Litigating against an Epidemic: HIV/AIDS and the Promise of Socioeconomic Rights in South Africa

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LITIGATING AGAINST AN EPIDEMIC: HIV/AIDS
AND THE PROMISE OF SOCIOECONOMIC
RIGHTS IN SOUTH AFRICA

Nathaniel Bruhn*

With one of the highest incidence rates in the world, the HIV/AIDS epidemic has taken a large toll on South Africa. Despite medical advances that have made the disease more manageable, many South Africans still do not have access to the medicines needed to control the disease. At the same time, the Constitution of South Africa grants individuals far-reaching socioeconomic rights, including the right to access health care. This Comment explores the intersection of the socioeconomic rights and the HIV/AIDS crisis. Although the Constitutional Court has developed a deferential approach to enforcing socioeconomic rights, substantial room remains to litigate on behalf of those affected by HIV/AIDS. Building off the judgment in the Treatment Action Campaign case, this Comment argues that further litigation should be used to hold the government to the standards of the Constitution and to mitigate the impact of the epidemic.

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* J.D., 2011, University of Michigan Law School, B.A., 2003, Vassar College. I am grateful to Mahendra Chetty and the staff at the Legal Resources Centre in Durban, South Africa for including me in their inspiring and important work. This Comment arose from my time at the LRC in Fall 2010. Thank you to Willene Holness at the LRC for her comments and review of prior drafts and to Professor Mark Rosenbaum for his guidance and encouragement. Thank you to the members of the Michigan Journal of Race & Law for their work on this Comment. Most of all, thank you to my wife Sarah and daughter Lillian.
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"During the last two decades, the HIV pandemic has entered our consciousness as an incomprehensible calamity. HIV/AIDS has already taken a terrible human toll, laying claim to millions of lives, inflicting pain and grief, causing fear and uncertainty and threatening economic devastation."


INTRODUCTION

Nelson Mandela’s release from prison in 1990 ushered in a wave of reforms in South Africa, dismantling the structures of apartheid and culminating in the country’s first universal elections in 1994 and the ratification of the Constitution of the Republic of South Africa in 1997. At the heart of the Constitution is the Bill of Rights, which “enshrines the rights of all people in our country and affirms the democratic values of human dignity, equality and freedom.” The Bill of Rights includes far-reaching and justiciable socioeconomic rights, among them the right to an environment that is not harmful to one’s well-being, the right to access adequate housing, the right to access health care, the right to access sufficient food and water, and the right to a basic education. These rights, especially the right to access health care, are fundamental to the success of mitigating the toll of the HIV/AIDS epidemic in South Africa.

4. Id. § 10 (dignity), § 11 (life), § 14 (privacy), § 24 (environment), § 26 (housing), § 27 (health care, food, and water), § 29 (education).
5. The human immunodeficiency virus (HIV), which was first recognized in 1981, leads to acquired immune deficiency syndrome (AIDS). HIV attacks the bodies CD4+ T cells, which play a crucial role in helping the body fight off diseases. AIDS is the late stage of HIV infection, at which point a person’s immune system is severely damaged and no longer has the same ability to fight diseases. Basic Information about HIV and AIDS, Cen-
Less than a decade before the fall of apartheid, the first case of HIV was reported in South Africa. The incidence of HIV/AIDS has since grown to become one of the highest rates in the world, with estimates that 12 percent of the general population is affected and upwards of 20 percent of the adult population is affected. South Africa has the world's largest population of people living with HIV and represents almost one-sixth of the global disease burden. HIV/AIDS has led to high mortality rates and ripped apart families. This is most evident in the number of children orphaned by the disease. The disease has taken a toll on the national economy and taxed the public healthcare system. Despite pockets of improvement, the crisis remains of critical national concern.

This Comment explores the intersection of the socioeconomic rights granted in the Constitution and the HIV/AIDS crisis in South Africa. HIV/AIDS is never mentioned in the Constitution, but it has been argued that the Constitution is nonetheless "the most important legal development impacting on HIV/AIDS." The South African Constitution has created a framework in which there is substantial room to litigate on behalf of those affected by HIV/AIDS. Holding the government to the standards set forth in the Constitution can mitigate the epidemic.

