICESCR.[241] These interpretations serve as benchmarks against which to measure State action or inaction, and importantly, prescribe specific content to the right to health.

Primarily of relevance herein, are CESCR General Comments 3 and 14.

(i) General Comment No. 3 on Article 2(1) on the Nature of State Parties Obligations ICESCR, 1990:

General Comment 3 underlines the responsibility of the government to "take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum extent of its available resources, with the view to achieving progressively the full realisation of the rights recognised [herein]."[242]

It was adopted on 14 December 1990, and significantly, the Committee confirms that States parties *have a core obligation* to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights enunciated in the Covenant, including essential primary health care.[243]

In ascribing the above minimum core obligation, the UN-CESCR is still cognisant of the limitations of resource constraints on a country, that may impact on that country's ability to meet such an obligation. Of significance is Paragraph 9,[244] in respect of

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[241] Liebenberg (see note 3 above) 107.

[242] B Rubenson Health and Human Rights' *Health Division Document* 2002:2A; Commissioned by Sida, Department for Democracy and Social Development, Health Division 12.

[243] UN-CESCR General Comment 3 at paragraph 10, which provides –

On the basis of the extensive experience gained by the Committee, as well as by the body that preceded it, over a period of more than a decade of examining States parties' reports the Committee is of the view ***that a minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights is incumbent upon every State party. Thus, for example, 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.*** If the Covenant were to be read in such a way as not to establish such a minimum core obligation, it would be largely deprived of its *raison d'être*. By the same token, it must be noted that *any assessment as to whether a State has discharged its minimum core obligation must also take account of resource constraints applying within the country concerned. Article 2 (1) obligates each State party to take the necessary steps "to the maximum of its available resources".* In order for a State party to be able to attribute its failure to meet at least its minimum core obligations to a lack of available resources it must demonstrate that every effort has been made to use all resources that are at its disposition in an effort to satisfy, as a matter of priority, those minimum obligations.

[244] Paragraph 9 provides –

The principal obligation of result reflected in article 2 (1) is to take steps *"with a view to achieving progressively the full realization of the rights recognized"* in the Covenant. The term "progressive realization" is often used to describe the intent of this phrase. 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… Nevertheless, the fact that realization over time,

Article 2 (1) of the ICESCR, which holds that the obligations therein are subject to a standard of progressive realisation. In terms of General Comment 3, progressive realisation means that while States can justify some health care deficiencies, they cannot justify the failure to work towards rectifying them.[245] There is thus a minimum obligation on government, beyond which rights are to be progressively realised. Our courts have recognised the legitimacy hereof.[246]

(ii) General Comment No. 14 on Article 12 on the Right to Health ICESCR, 2001:

In this Comment, the UN-CESCR in collaboration with the WHO has developed comprehensive guidelines for the interpretation of "the right to health". It discusses how "health" should be understood, the obligations of the state to respect, protect and fulfil[247] the right to health, and what the responsibility of the individual should be.[248] Critically, it defines the requirements of the minimum core to the right to health,[249] as well as obligations of comparable priority.[250]

Thus, in order to meet the requirements of this right, the social determinants of the right must also be addressed. Further, in terms of General Comment 14, the right to health prescribes essential elements such as public health and health care facilities, goods and services, including hospitals, clinics, personnel and essential drugs, which are available in sufficient quality and standards, accessible to all physically,

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or in other words progressively, is foreseen under the Covenant should not be misinterpreted as depriving the obligation of all meaningful content. It is on the one hand a necessary flexibility device, reflecting the realities of the real world and the difficulties involved for any country in ensuring full realization of economic, social and cultural rights. On the other hand, the phrase must be read in the light of the overall objective, indeed the *raison d'être*, of the Covenant, which is to establish clear obligations for States parties in respect of the full realization of the rights in question. It thus *imposes an obligation to move as expeditiously and effectively as possible towards that goal.* Moreover, any deliberately retrogressive measures in that regard would require the most careful consideration and would need to be fully justified by reference to the totality of the rights provided for in the Covenant and in the context of the full use of the maximum available resources.

[245] Forman (see note 98 above) 66.

[246] *Grootboom* (see note 67 above) at paragraph 45.

[247] The obligation to fulfil is further divided into the following elements that must be satisfied –

(a) availability, which includes functioning health care facilities as well as the underlying determinants for health such as water, sanitation, housing and food;

(b) accessibility – which requires non-discriminatory access, physical accessibility, economic accessibility and accessibility to information for all sections of the population;

(c) acceptability – the need for respect for the individual and the culture, medical ethics, the confidentiality of the individual and for gender and generation sensitivity. It includes the need for ability among health staff and decision makers to speak and understand the language as well as the beliefs around health and disease of the community and need for participation and influence from those concerned; and

(d) quality – which requires that health services should provide care, which is scientifically and medically appropriate and of good quality. This requires adequate regulations and control mechanisms and continuous training of staff.

[248] Rubenson (see note 242 above) 13; UN-CESCR General Comment 14, Paragraph 12.

[249] UN-CESCR General Comment 14 (see note 91 above).

[250] UN-CESCR General Comment 14 (see note 92 above).

economically, and without distinction, and of good quality.

General Comment 14 places a non-derogable obligation on States,[251] whereby a State cannot under any circumstances justify non-compliance with the core obligations. This is a development from General Comment 3, which provided that a State could justify non-compliance with minimum core obligations by demonstrating that every effort to use all resources available to satisfy those obligations as a matter of priority has been made. This development, it is submitted, is interpreted to indicate the level of commitment required of States - that it is not a matter of *"refusal"* but *"incapability"* to meet its obligations that is of importance.[252] The former will not be accepted on any level, while the latter affords States a measure of flexibility taking into account *maximum* available resources.

3.3.2 Relevance of the above instruments to HIV-positive individuals:

General Comment 14 requires that health care facilities, goods and services should be available in sufficient quantity bearing the State's developmental level in mind. These should be physically and economically accessible without discrimination. Furthermore, they should be ethically and culturally acceptable, scientifically and medically appropriate, and of good quality.[253]

Of importance in respect of HIV/AIDS infected and affected individuals, is the obligation on States to provide access to essential medicines.[254] The right to treatment involves the provision of urgent healthcare and assistance, while prevention and education programmes must also be initiated. Further, aid should be provided with the confidentiality of individuals protected and on a non-discriminatory basis.[255]

In terms of Articles 2 and 3 of the ICESCR any discrimination in access to healthcare and underlying determinants of health, as well as to the means for their purchase, is

[251] General Comment 14, paragraph 47.
[252] Ibid; Forman (see note 98 above) 68.
[253] General Comment 14 at paragraphs 8, 9, 12 & 13.
[254] General Comment 14 at paragraph 16; WHO Fact sheet 31 (see note 23) 3.
[255] Pavone (see note 32 above) 103.

strictly prohibited.[256] This is an obligation of immediate effect. Equality of access to healthcare also implies provision of healthcare facilities to those who are unable to provide for themselves. This should be realised through appropriate health resource allocation.[257]

The World Health Organisation has derived the following basic, or core, entitlements to the right to health from Article 12 of the ICESCR and General Comment 14 –

"The right to –

- a system of health protection providing equality of opportunity for everyone to enjoy the highest attainable level of health;
- prevention, treatment and control of diseases;
- access to essential medicines;
- emergency medical treatment
- maternal, child and reproductive health;
- equal and timely access to basic health services;
- the provision of health-related education and information; and
- participation of the population in health-related decision-making at the national and community levels."[258]

Based on Section 27's genesis in the ICESCR, as well as the provisions of General Comment 14, it is submitted that Section 27 may be said to contain the above minimum core entitlements as well.

One may surmise thus: *a minimum obligation to HIV-positive individuals under the right to health encompasses the duty of treatment and prevention and control in respect of the epidemic, on a non-discriminatory basis.*

3.4 Does a minimum core obligation in respect of HIV/AIDS prioritise treatment over prevention given resource constraints?

Anti-retroviral drugs are used to prevent the transmission of the HIV virus in cases

[256] General Comment 14 at paragraphs 18 & 19.
[257] Ibid.
[258] WHO Fact Sheet 31 (see note 23 above) 4.

where individuals have been exposed to it in various circumstances (as prevention); and administered to HIV positive individuals at a certain stage of the progression of the HI virus to suppress HIV viral activity and thus to prolong and improve the person's quality of life (as treatment).

The argument against allocating medication to prevention, however, is that in a resource-constrained country such as South Africa, diverting a major share of ART to prevention could deny treatment to deserving people.[259] A further concern is that infected patients in the early stages of the disease have a "virtual certainty of benefiting" from ARV drugs while "much greater uncertainty surrounds the benefits for prevention" with PrEP - given that the "effectiveness of that method depends on constant and appropriate use by people who engage in high-risk behaviour."[260] As such, in terms of this argument, as long as ARVs need to be allocated between prevention and treatment, first priority should be given to treatment, and second priority to the treatment-as-prevention (TasP) strategy.

Singh advances the argument that a state's minimum core obligation in relation to HIV does extend to PrEP, especially where vulnerable individuals are unable to access interventions because of debilitating social factors.[261] Given our resource constraints, Singh suggests that policymakers may have to consider restricting PrEP access in the short to medium term to vulnerable individuals in 'urgent need' based on the contextual epidemic and that "human rights doctrines would hold that such prioritization is equitable and reasonable".[262] However, determining what constitutes 'urgent need' and who qualifies for this status will have to occur in a transparent manner to be ethically defensible. This, according to Singh, will necessitate "engagement between health officials at all levels of government, social welfare, the scientific community, civil society, and affected communities."[263]

It is thus concluded that a government's minimum core obligation in regard to the right to health in the context of HIV includes both the progressive provision of treatment

[259] R Macklin and E Cowan 'Given financial constraints, it would be unethical to divert antiretroviral drugs from treatment to prevention' *Health Affairs* 2012; 7:1537–1544; Singh (see note 19 above) 864.
[260] Singh ibid.
[261] Singh (see note 19 above) 864.
[262] Ibid.
[263] Ibid.

and prevention interventions. The rollout of new interventions should not, however, compromise existing effective programmes.[264]

Karim records findings that since the 2010 Vienna AIDS conference, five studies have demonstrated that ART, when used as prescribed, either to treat HIV-infected individuals (treatment for prevention) or as oral/topical pre-exposure prophylaxis (PrEP), effectively prevents the sexual transmission of HIV.[265]

In this respect, the precariously vulnerable position of women in sero-discordant relationships must be highlighted. Gender inequality, abuse and failure to respect the rights of women and girls are critical social determinants of the HIV/AIDS pandemic in South Africa. For example, disempowerment as a result of cultural practices may prevent women from negotiating safe sex practices.[266] Young women in particular, are especially vulnerable to infection. In addition, women have generally less access to available treatments and adequate information. They are also disproportionately affected by the burden of caregiving.

Following the recognition by the WHO in its June 2013 Guidelines on Prevention and Treatment of Infectious Diseases, that "when sero-discordant couples are identified and where additional HIV prevention choices for them are needed, daily oral pre-exposure prophylaxis may be considered as a possible additional intervention for the uninfected partner,"[267] states should put in place laws and policies that challenge gender inequality and social norms that contribute to HIV/AIDS expansion. They should also provide equal access to HIV-related information, education, means of prevention, and health services. Significantly, they should ensure women's sexual and reproductive rights, which are key to HIV prevention. In this respect preventing HIV transmission in pregnant women, mothers and their children is crucial. States should also protect women against sexual violence, which makes them more vulnerable to HIV infection and other sexually transmitted infections.[268]

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[264] Ibid.
[265] Abdool Karim (see note 19 above) 133.
[266] A Outwater 'Women in South Africa – Intentional Violence and HIV/AIDS: Intersections and Preventions' *Journal of Black Studies* Vol.35 No.4 (2005) 138.
[267] WHO 'Consolidated Guidelines on the Use of ARV Drugs for the Treating and Preventing HIV Infection – Recommendations for a Public Health Approach' June 2013, at paragraph 5.2.2.
[268] Outwater (see note 266 above) 140.

In respect of vulnerable women in South Africa, especially the millions of disempowered black rural women and girls, it is submitted that prevention may be tantamount to treatment in saving lives. With this in mind, there can be no debate regarding the need for ART as prevention, and no talk of prioritising one over the other. As Singh has suggested, "treatment rollout and PrEP rollout should occur simultaneously, and concurrent to a sustained and expanded HCT programme, and all role players should maximise their efforts to integrate HCT, treatment and prevention in an efficient and cost-effective way."[269] Karim similarly argues "a potential combination of therapeutic and prophylactic antiretroviral strategies brings the prospect of HIV control within reach."[270]

The argument in favour of a combined HIV prevention strategy includes a "structural approach" to prevention, which involves the process of selecting a set of interventions that address structural factors to reduce HIV risk at the individual and/or group level.[271] It is submitted however, that there is no "one size fits all" structural approach that is appropriate for all epidemics, settings, or target populations.[272] It is important to choose interventions according to an analysis of the particular characteristics of the target population, the context, and of the risk to be addressed for HIV prevention in that specific setting.