The South African Constitutional Court has developed a deferential approach to socioeconomic rights, reflecting the tension between judicial enforcement of socioeconomic rights and the limits on the Court's power in a constitutional democracy. Respecting a separation of powers was a crucial concern of the Court in its most promising ruling to date addressing HIV/AIDS and socioeconomic rights, Minister of Health v.
Treatment Action Campaign. That 2002 decision held that a limited drug distribution program fell short of the State’s constitutional duties. That Treatment Action Campaign and other cases have shut doors to further litigation in the HIV/AIDS arena, but others remain open and should be explored. Further litigation to enforce the socioeconomic rights of those affected by HIV/AIDS will directly and indirectly ameliorate the burden of the epidemic on individuals, families, communities, and the nation as a whole.

Part I discusses the HIV/AIDS epidemic in South Africa, including its history and its extraordinary impact. Part II studies the South African Constitution and the important role of socioeconomic rights in fulfilling the promises of a post-apartheid South Africa. Part III surveys the first cases addressing socioeconomic rights decided by the Constitutional Court. Part IV analyzes the Treatment Action Campaign case and the response that followed. Part V addresses the impact of HIV/AIDS litigation, including the obstacles blocking future litigation and the benefits of pursuing further litigation as a strategy for fighting the disease. Finally, Part VI envisions the way forward in fighting the HIV/AIDS epidemic through constitutional litigation.

I. HIV/AIDS in South Africa

AIDS is only one of Africa’s current adversities. But amidst all these others AIDS is an important adversity, important morally and practically and socially, because it tells us so much about ourselves and about our other problems. Our responses to a sexually transmitted disease that is potentially fatal show us how much the facts of sex and death still provoke fear and flight, rather than understanding and acceptance, in our cultures. Our responses to a disease whose greatest impact is now on poor black Africans tell us much about our attitudes to poverty and to race.


14. Most notably, the Constitutional Court has rejected the minimum core approach to socioeconomic rights. Grootboom 2000 (11) BCLR 1169 (CC) at para. 10 (S. Afr.), available at 2000 SACLR LEXIS 126 (SACLR 2000).

15. It is important to note that this Comment focuses on cases addressing socioeconomic rights and HIV/AIDS, and does not focus on other cases that touch on HIV/AIDS. One important area of the law that impacts the HIV/AIDS epidemic in South Africa is international patent law and the workings of international organizations and pharmaceutical companies in providing or preventing the necessary drugs from reaching South Africa. This area of the law is crucial to the HIV/AIDS discussion but is beyond the scope of this Comment.

HIV/AIDS continues to be an immense challenge facing Sub-Saharan Africa. The relatively recent and rapid spread of the disease and its impact at every level has, in many ways, defined modern South Africa. Although the disease has a disproportionate impact on certain populations, including young women, the poor, and those in less developed areas of the country, the disease affects the lives of all South Africans.17

It is estimated that 39.5 million people live with HIV worldwide.18 Sixty-four percent of those individuals live in sub-Saharan Africa.19 UNAIDS estimated that 5.6 million people were living with AIDS in South Africa in 2009.20 Among adults (15–49), 17.8 percent of the population was infected with HIV in 2009,21 but the prevalence is highly dependent on the region of the country. The province of Kwazulu-Natal has adult rates of infection as high as 39 percent and some districts have rates nearing 50 percent.22

Significant developments over the past two decades have made HIV/AIDS a manageable disease.23 "The drugs to treat AIDS exist and have rendered the vast majority of these deaths entirely avoidable."24 However, there is still no cure for HIV infection, and controlling the disease requires strict adherence to a drug treatment plan. Illnesses and deaths related to AIDS have been reduced by as much as 90 percent in areas where drugs are available, accessible, and administered under proper medical management.25 However, this has happened mostly in affluent areas of the world. Edwin Cameron, a Constitutional Court Justice openly living with AIDS, framed the moral issue at its broadest:

The epidemic therefore confronts business and political leaders with a pressing moral question. The means to prevent death from AIDS exist. Are they willing to take the measures needed to ensure that adequately supervised treatment reaches thirty