3.5 The critical issue of access to health care – intellectual property barriers and access to medicines

The high cost of medicines and a lack of resources inevitably means that there is limited access to medicines for the treatment of HIV opportunistic infections and ART. This amounts to a limitation of fundamental human rights of those infected with the disease, especially the rights to human dignity, equality and freedom.[273] As such, effective resolution of the HIV/AIDS crisis will depend significantly on whether the

[269] Singh (see note 19 above) 865.
[270] Abdool-Karim (see note 19 above) 133.
[271] JO Parkhurst An Overview of Structural Approaches to HIV Prevention' August 2013; Accessed at*http://www.aidstarone.com/focus_areas/prevention/pkb/structural_interventions/overview_structural_approaches_hiv_prevention.*
[272] Ibid.
[273] Joni (see note 31 above) 274; Section 7(1), 1996 Constitution.

majority of infected and affected South Africans are able to access to essential drugs for prevention or treatment of the epidemic and opportunistic diseases.[274] High rates of HIV infection and high mortality rates make improved access to treatment imperative.

Do governments have a duty to provide antiretroviral treatment?

The Covenantal and constitutional duty on government to fulfil obligations, which in turn gives rise to the issues of accessibility, acceptability, quality and availability, is of relevance in respect of AIDS medicines and health care facilities.

De Vos notes that one of the core obligations identified in terms of General Comment 14 above, is the right of access of all individuals to essential drugs, as defined in the WHO essential drugs list.[275] It is recorded that anti-retroviral medicines were included in the essential drugs list at the 12th meeting of the Expert Committee on the Selection and Use of Essential Medicines. [276]

Access to ART is thus a fundamental core obligation of the State. While South Africa has taken steps towards lowering the costs of drugs by the adoption of the Medicines and Related Substances Amendment Act,[277] there is a pressing need for South Africa to take urgent steps to address the lack of access to many important, life-saving medicines and curb the rising costs of medicines.

Through vigilant activism by the TAC and civil society, anti-competitive complaints, as well as the licensing and availability of generic medicines, a number of affordable 1st line antiretroviral medicines for HIV is now accessible.[278] Generic competition has reduced the cost of ARVs from around US$10 000.00 per patient per year, to

[274] P de Vos 'So Much to do, so Little Done: The Right of Access to Anti-Retroviral Drugs Post-*Grootboom'* 7 *Law Democracy & Development* 83 2003 86; Joni ibid.
[275] de Vos (see note 274 above) 102; WHO - *http://www.who.int/selection_medicines/committees/en/*.
[276] WHO - *http://archives.who.int/eml/expcom/expcom12/expertcomm12.htm.*
[277] The Medical and Related Substances Control Amendment Act 90 of 1997; Amendments that were important in bringing down the price of drugs include: making provision for the generic substitution of off-patent medicines and medicines imported and produced under compulsory licenses; the allowance for the parallel importation of patented medicines; and provisions for a transparent medicine pricing system through the establishment of a pricing committee.
[278] Treatment Action Campaign (TAC): Accessed at *http://www.tac.org.za*.

approximately US$ 150.00 per patient per year within a few years.[279] However, as noted by the TAC, "some important 1st and 2nd line medicines remain unavailable because of patent protection."[280] In addition, currently "there are no 3rd line antiretroviral treatments provided through the public sector, despite the growing number of patients in need of these medicines."[281]

The issue of drug patents is therefore critical to the accessibility of health care in South Africa. The shortage of affordable drugs and the lack of a reliable supply, obstruct HIV treatment and prevention programmes.[282] Further, patients who have commenced with a treatment regime are compromised if their drug supply is halted or interrupted. It is thus imperative that this core obligation be stringently fulfilled.

It is further believed that the right of everyone to enjoy the benefits of scientific progress and its applications as established in Article 15(1)(b) of the ICESCR "implies the duty for developed countries to make antiretroviral drugs available to those countries that cannot afford it but are most severely affected by the HIV/AIDS pandemic."[283]

Gray and Vawda note that the South African case presents both challenges and opportunities for access to medicines.[284] As noted above, South Africa has failed to use all available flexibilities, and has a weak patent-granting system, but this the authors attribute ultimately to a lack of political will, which they censure. It is suggested that "stronger leadership regarding its obligations to its citizens"[285] is required, as well as better jurisprudence which secures minimum core entitlements in respect of access to health care.

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[279] Médecins Sans Frontières 'Untangling the Web of ARV Price Reductions' 16th ed. July 2013; available at at *http://utw.msfaccess.org.*
[280] Treatment Action Campaign (TAC) (see note 278 above).
[281] Ibid.
[282] Pavone (see note 32 above) 103.
[283] Ibid.
[284] AL Gray and YA Vawda 'TRIPS, Access to Medicines and Local Production in South Africa' in H Löfgren, H and OD Williams (eds.) '*The New Political Economy of Pharmaceuticals'* Chapter 10 (2013)
[285] Ibid.

CHAPTER 4:

Implementation and Enforcement of the Minimum Core, and the path going forward:

4.1 Mechanisms of enforcement:

The concept of 'minimum core obligations' requires that meeting basic needs must take priority in the State's realisation of rights. Forman suggests that inaccess to health care where there *are* resources and no scarcity, but because of corrupt or neglectful governance "shall be construed as a human rights violation of the highest order."[286]

In terms of the 2011-2012 Consolidated General Report on National and Provincial Audit Outcomes,[287] findings in respect of government expenditure and accounting include[288] –

- 292 (58%) auditees submitted financial statements with material misstatements;
- Unauthorised expenditure totaled R2.9-billion;
- Irregular expenditure has risen to R28.3-billion;
- Fruitless and wasteful expenditure has risen to almost R1.8-billion; and
- Provincial departments account for 73% of irregular expenditure and 55% of fruitless and wasteful expenditure. [289]

Audited figures clearly reveal a constant, year-on-year increase in government misspending and the questionable use of public funds. Dhai[290] is further critical of the State's response to human rights issues, including a lack of access to health care. She is vociferous in her claim that –

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[286] Forman (see note 98 above) 68.

[287] This report is compiled in terms of the Public Finance Management Act 1 of 1999, which requires all departments and public entities of national and provincial governments to be audited annually.

[288] A. Fraser '2011-2012 Consolidated General Report on National and Provincial Audit Outcomes' 14 March 2013; accessed at *http://hsf.org.za/resource-centre/hsf-briefs/2011-2012-consolidated-general-report-on-national-and-provincial-audit-outcomes.*

[289] In respect of the 2011-2012 fiscal period, Ames Dhai reports that –
"The *General Report on the National Audit Outcomes 2010 - 2011* reveals that national and provincial government departments and public entities wasted and misused more than R20 billion of taxpayers' money over the past financial year (2010/2011), with a 12% increase in wasteful and fruitless expenditure by provincial departments as compared with 2009/2010"; A Dhai 'A health system that violates patients' rights to access health care' *The South African Journal of Bioethics and the Law* Vol.5, No. 1(2012); available at *http://www.sajbl.org.za/index.php/sajbl/issue/view/10.*

[290] Dhai (see note 289 above).

"Instead of a progressive realisation of socio-economic rights, the experience has been a progressive infringement of these rights, as evidenced by the progressive deterioration of most services. The trajectory in the evolution of our democracy is somewhat regressive rather than forward moving when viewed through the lenses of socio-economic rights. No doubt the state has the resources to provide better services, but our democracy fails to do so because it is plagued with inefficiencies, incompetent management, corruption and lack of accountability."[291]

The HIV/AIDS crisis, no doubt, presents society with a complex set of problems that necessitates an integrated and holistic response. To be effective, the state response is required to incorporate afore-mentioned minimum core obligations, in accordance with international guidelines, in order to address an array of issues, including –

- the prevention of HIV transmission;
- adequate and effective treatment of HIV-positive individuals;
- discrimination and abuse of HIV-affected individuals; and
- infection epidemiology.[292]

Following a holistic approach, in the context of HIV/AIDS, what is required *inter alia*, is access to primary health care services, to information about HIV, to voluntary testing and counselling facilities and to provision of ART and medication to treat opportunistic infections.[293] But essential to this process is the monitoring of progress in the realisation, or the violation of human rights, on the assumption that "what gets measured gets done."[294]

To this end, it is vital to the enforcement of the right to health that national monitoring and accountability mechanisms are put in place to assess the extent to which the government complies with its obligations in relation to the right to health. Misspending and maladministration such as that recorded above must be confronted and addressed. Complaint procedures and public participation through NGOs are important tools to arrive at an independent impact assessment. Moreover, incorporation of international rules on the right to health into national law greatly contributes to the justiciability and

[291] Ibid.
[292] De Vos (see note 274 above) 85.
[293] Ibid 89.
[294] Watchirs (see note 16 above) 78.

thereby enforcement of the right to health.[295] Mechanisms are varied, but at a minimum, all accountability mechanisms must be accessible, transparent and effective, and include–

- Judicial mechanisms
- Administrative, policy and political mechanisms
- National human rights institutions

4.1.1 Judicial mechanisms:

The South African experience reflects various landmark cases whereby the court exercised judicial power in order to enforce State compliance with policy; and while the intervention of the court is lauded, criticism has been levelled against the implementation and actual enforcement of the said court orders for not being as effective as the constitutional mandate requires the judiciary to be.[296]

4.1.1.1 The Constitutional Court's approach to a minimum core content to the rights at issue:

It is submitted that the court in ***Soobramoney***[297] applied a very 'thin'[298] standard of review. For, while the court may be commended for acknowledging that "there is a high level of unemployment, inadequate social security, and many do not have access to clean water or to adequate health services" and that "for as long as these conditions continue to exist that aspiration will have a hollow ring"[299], the court disappointingly went on to hold that *"a court will be slow to interfere with rational decisions taken in good faith by the political organs and medical authorities whose responsibility it is to deal with such matters."*[300]

Soobramoney was the first Constitutional Court case that dealt with a socio-economic rights issue; and a visionary, socially relevant and precedent-setting judgment was

[295] WHO Fact Sheet 31(see note 23 above) 31- 32.
[296] Section 172, 1996 Constitution.
[297] *Soobramoney* (see note 126 above).
[298] Liebenberg (see note 3 above) 152.
[299] Soobramoney (see note 126 above) at paragraph 8.
[300] Ibid at paragraph 29.

expected from the court – one that gave clarity to the interpretation and content of such rights, particularly the right to access health care in this case. Instead, the decision demonstrates an undue deference to the legislature.[301] One is forced to question the wisdom of the court in assuming that decisions taken by the legislature and other role players would necessarily be taken in 'good faith', and dismissing the need to interrogate such decisions as to its reasonableness within the social context.

It is significant that the court in ***Soobramoney*** failed to acknowledge the possibility of according a minimum core content to the right to access health care, given the court's apparent support for the importance of a transformative approach to the interpretation of socio-economic rights. The court was further remiss in its failure to refer to International law, in this regard, in its judgment.

Although the court in ***Grootboom***[302] opted against the adoption of a minimum core content to the socio-economic right in question, it is respected for considering the arguments of the *amici curiae* and international law in this regard, before rejecting the concept. Having reflected on the provisions of the ICESCR, and the explanatory comments developed by the UN-CESCR for the interpretation thereof, the court reasoned that it was not placed, within the circumstances and facts of the case, to determine the relevant minimum core obligations to the right in question.[303]

The court, per Yacoob J, indicated that –

"Although evidence in a particular case may show that there is a minimum core of a particular service that should be taken into account in determining whether measures adopted by the state are reasonable,

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[301] A Pillay 'Reviewing Reasonableness: An Appropriate Standard For Evaluating State Action and Inaction?' 122 *South African Law Journal* 419 2005 – 'deference' entails "a complete submission of the courts to the administration, entails a complete submission of the courts to the administration".

[302] *Grootboom* (see note 67 above).

[303] The court held at paragraph 33 –

> "The determination of a minimum core in the context of "the right to have access to adequate housing" presents difficult questions. This is so because **the needs in the context of access to adequate housing are diverse: there are those who need land; others need both land and houses; yet others need financial assistance…There may be cases where it may be possible and appropriate to have regard to the content of a minimum core obligation to determine whether the measures taken by the state are reasonable. However, even if it were appropriate to do so, it could not be done unless sufficient information is placed before a court to enable it to determine the minimum core in any given context. In this case, we do not have sufficient information to determine what would comprise the minimum core obligation in the context of our Constitution. It is not in any event necessary to decide whether it is appropriate for a court to determine in the first instance the minimum core content of a right".**

the socio-economic rights of the Constitution should not be construed as entitling everyone to demand that the minimum core be provided to them."[304]

The minimum core was deemed as "possibly being relevant to reasonableness under section 26(2), and not as a self-standing right conferred on everyone under section 26(1)."[305]

In the ***TAC*** case, [306] following the jurisprudence in ***Grootboom***, the court opted for the reasonableness standard of review as well. The court acknowledged the severity of the HIV/AIDS crisis in South; and confirmed that government action must be transparent, and the involvement of civil society mandatory in order for policies and programmes to be considered reasonable.

Swart[307] commends the court's approach in protecting and advancing the pivotal role played by the judiciary in assessing health policy and in supervising and censuring government inaction. However, she berates the court for not using this platform to provide guidance as to the basic entitlements of the right to health. She is also critical of the court deeming the governmental obligation in this case as a negative one to refrain from interfering with the right, rather than a positive one to provide health care.