17. 2007–2011 STRATEGIC PLAN, supra note 6, at 17.
18. Id. at 20.
19. Id.
21. Id.
23. See, e.g., South Africa Expanding Access to ARV Therapy, supra note 8 (reporting that a reduction in drug prices will allow South Africa to provide antiretroviral drugs for twice as many people).
25. CAMERON, supra note 16, at 44.
million Africans and other people in the resource-poor world—or will they let them die because they are poor?26

It has been estimated that in the five years prior to 2009, ten million Africans died of AIDS who would likely be alive had they lived elsewhere.27

A. Complicated History

A rapid spread of the disease accompanied by detrimental missteps and failures by the government mark South Africa’s history with HIV/AIDS. The system of apartheid that ruled South Africa from 1948 until it started to break down in 1990 created a country starkly divided on racial and economic grounds. South Africa’s classification as a middle-income country28 is deceptive as large portions of the population live in poverty, and the poverty is concentrated among the Black population.29 This disparity is reflected in the fact that South Africa has long had one of the highest Gini coefficients in the world.30 South Africa currently has the second highest coefficient, behind Namibia, among countries with available information.31

South Africa’s history with HIV/AIDS has largely tracked racial and economic lines. The race-based healthcare system under apartheid was not equipped to confront the disease, and when apartheid ended the structures and underpinnings of the racist regime did not disappear overnight. “At the advent of democracy, the apartheid-era public health care system was highly inequitable and deficient, characterized by fragmented service delivery, insufficient rural facilities, and highly limited access to health care services for women, children and farm workers.”32 Some believe South Africa was positioned to mobilize behind HIV prevention at the end of apartheid, but that result did not materialize.33 Although there

26. Id.
29. Id. at 357 (“[Sixty-one percent] of Africans and 38% of coloureds (mixed race) are poor compared with 5% of Indians and 1% of whites.”).
30. Id. at 358. The Gini coefficient is a measure of the equality of income distribution in a country. A value of 0 represents complete equality and a score of 1 represents maximum inequality.
33. Mark Heywood, Shaping, Making and Breaking the Law in the Campaign for a National HIV/AIDS Treatment Plan, in DEMOCRATISING DEVELOPMENT: THE POLITICS OF
has been some progress in providing health services, electricity, sanitation, housing, and other basic needs to those living in persistent poverty, access to adequate services remains severely limited for many.\textsuperscript{34}

The severe inequality between the private and public healthcare systems in South Africa contributes to the epidemic. While the public system treats 80 percent of the population, it employs only 30 percent of South Africa's health personnel and receives only 40 percent of total health funding.\textsuperscript{35} There has been an increase in health spending, but the additional allocations have not kept pace with inflation and the increasing demands on the public health system, including the enormous costs imposed by HIV/AIDS.\textsuperscript{36}

The inadequacy of government efforts on health are borne out by the appalling regression in all major health indicators over the past decade .... The primary factor in this deterioration is the virtually unchecked growth of the nation's HIV/AIDS pandemic, the largest in the world. From 1.8 million people infected in 1996, infection rates soared to an estimated 6.29 to 6.57 million people in 2004—over 14 percent of the population.\textsuperscript{37}

Although South Africa has the best health infrastructure in Africa, there is still inadequate access to medicines for those with HIV.\textsuperscript{38}

There is no single cause of the HIV/AIDS epidemic in South Africa, but there is widespread agreement that poor governance has been a critical factor.\textsuperscript{39} The post-apartheid government's early efforts to address HIV/AIDS were focused on messages of prevention instead of treatment, in part because of the high cost of the drugs needed to treat the disease.\textsuperscript{40} Over time and with support from the international community, the price of drugs dropped dramatically.\textsuperscript{41} However, even after the price of treatment dropped, the government did not take sufficient steps to improve access to the drugs.