In the ***TAC*** case, the Constitutional Court accommodated the arguments presented by the first and second *amici curiae* to the court's proceedings. The *amici* contended that section 27(1) of the Constitution established an individual right vested in everyone, that has a minimum core to which every person in need is entitled. The *amici* further clarified the concept of "minimum core" that was consistent with the definition accorded thereto by the UN-CESCR in General Comment 3.[308]

The court held that "it should be borne in mind that in dealing with such matters the courts are not institutionally equipped to make the wide-ranging factual and political enquiries necessary for determining what the minimum-core standards called for by the

[304] *Grootboom* (see note 67 above) at paragraph 34.
[305] Ibid.
[306] *TAC* (see note 110 above).
[307] M Swart 'Left Out in the Cold - Crafting Constitutional Remedies for the Poorest of the Poor' 21 *South Africa Journal on Human Rights* 215 (2005).
[308] *TAC* (see note 110 above) at paragraph 26.

first and second *amici* should be, nor for deciding how public revenues should most effectively be spent."[309] It noted that "there are many pressing demands on the public purse."[310]

The court held further that "courts are ill-suited to adjudicate upon issues where court orders could have multiple social and economic consequences for the community";[311] that the Constitution contemplates rather a restrained and focused role for the courts, namely, to require the state to take measures to meet its constitutional obligations and to subject the reasonableness of these measures to evaluation. Such determinations of reasonableness may in fact have budgetary implications, but are not in themselves directed at rearranging budgets. In this way the judicial, legislative and executive functions achieve appropriate constitutional balance."[312]

4.1.1.2 Is an amended judicial approach required?

It is respectfully submitted that the Constitutional Court's approach has thus far, fallen far short of the requirements of transformative adjudication, primarily by rejecting a minimum core content to socio-economic rights, and by failing the poor and indigent that have approached it for recourse.

Stewart contends that by merely focusing on an assessment of reasonableness in respect of government measures, the court defeats the aim of a purposive constitutional interpretation required by the Preamble[313] and Section 39 of the Constitution, which requires the court, when interpreting a fundamental right "to promote the values that underlie an open and democratic society based on human dignity, equality and freedom." The court is *required* to consider international law and *may* also consider foreign law.[314]

While one may concede that the reasonableness review addresses concerns in respect of the separation of powers; the counter majoritarianism debate and judicial

[309] Ibid at paragraph 37.
[310] Ibid.
[311] Ibid at paragraph 38.
[312] Ibid.
[313] Stewart (see note 150 above) 507.
[314] Section 39, 1996 Constitution.

competence, a deemed disadvantage of the reasonableness model of review is that there is no differentiation between defining the scope and meaning of the right, and the justification for possible infringements of the right. As such, the court fails to conduct an analysis of the underlying purpose of the right – and the violation of a socio-economic right in particular, inevitably impacts on the lives of those materially deprived of basic human entitlements. The court consequently negates to give attention to the actual impact of such action on the social reality and the lives of many. The assessment whether measures adopted by the state are reasonable thus occurs in a 'normative vacuum.'[315] Without this specification of standards to be met, government action, or inaction, cannot be measured.

According to Currie,[316] reasonableness is no more than a relational standard whereby ends are measured against needs – it is not an obligation to provide something specific. It thus reduces the value of socio-economic right entitlements, for example, the right to access to ARVs becomes a right to an evaluation of reasonableness.

The control test, at the end of the day, involves asking: "In terms of the current approach of the courts, what does the right of access to health care actually mean and provide for?" We have no clear answer to this question in terms of current jurisprudence.

Further, it is apparent that by using the reasonableness model of review, the court is seen as disguising inaction under the cover of the progressive realisation of rights. Twenty years into our democratic era, millions of South Africans are bound to question what time–frame should be ascribed to such progressive realisation of rights – for, by no means can the government continue to claim this indulgence indefinitely, and especially not without providing for basic human rights entitlements in the interim. The court in ***Grootboom*** endorsed the definition accorded to progressive realisation by the CESCR in General Comment 3, which provides that it is the *full* realisation of the right that must be achieved progressively – implying that a minimum level of basic entitlements that must be met immediately.[317]

[315] Bilchitz (see note 84 above) 143.
[316] I Currie & J de Waal (eds) *The Bill of Rights Handbook* 166 5th ed. 2005 Juta.
[317] UN-CESCR General Comment 3 (see note 88 above); WHO Fact Sheet 33 '*Frequently Asked*

It is submitted that all states are bound to experience resource constraints and challenges. However, this should not be a debilitating factor that impacts so severely on the indigent and vulnerable primarily. It would seem that these individuals are made to sacrifice the most, without an expectation of an improvement in their standard of living. Government is required to resort to innovative policy-making and to commit to the judicious and prudent use of resources; and this may only be achieved if the state is held to temporal performance guidelines, and made to account for its allocation of reserves.

Pillay notes that the decision of the Constitutional Court in the ***Grootboom***[318] may be regarded as a significant victory for the displaced and homeless people of South Africa.[319] However, she believes that while the judgment may be seen as a momentous constitutional achievement in respect of the development of socio-economic rights, the judgment has failed to live up to the expectations of the litigants. A key problem, Pillay suggests, lies in the nature of the orders handed down by the Constitutional Court.

In ***Grootboom***, the Constitutional Court handed down two orders. The first essentially made a settlement agreement between the parties an order of court, and was implemented to a limited extent. The Court handed down a second general order declaring that the State is obliged "to devise and implement within its available resources a comprehensive and coordinated programme progressively to realise the right of access to adequate housing".[320] This order was merely a declaratory order and did not compel the State to take steps to ensure that its programme complies with the court order.[321] A further problem therewith, is that the order did not contain any time frames within which the State had to act. The result is that after the ***Grootboom*** judgment was handed down; there had been little tangible or visible change in housing policy so as to cater for people who find themselves in desperate and crisis situations.[322]

Questions on Socio-Economic Rights' 13; Grootboom (see note 66 above) at paragraph 45.
[318] *Grootboom* (see note 67 above).
[319] K Pillay 'Implementing Grootboom: Supervision needed' *ESR Review* Vol. 3 No. 1 (2002) 256.
[320] *Grootboom* (see note 67 above) at paragraph 96.
[321] Pillay (see note 319 above) 264.
[322] Ibid.

In respect of both orders, the Constitutional Court elected neither to play a supervisory role nor to oversee the implementation of the orders. This clearly has social and economic repercussions for indigent communities left bereft in the event of State non-compliance, as new court proceedings have to be instituted to compel such performance.

Swart [323] believes that there is reason to be critical of the relief granted in the Constitutional Court's socio-economic jurisprudence. Referring to the decisions in both the ***Grootboom***[324] and ***TAC*** cases,[325] which resulted in ineffectual compliance with the awards in the judgments, she is extremely critical of the State's inaction.

It is noted that there exists potential on the part of the courts to move from ordering the "soft" remedy of a declarator to the "hard" remedy of a structural interdict. This was evident from the so-called "Westville prisoners" case[326], where the eminent Justice Pillay ruled that the Respondent (the government) was not complying with its constitutional obligation to provide adequate medical treatment to prisoners. He issued an order directing the government to provide ARV treatment as well as a "supervisory order". The supervising order necessitated a reporting and supervisory process, which was judicially monitored.[327]

While the government appealed this judgment, and subsequently failed to comply with the court order, the Appeal Court, per Justice Nicholson, chastised such conduct by the State, in holding –

"If the refusal to comply does not result from instructions from the first respondent, the Government of the Republic of South Africa, then the remaining respondents must be disciplined, either administratively or in an employment context, for their delinquency. If the Government of the Republic of South Africa has given such an instruction then we face a grave constitutional crisis involving a serious threat to the doctrine of the separation of powers. Should that continue the members of the

[323] Swart (see note 307 above) 216.
[324] *Grootboom* (see note 67 above).
[325] *TAC* (see note 110 above); The court in fact held - "In appropriate cases they (courts) should exercise such power if it is necessary to secure compliance with a court order. That may be because of the failure to heed declaratory orders or other relief granted by a court in a particular case. We do not consider, however, that orders should be made in those terms unless this is necessary. *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".*
[326] *E & N v Minister of Correctional Services* Durban High Court Case no. 4576/2006 (unreported).
[327] A Hassim 'The '5 star' prison hotel? The right of access to ARV treatment for HIV positive prisoners in South Africa' *International Journal of Prisoner Health*, September 2006; 2(3): 157-171.

judiciary will have to consider whether their oath of office requires them to continue on the bench."

It is thus suggested that the Constitutional Court should be concerned with remedies that assist in realising socio-economic rights, such as the right to health and therefore primarily with "affirmative remedies including declarations, damages, reading-in, mandatory interdicts and structural interdicts."[328] Of these, constitutional damages and structural interdicts are recommended as "particularly suitable as remedies that would increase government accountability."[329]

When evaluating state action or inaction, the judiciary will have to assess whether, given the state's wide range of health commitments, special emphasis should be placed on the provision of ART and access to health care for HIV-positive individuals. It is submitted that the above minimum core obligations to the right to health, especially to access medicines, renders it a basic "floor" level entitlement that is non-derogable.[330] Ascribing the minimum content of the right to health thereby places the onus of proving incapacity on the State and not the individual.

If a State is unable to fully comply with the right, particularly the minimum core obligations the right includes, it has to show it has taken all necessary measures and used all its available resources to try to comply. The minimum core obligations nevertheless have immediate effect. General Comment 14 provides that the limitation clause found in Article 4 of the ICESCR is intended to *protect* individuals rather than *justify* limitations.

4.1.2 Administrative mechanisms, policy and political mechanisms:

4.1.2.1 Constitutional administrative justice rights:

Administrative justice rights have also constituted an important vehicle for protecting socio-economic rights.[331] Responsiveness to people's needs, public participation in

[328] Swart (see note 307 above) 218; Gloppen (see note 57 above) 13.
[329] Swart (see note 307 above) 219; Pieterse (see note 43 above) 248.
[330] Pieterse (see note 94 above) 481.
[331] Liebenberg (see note 3 above) 133.

policy-making and transparency are among the basic values and principles governing public administration in terms of Section 195 (e) and (g) of the Constitution.

One of the advantages of the minimum core is that it places a weighty burden of justification on the state in cases where people are deprived of their basic needs. This promotes social and economic policies which are responsive to people's needs, and accords with the requirements of Section 195 (1)(e) of the Constitution, which provides that the key principle regarding public administration in South Africa is that people's needs must be responded to and the public must be encouraged to participate in policy-making.

The institution of the Colombian *tutela*-like court processes, for example, would prove highly beneficial to disenfranchised individuals. It would provide such aggrieved persons with an urgent action for immediate relief. As such, access to justice shall be facilitated, and constitutional norms met. Further, with stringent time-based performance restrictions, and possible imprisonment and/or cost orders against defaulting public officials, constitutional rights face a better prospect of being realised. Iniquitous State spending may also be monitored and restrained. This is especially so if minimum levels of government obligations are safeguarded and enforced.

Important in the context of the interpretation and implementation of health rights, are the following provisions, which have a bearing on the concerns raised by critics in respect of the separation of powers doctrine –

- Section 41[332] of the Constitution provides, *inter alia*, for the effective, transparent, accountable and coherent government for the Republic as a whole; respect for the constitutional status, institutions, powers and functions of government in the other spheres; co-operate with one another in mutual trust and good faith; and co-ordinating their actions and legislation with one another.
- Section 85 regulates the executive authority of the country and the development and implementation of national legislation and national policy.
- Section 165 vests judicial authority in the courts, which are deemed independent and subject only to the Constitution and the law that they must

[332] Section 41: Principles of co-operative government and inter-governmental relations

apply impartially and without fear, favour or prejudice.[333]

4.1.2.2 National Policy – the National Strategic Plan (NSP):

Further to the Constitutional, legal and humanitarian obligations placed on government to respond to the AIDS crisis, South African has implemented the National Strategic Plan (NSP) for HIV, Sexually Transmitted Infections (STIs) and Tuberculosis (TB) as a framework to guide policies and programmes in respect of HIV, STIs and TB in South Africa.[334] The current plan provides goals and strategies for the country's response to these diseases during the period 2012 to 2016.

The NSP has five goals, as listed in the Plan[335] –

- halving the number of new HIV infections;
- ensuring that at least 80% of people who are eligible for treatment for HIV are receiving it;
- halving the number of new TB infections and deaths from TB;
- ensuring that the rights of people living with HIV are protected; and
- halving the stigma related to HIV and TB.

The NSP has identified a number of strategic objectives that will help South Africa reach these goals.[336] These are:

- Address social and structural factors that drive these epidemics, influence their impact, and affect the way affected people are cared for.
- Prevent new HIV, STIs and TB infections through a combination of interventions.

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[333] Specifically with reference to constitutional adjudication, Section 172 provides for the following –
Powers of courts in constitutional matters

1. When deciding a constitutional matter within its power, a court -
- **a. must declare that any law or conduct that is inconsistent with the Constitution is invalid to the extent of its inconsistency; and**
- **b. may make any order that is just and equitable, including -**
  - **i. an order limiting the retrospective effect of the declaration of invalidity; and**
  - **ii. an order suspending the declaration of invalidity for any period and on any conditions, to allow the competent authority to correct the defect.**

[334] The National Strategic Plan (NSP) for HIV, Sexually Transmitted Infections (STIs) and Tuberculosis (TB) (2012-2016); available at *http://www.doh.gov.za/docs/stratdocs/2012/NSPfull.pdf.*
[335] Ibid.
[336] Ibid.