From 1999 to 2008, Thabo Mbeki served as the second post-apartheid President. In 1999, President Mbeki began publicly endorsing

\textsuperscript{34} Forman, \textit{supra} note 32, at 716.
\textsuperscript{35} Id.
\textsuperscript{36} Id.
\textsuperscript{37} Id.
\textsuperscript{38} Cameron, \textit{supra} note 11, at 80.
\textsuperscript{39} Forman, \textit{supra} note 32, at 717.
\textsuperscript{41} Id. Drugs that cost between $10,000 and $15,000 per patient per year (U.S. dollars) in 2001 were down to $132 in 2009. Novogrodsky, \textit{supra} note 24, at 3.
AIDS denialism, a belief that disputes the causal link between HIV and AIDS. Denialists assert that immune failure attributed to AIDS results instead from the toxicity of antiretroviral treatment (ARV), promiscuous, drug-abusive gay ‘lifestyles,’ and in Africa, from poverty-related malnutrition and illness.

Although these beliefs have been discredited by scientific evidence, the effect of the denialism movement was “palpable.” Until 2003, President Mbeki effectively refused to distribute the antiretroviral drugs (ARVs) necessary to treat HIV/AIDS patients. At the same time, he appointed scientists who adhered to denialism to top-ranking government positions. This delay and opposition to the distribution of drugs occurred “despite the desperate need for the drugs, the massive reductions in illness and death that results from their use, and the growing negative impact of the epidemic on health, health care access, and social welfare more broadly.”

With reduced drug prices and the Constitutional Court’s decision in the Treatment Action Campaign case, the government could no longer continue on a path of inaction. In 2003, President Mbeki began investigating treatment options for HIV/AIDS and eventually announced a three-year, $1.2 billion program to fight HIV/AIDS. Despite these steps forward, the lives lost and new infections that could have been avoided at such an important time in the spread of HIV/AIDS cannot be overstated. “There is absolutely no doubt that the President’s flirtation with the dissident position has profoundly influenced, and many would say retarded, the implementation of effective government policy on AIDS in southern Africa.”

Jacob Zuma was elected president after President Mbeki, but his history with HIV/AIDS is similarly troubling. In 2005, while he was head of the National AIDS Control Council, Zuma was prosecuted for the rape of an HIV-positive woman. Trial testimony revealed that Zuma had refused to wear a condom and felt that he was immune from the disease because he had showered after the sexual encounter. The myth of showering after sex is one of many that have hindered efforts to stop the

42. Forman, supra note 32, at 717.
43. Id.
44. Id.
45. Phillips, supra note 40, at 11–12.
47. Forman, supra note 32, at 717.
48. See infra Part IV for a discussion of the Treatment Action Campaign case.
49. Phillips, supra note 40, at 12.
51. Heneke, supra note 46, at 771.
52. Id.
spread of the disease.\textsuperscript{53} Such public failures to confront the realities of HIV/AIDS were unjustifiable in the face of contradicting evidence and facilitated the rapid spread of the disease.

\textbf{B. HIV/AIDS and the Impact on South Africa}

HIV/AIDS has had an immeasurable impact on South Africa, both because of the number of people infected and because of the impact it has on every aspect of life. Under apartheid, the healthcare system was legally demarcated along lines of race, with non-White departments of health allocated lower budgets than White departments of health.\textsuperscript{54} As a result, little was done to address the growth of the disease amongst the marginalized Black community. Around the world, as the HIV epidemic has grown, its greatest toll is on those populations that were already discriminated against, marginalized, and stigmatized.\textsuperscript{55} South Africa has been no different.

The cost of HIV/AIDS can be particularly high for individual households when the lone income earner is the one infected. Within two generations, it is estimated that the average household income in South Africa will be one quarter of what it would be without HIV/AIDS.\textsuperscript{56} In addition to the loss of income, the family may be required to spend what little money they have to care for family members infected with the disease. A vicious cycle, lower income results in higher levels of poverty and malnutrition, which increases the danger of the disease.\textsuperscript{57}

The HIV/AIDS epidemic has also led to a rise in orphaned children. By 2003, 12.3 million children had been orphaned by AIDS in Africa and another twenty million AIDS orphans were expected over the following decade.\textsuperscript{58} In South Africa, one study estimated that over 1.5 million children under the age of seventeen were directly affected by the disease in 2006–2007, either through their own infection, living in a house with a sick caregiver, being abandoned, or living in a house that cares for many children.\textsuperscript{59}