- Protect the human rights of people living with HIV and improve their access to justice.
- Sustain health and wellness, primarily by reducing deaths and disability from HIV, AIDS and TB.

It clear that the NSP engages with the needs of HIV-positive individuals. It is submitted however, that the success or failure of such laudable plans lies in the extent to which they are enforceable. High infection rates, inaccess to medicines and misspending of public funding suggest that there still remains much work to be done.

4.1.2.3 National Health Insurance:

The Ministerial Advisory Committee on National Health Insurance (NHI)[337] was established by the Department of Health in 2009. [338] The Minister of Health released the NHI Policy Paper in August 2011.[339] The NHI is expected to provide all South Africans "access to appropriate, efficient and quality health services and affordable, quality health care, regardless of socio-economic status".[340] Masanque postulates that the NHI might be "South Africa's single most important step towards fully realising socio-economic rights". [341] It will extend health care coverage to the entire population over the next fourteen years,[342] and is hoped to address the inequity inherent in national health as a result of the two-tier health care system.[343] In this way, it is suggested that the NHI meets the obligations of access to health care, imposed by the minimum core.

Successful implementation of the NHI depends on the concerted effort of the Department of Health and all role-players involved, the efficient allocation of resources and the monitoring and review of efficacy.

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[337]Department of Health. Policy on National Health Insurance. National Health Act No. 61 of 2003, Section 3; Number 657: 12 Aug 2011; available at *http://www.doh.gov.za/docs/ notices/2011/not34523.pdf.*

[338] "Statement on the Appointment of a Ministerial Advisory Committee on the National Health Insurance" issued by the Ministry of Health on 05/11/2009, available at *http://www.doh.gov.za/docs/pr/2009/pr1105.html.*

[339] G Ogunbanjo 'National Health Insurance: The "Shosholoza" train is already on the move!' *South African Family Practice* (2011) Vol 53 No. 5 399.

[340] NHI (see note 327 above) at paragraph 1.2.

[341] IR Masanque 'Progressive Realisation Without the ICESCR: The Viability of South Africa's Socio-Economic Rights Framework, and its Success in the Right to Access Health Care' 43 *California Western International Law Journal* 461 2012-2013 481.

[342] NHI (see note 337 above) at paragraph 1.1

[343] Masanque (see note 341 above) 483.

4.1.3 National human rights institutions:

Chapter 9 of the Constitution provides a further mechanism for public accountability and protection by creating State institutions supporting constitutional democracy. These include the Public Protector [344] and the South African Human Rights Commission (SAHRC).[345] It is submitted that the utility of these offices in the enforcement and over-seeing of state action may be further exploited than it has been in the past.

Section 184 (3) of the Constitution specifically mandates the SAHRC to monitor the implementation of economic and social rights by the relevant organs of the state. Pursuant hereto, the Commission compiles periodical reports, which analyse South Africa's progress in respect of the MDGs and the progressive realisation of socio-economic rights. In terms of the latest publication in 2009,[346] the following disturbing findings were made –

- "There is inconsistency in data gathering on health issues, and the consequent unreliable statistics and lack of disaggregation of certain indicators make it difficult to measure the progressive realisation of the right to health care services.
- South Africa is not even close to halfway on meeting the target for the child mortality rate, after nine years of commitment to the MDG and with only six more years to go.
- South Africa is a far way from reaching the target of reducing the maternal mortality rate by three quarters. In fact the trend is suggesting that it is increasing.
- New patients living with and affected by HIV/AIDS find it difficult to access ARV programmes due to a lack of additional resources, and therefore their right to adequate health care is compromised.
- Access to health care services for the poor is severely constrained by expensive, inadequate or nonexistent transport, by serious shortages with regards to emergency transport, and by long waiting times at clinics and other health care facilities.
- There is insufficient access to health care for vulnerable groups such as women, sex workers, prisoners and older persons."

Clearly, there is a dire need to monitor, address and, if necessary, to sanction, government inaction. Undoubtedly, this will be greatly facilitated by enforcing a

[344] Section 182.
[345] Section 184.
[346] SAHRC 7th Report on Socio-Economic Rights (2006-2009).

minimum core obligation on the State.

4.2 South African ratification of the ICESCR and implementation in national law:

Ratification of the ICESCR and thereafter signing the OP-ICESCR (the Optional Protocol to the ICESCR) will hold South Africa accountable in terms of the reporting mechanism of the OP-ICESCR. Until recently, the rights outlined in the ICESCR did not have an individual complaints system, and it was believed that "the absence of strong enforcement mechanisms in the ICESCR has marginalised economic, social and cultural rights and stymied their full realisation."[347]

On 10 December 2008, the UN General Assembly adopted an individual complaints mechanism for violations of socio-economic rights. As such, any country that has ratified the ICESCR, and signs onto the Optional-Protocol to the ICESCR may be answerable to the CESCR for violations of the ICESCR.

Brennan reports that the OP-ICESCR may be considered a "milestone which will mark a high point of the gradual trend towards greater recognition of the indivisibility and interrelatedness of all human rights; greater accountability and transparency; and more judicious use of resources."[348] Signatory states may be forced to review policies and actions more stringently for fear of such a mechanism of answerability.[349]

4.3 Minimum core obligations of the private sector – horizontal application of the Bill of Rights in order to supplement available resources:

Respect for the rights enshrined in the Bill of Rights by juristic persons is required by section 8(2) of the Constitution (the horizontal application of the Bill of Rights).[350]

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[347] M Brennan 'To Adjudicate and Enforce Socio-Economic Rights: South Africa Proves That Domestic Courts are a Viable Option' 9 *Queensland University of Technology Law & Justice Journal* 64 2009 68; MJ Dennis and DP Stewart 'Justiciability of Economic, Social and Cultural Rights: Should there be an International Complaints Mechanism to Adjudicate the Rights to Food, Water, Housing and Health?' (2004) 98 *American Journal of International Law* 462: 463.

[348] Brennan (see note 347 above) 68.

[349] Ibid 69.

[350] Section 8(2) provides - A provision of the Bill of Rights binds a natural or a juristic person if, and to

Such an application of the minimum core obligations of the right to health would mean that the private sector – individuals, corporations and business entities, may also be obligated to meet the requirements of the minimum core.

In this respect, the private sector, and 'big business' in particular can contribute significantly to the fight against HIV/AIDS in terms of financial contributions, resource allocation and communal involvement and support. It is submitted that at a time when international aid may be declining, and domestic avenues are constrained, especially as HIV/AIDS impacts on the interests of such businesses as well, it would be mutually beneficial for such concerns to invest in resolving the crisis.