\bibliography{references}{\bibliographystyle{chicago}}

\begin{thebibliography}{99}
\bibitem{*} \textsuperscript{53} Another prominent belief is that sex with a virgin can cure a person of HIV/AIDS. Erika R. George, \textit{Virginity Testing and South Africa’s HIV/AIDS Crisis: Beyond Rights Universalism and Cultural Relativism Toward Health Capabilities}, \textit{96 Calij L. Rev.} 1447, 1461 (2008). One result of this belief is that men have targeted virgins as victims of sexual assault in an attempt to rid themselves of the disease. This practice has raised concerns about the traditional practice of virginity testing in some South African communities. \textit{Id.}
\bibitem{Singh} Singh et al., \textit{supra} note 28, at 356.
\bibitem{George} George, \textit{supra} note 53, at 1516.
\bibitem{Novogrodsky} Novogrodsky, \textit{supra} note 24, at 10.
\bibitem{Id} \textit{Id.}
\bibitem{Id} \textit{Id.} at 9.
\end{thebibliography}
are orphans, but in South Africa that number is projected to be between nine and 12 percent by 2015.\(^6\) Many HIV/AIDS orphans find themselves living in child-headed households where one sibling is the primary caregiver and income earner after the death of parents.\(^6\) As a result, many older children are forced to drop out of school in order to provide for their siblings.\(^6\) These children face a range of additional problems including food insecurity, loss of housing, and exploitation in domestic work and prostitution.\(^6\)

The deceased parents who leave behind orphaned children represent the loss of working age adults in South Africa. AIDS commonly kills people at a time in their lives when they are sexually active, which correlates with the time when they tend to be most economically productive.\(^6\) It is not just the poor that have been affected by the disease; HIV/AIDS has severely impacted the skilled labor force, including teachers, doctors, nurses, small business owners, and others.\(^6\) The World Bank estimated that by 2010, the South African GDP would be 17 percent lower than it would have been without the impact of the disease.\(^6\)

The healthcare system and other public services have also felt the weight of the epidemic:

The public health care system has buckled under the impact of the HIV/AIDS epidemic and its overwhelming illness and death .... The epidemic's negative socioeconomic impact is even broader, and through Sub-Saharan Africa HIV/AIDS is deepening household poverty, reversing gains in human development, worsening gender inequality and ultimately eroding governments' ability to maintain essential services.\(^6\)

The measurable impact of the disease is accompanied by immeasurable burdens that shape the experience of being HIV-positive in South Africa.

C. An Extraordinary Disease

The stigma and discrimination that often accompany HIV/AIDS intensify the impact of the disease. The stigma associated with the disease

\(^{60}\) Id. at 409–10.

\(^{61}\) Id. at 408.

\(^{62}\) Id.

\(^{63}\) Id. at 411.

\(^{64}\) This is in contrast to diseases like tuberculosis and malaria that most markedly affect the young and old. Novogrodky, supra note 24, at 11.

\(^{65}\) Id. at 10.

\(^{66}\) Id.

\(^{67}\) Forman, supra note 32, at 716–17.
has been felt throughout South Africa, from fueling denialism, to inciting discrimination, to affecting personal decisions about whether to get tested. "Considerable social stigma still attaches to HIV infection, with the consequence that those unsure about or ignorant of their HIV status often deny or ignore potentially risky behaviour as they have no incentive to ascertain or disclose their HIV status." The stigma is not unique to South Africa; "the denial, blame, stigmatisation, prejudice and discrimination that fear of AIDS evokes have been found—and continue to be found—in virtually every society affected by the virus." The combination of stigma, the poverty amongst those communities most affected, and the government’s inaction has made the disease especially lethal in South Africa.

The term “AIDS exceptionalism” has been used to describe the unique characteristics of AIDS that makes it significantly different than other diseases. "Unlike malaria, HIV/AIDS continues to be associated with a wide range of human rights abuses, both those that facilitate HIV transmission, including intergenerational sex, and those that target persons already infected, such as discrimination in employment and in access to services of the state." AIDS is also set apart because sexual behavior is a common mode of transmission, the disease can take time to develop, and there is no known cure. These unique characteristics have contributed to the growth of the disease, the stigma that accompanies the disease, and the failure of the government to take the necessary steps to address the epidemic.

II. CONSTITUTION

We live in a society in which there are great disparities in wealth. Millions of people are living in deplorable conditions in great poverty . . . . These conditions already existed when the Constitution was adopted and a commitment to address them, and to transform them in our society into one in which there will be human dignity, freedom and equality, lies at the heart of our new constitutional order.

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68. Cameron, supra note 11, at 52. However, there are signs that this is changing. Where President Mbeki’s denialism levied a heavy blow to efforts to address the disease, President Nelson Mandela helped move the discussion in the other direction when he publicly stated that his son had died of AIDS in 2005. Heneke, supra note 46, at 775.

69. Cameron, supra note 11, at 51.

70. Novogrodsky, supra note 24, at 11.

71. Cameron, supra note 11, at 52.

The post-apartheid transition encompassed the hope of a new era, but also disagreement about the way forward. The decision to include broad socioeconomic rights in the Constitution was a contested one, and questions regarding the strength and enforceability of those rights remain today.

A. The Fight over Socioeconomic Rights

After the fall of apartheid, South Africa adopted the South African Constitution through a two-stage process. First, a non-elected group drafted an interim constitution, which came into effect in April 1994 on the same day as South Africa's first multiracial elections. The interim constitution remained in effect for two years, during which time the new legislature undertook the second stage of drafting a final version of the constitution, which had to abide by thirty-four principles established in the interim constitution. The Constitutional Court, whose members were appointed after the 1994 elections, had to certify that the final version complied with the principles before it could be signed by the president.

In May 1996, the legislature approved a final version of the constitution, which was submitted to the Constitutional Court for certification. The Constitutional Court sent the draft back to the legislature after finding that the constitution did not meet all thirty-four principles. The legislature made the necessary adjustments, and the Court approved the new constitution on December 4, 1996. The Final Constitution went into effect on February 4, 1997.

The Constitution includes an expansive Bill of Rights that stands in stark contrast to the oppression and inequality of the apartheid era. However, these broad rights are limited by a general limitations clause: “The rights in the Bill of Rights may be limited only in terms of law of

74. Id. at 327.
75. Id.
76. Id. at 327–28.
77. Id. at 327.
80. Reference to the Constitution from this point forward refers to the Final Constitution, which went into effect in 1997, unless otherwise noted.
81. Id.
82. See supra Introduction.
general application to the extent that the limitation is reasonable and jus-
tifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors ... .  

Socioeconomic rights can be defined as "rights which correspond to a particular set of international human rights norms .... The South African Constitution echoes these norms when it recognises rights to housing, health care, food, water, social security and education, with special protection of these rights for children." The inclusion of the justiciable socioeconomic rights in the Constitution was not uncontested during the drafting period. Advocates for inclusion "argued that the struggle against apartheid was as much about access to socio-economic rights, such as the right to land, housing, education and health care, as it was about the right to vote and other civil liberties." They argued that the rights would give disadvantaged communities a tool to protect themselves and the new government the power to affect its reconstruction and development programs. Those opposed argued that the inclusion of socioeconomic rights would violate the separation of powers by encroaching on the legislature's terrain, including potential budgetary implications. Despite these strong arguments for leaving social rights to the political realm, the Constitutional Court, in deciding whether the draft constitution conformed to the thirty-four principles, held that the socioeconomic rights were rightfully included in the Constitution.  

B. HIV/AIDS and the Constitution

Although HIV/AIDS is never mentioned in the Constitution, the Bill of Rights' expansive protections include diverse provisions that can be used to address HIV/AIDS, including equality, dignity, life, privacy,
freedom of trade, occupation and profession, fair labor practices, an environment that is not harmful, health care, education, information, and specific rights for children. One of the most important features of the Bill of Rights is that it cannot only be applied vertically against the state, but can also be applied horizontally under certain circumstances. When applied horizontally, the Bill of Rights protects against abuses by individuals—not just the State—and imposes duties on all to respect the rights of others.

In the fifteen years the Constitution has been in effect, only a relatively small number of cases addressing HIV/AIDS and the Constitution have been litigated. This Comment focuses exclusively on those cases that address the enforcement of socioeconomic rights that relate to HIV/AIDS. Although the Court has provided protection of the negative rights of HIV-positive individuals, such as enforcement of equal protection rights, the Court has been more hesitant in the enforcement of positive socioeconomic rights. However, progress has been made in the past, and litigation has the potential to yield further progress.