While it may be accepted that the pharmaceutical industry undeniably contributes to the fight against HIV/AIDS, one may argue that it simultaneously thwarts access to treatment by their patents.[351] De Jongh suggests that measures to redress this lies in improving access to medicines by, for example, providing medicine in remote areas and an improved pricing policy.[352] Moreover the industry should ensure good quality and availability of the medicines, especially certain 2nd and 3rd line ARV treatments. Pharmaceutical companies are also well-placed to contribute financially toward the constrained reserves of developing countries.

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the extent that, it is applicable, taking into account the nature of the right and the nature of any duty imposed by the right.

[351] de Jongh (see note 14 above) 135.

[352] Ibid 148.

CHAPTER 5:

CONCLUSION:

This dissertation involved an evaluation of the concept of a minimum core content to the Constitutional right to health with reference to HIV-positive persons in South Africa, and whether South African jurisprudence allows for such a concept. The assessment has sought to establish what this concept entails, whether such a construction is necessary in the South African context, how it may be enforced, as well a legal basis for same – either in National or International law.

An appraisal of the South African social reality has revealed the extent of the suffering of HIV-positive individuals and the difficulties experienced in accessing basic health care. It has been established that a key debilitating factor is the uncertainty that surrounds the basic entitlements of affected people. There is thus a fundamental need to move away from perceived judicial insouciance that allows such vagueness to fester, and develop an approach that is meaningful to the lives of the indigent in our country.

The first step is to develop a construction of human rights that accords with the canons of the Constitution. This mandates an interpretation of human rights that fosters transformative constitutionalism in order to heal our society of past injustice and secure a better future for all.

One such course of action is the adoption of the minimum core, which prescribes a basic level of human rights that is guaranteed to all people – and which may withstand legislative challenge on the basis of resource constraints or progressive realisation.

Implementing a core content to the right to health, in turn, requires adjudication that legitimises the minimum core credo and develops our jurisprudence so as to give form and substance to the concept in light of our own peculiar social context. Reference to International law assists us to overcome the shortcoming in domestic legislation in this regard. Of particular relevance is covenantal guidance offered by the ICESCR, and its guidelines of interpretation, which include the CESCR General Comments and the WHO recommendations.

The aforementioned instruments advocate the following minimum obligations in respect of the right to health –

- a system of health protection providing equality of opportunity for everyone to enjoy the highest attainable level of health;
- prevention, treatment and control of diseases;
- access to essential medicines;
- emergency medical treatment
- maternal, child and reproductive health;
- equal and timely access to basic health services;
- the provision of health-related education and information; and
- participation of the population in health-related decision-making at the national and community levels.

It has thus been postulated that a minimum obligation to HIV-positive individuals under the right to health encompasses the duty of treatment and prevention and control in respect of the epidemic, on a non-discriminatory basis.

The core content having been identified, enforcement and implementation of such health rights must be strictly and timeously effected. Of crucial importance in such a process is a competent judiciary that is able to resist an undue deference to the legislature.

A review of court judgments, however, reveals a less than satisfactory execution of the constitutional mandate in this regard. A call is thus made for progressive judicialism, or judicial activism, within prescribed Constitutional parameters, so as to safeguard Constitutional guarantees and enforce their realisation. Perhaps, what is sought is a return to the 'golden era' of ***Makwanyane*** when the Constitutional Court committed itself to an interpretation of the Bill of Rights that accorded with Constitutional values, such as *uBuntu*, rather than bend to the strong will of political expediency.

It is proposed that this process may thus entail –

- judicial supervision of administrative function by structural interdicts and supervisory orders;
- punitive cost orders against those in default; and
- an adjudicative process that is accessible and effective, especially to the indigent and sick.

Guidance from International cohorts in this respect is instructive. Uganda demonstrates that legal incorporation of the minimum core in domestic legislation is possible and the success of grass-roots implementation of HIV/AIDS policy. Colombia provides us with insight as to the accomplishments that may be made by recognising the minimum core and progressive judicial action, that is accessible and relevant for millions of people.

It is submitted that a failure to acknowledge the basic human entitlements of the poor, sick and marginalised in South African, is a miscarriage of justice that we can ill-afford. We cannot subsist in a society devoid of a moral compass or a social conscience, that permits the suffering of an entire people. The minimum core allows rights to have pervasive and beneficial value, and restores the dignity of our country. It draws mandatory attention to plight of the sick, and the hard truth of HIV/AIDS, poverty and poor governance.

It is time for the axiom *"ubi jus ibi remedium"* (where there is a right there is a remedy),[353] to have literal meaning in the context of health care, and in respect of HIV-positive South Africans most especially. The minimum core shall enable us to accomplish this.

[353] *http://definitions.uslegal.com/u/ubi-jus-ibi-remedium/*; the maxim contemplates that "when a person's right is violated the victim will have an equitable remedy under law." The maxim also states "the person whose right is being infringed has a right to enforce the infringed right through any action before a court."

APPENDIX: LIST OF ACRONYMS AND ABBREVIATIONS

The list hereunder describes in full the various acronyms and abbreviations that appear in this dissertation –

ACP	AIDS Control Program (Uganda)
AIDS	Acquired Immunodeficiency Syndrome
ART	Anti-retroviral Treatment
ARV	Anti-retroviral
CEDAW	Convention on the Elimination of All types of Discrimination Against Women (UN)
CRC	Convention on the Rights of the Child (UN)
CSO	Civil Society Organisation (Uganda)
HIV	Human Immunodeficiency Virus
ICESCR	International Convention on Economic, Social and Cultural Rights (UN)
MDG	Millennium Development Goal (UN)
NGO	Non-governmental Organisation
NHI	National Health Insurance
NSP	National Strategic Plan for HIV, Sexually Transmitted Infections and Tuberculosis
OAU	Organisation of African Unity
OP-ICESCR	Optional Protocol to the International Convention on Economic, Social and Cultural Rights (UN)
PEAP	Poverty Eradication Action Plan (Uganda)
PEPFAR	President's Emergency Plan for AIDS Relief (USA)
PHM	People's Health Movement
PMTCT	Prevention of Mother to Child Transmission (of HIV)
PrEP	Pre-Exposure Prophylaxis
SADC	Southern Africa Development Community
SAHRC	South African Human Rights Commission
STI	Sexually Transmitted Infection
TAC	Treatment Action Campaign
TasP	Treatment as Prevention Strategy
TB	Tuberculosis

UN-ICESCR	United Nations Committee on Economic, Social and Cultural Rights
UN	United Nations
WHO	World Health Organisation

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