89. Cameron, supra note 11, at 66.
91. Cameron, supra note 11, at 66.
92. Id. at 72.
93. Other cases have addressed HIV/AIDS and the Constitution. Hoffmann v. South African Airways was a landmark ruling on the equal protection of HIV-positive individuals. 2000 (11) BCLR 1211 (CC) at para. 23 (S. Afr.), available at 2000 SACLR LEXIS 127 (SACLHR 2000). Mr. Hoffmann passed all of the requirements to be a cabin attendant on South African Airways, but he was subjected to an HIV/AIDS blood test, which revealed that he was HIV-positive. Id. at para. 5. The airline then informed him that he could not be a cabin attendant. Id. The Constitutional Court, in a forceful opinion, held that the airline had violated Mr. Hoffmann's right to equality by refusing to employ him. Id. at paras. 28, 41 ("People who are living with HIV/AIDS are one of the most vulnerable groups in our society .... Notwithstanding the availability of compelling medical evidence as to how this disease is transmitted, the prejudices and stereotypes against HIV positive people still persist. In view of the prevailing prejudice against HIV positive people, any discrimination against them can, to my mind, be interpreted as a fresh instance of stigmatisation and I consider this to be an assault on their dignity. The impact of discrimination on HIV positive people is devastating. It is even more so when it occurs in the context of employment. It denies them a right to earn a living. For this reason, they enjoy special protection in our laws.").
III. ENFORCING SOCIOECONOMIC RIGHTS

Traditionally, there has been widespread opposition to including socioeconomic rights in bills of rights. This opposition arises out of concerns for the vagueness of these rights, the cost and complexity of their enforcement, and the fine line between enforcement of these rights in courts and usurpation of the roles of the legislature and executive. When included in bills of rights (as they are in South Africa) socioeconomic rights provoke competing approaches as to how to enforce them in light of these concerns. The South African Constitutional Court adopted a deferential review approach. Under this approach, courts set the broad bounds within which government can operate and interfere only when governments fail to act or where governments fail to show that policies are reasonably directed toward fulfillment of the rights. In this way, courts would leave the government both to develop the content of the rights and to determine remedies for violations. The Court developed this approach over three cases. Only the third case, Treatment Action Campaign, dealt directly with HIV/AIDS treatment. The first two cases, Soobramoney and Grootboom, addressed health and housing rights, respectively.


Soobramoney was the first major case to address the enforceability of the socioeconomic rights in the South African Constitution. The case involved an unemployed individual who required regular dialysis to stay alive but could not afford the treatment at a private hospital. He sought treatment at the Addington State Hospital instead, but the hospital denied the treatment because of guidelines limiting dialysis treatment to those

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97. Alana Klein identifies three approaches. Id. at 362–63. The first is to treat the rights as non-justiciable, allowing them to serve as behavior guides but not as the sole basis for individual enforcement actions. Id. The second is a case-by-case model in which courts only enforce the rights in circumstances where concerns for separation of powers and judicial capacity are limited. Id. The third is deferential review. Id.
98. Id. at 363 (citation omitted).
patients who qualified for a kidney transplant. The hospital did not have sufficient resources to provide dialysis to all patients in need.

The applicant brought an action challenging the hospital’s decision to deny him dialysis. He sued under Section 27(3) of the Constitution, which states, “[n]o one may be refused emergency medical treatment,” and under Section 11, which states, “[e]veryone has a right to life.” The Constitutional Court held that the State could rightfully deny the applicant dialysis. The Court relied on the identical internal limitations clauses in Sections 26 (housing) and 27 (health care, food, water, and social security), which provide that the State “must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.” Because the state hospital was restricted by a lack of resources, “an unqualified obligation to meet these needs would not presently be capable of being fulfilled.” The Court held that it was rational to reserve limited resources for those who would benefit from them most.

The reaction to Soobramoney was not positive amongst those advocating for broad enforcement of socioeconomic rights. The decision sent signals that socioeconomic rights were only an aspiration, and that the Court was adopting a deferential standard of rationality when reviewing the State’s fulfillment of its obligations regarding socioeconomic rights.


Grootboom, the second socioeconomic rights case heard by the Constitutional Court, involved individuals who formerly lived in an informal squatter settlement where there was no water, no sewage, no refuse removal, and minimal electricity. Although these individuals were on a long waiting list for subsidized housing, the deplorable conditions pushed them to find new housing prior to getting off the waitlist. They moved, without permission, onto a private plot of vacant land earmarked for

100. Id. at paras. 1–4.
101. Id. at para. 3.
102. Id. at paras. 5–7.
103. Id. at para. 7.
104. Id. at para. 36.
105. Id. at paras. 9–11.
108. Forman, supra note 32, at 713.
109. Id. at 713–14.
111. Id. at para. 8.
low-cost housing.\(^{112}\) The group was eventually evicted, but they did not leave—they had nowhere else to go, as others had taken over their previous squatter settlement.\(^{113}\) In the end, the municipality forcibly evicted the applicants from the private land in what the Court described as “apartheid-style evictions.”\(^{114}\) The applicants set up temporary shelters on a local sports field and proceeded to file a lawsuit.\(^{115}\)

The applicants sued various governmental entities under Section 26 of the Constitution (right of access to adequate housing) and under Section 28(1)(c) (right of children to shelter).\(^{116}\) Moreover, some advocates pushed the Court to establish a minimum core obligation that would provide a floor for state conduct, explicitly drawing the line below which state conduct would be considered noncompliant with constitutional duties.\(^{117}\) The analysis of housing rights in Grootboom provided more clarity and helped define the Court’s approach to socioeconomic rights. First, the Court held that the socioeconomic rights could not be read in isolation:

The State is obliged to take positive action to meet the needs of those living in extreme conditions of poverty, homelessness or intolerable housing. [The] interconnectedness [of the socioeconomic rights] needs to be taken into account in interpreting the socioeconomic rights, and, in particular, in determining whether the State has met its obligation in terms of them.\(^{118}\)

Second, the Court held that there was no minimum core obligation under the Constitution.\(^{119}\) Third, the Court held that the measures taken by the State to realize the rights to housing and other socioeconomic rights need only be reasonable to pass constitutional muster.\(^{120}\)

In its narrow holding, the Court found that the housing programs adopted by the State were not reasonable, placing special focus on the failure to provide for those in desperate need.\(^{121}\) However, the Court also found that the Constitution did not entitle the applicants to claim shelter or housing on demand.\(^{122}\) Instead, the Court issued a declaratory order

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112. Id.
113. Id. at para. 9.
114. Id. at para. 10.
115. Id. at para. 11.
116. See id. at para. 12.
117. Id. at para. 31.
118. Id. at para. 24.
119. Id. at para. 33.
120. Id.
121. Id. at para. 69.
122. Id. at paras. 94–95 (“[I]t is in an extremely difficult task for the State to meet these obligations in the conditions that prevail in the country. This is recognized by the
requiring the State to meet its obligations under the housing provision of the Constitution, including “the obligation to devise, fund, implement and supervise measures to provide relief to those in desperate need.”

_Grootboom_ has been applauded for cementing the justiciability of socioeconomic rights, and for “carving out space” for the Court to take action “without usurping the space for political decision-making.” By allowing the State to retain control, the Court was seen as merely monitoring and enforcing the government’s constitutional obligations, not legislating substantive decisions. Nonetheless, critics faulted _Grootboom_ for its refusal to read a minimum core obligation into the right of housing and for limiting the Court’s role to that of “policing the policy-making process.”

While _Soobramoney_ and _Grootboom_ indirectly implicated issues important to the HIV/AIDS epidemic, the third case, _Treatment Action Campaign_, brought HIV/AIDS to the forefront of the socioeconomic debate.

IV. Treatment Action Campaign

The Treatment Action Campaign (TAC) is a South African nonprofit organization that uses litigation and advocacy to promote and protect the rights of those living with HIV/AIDS. In the landmark case bearing its name, TAC successfully established that the government’s inadequate distribution of the drug nevirapine, which reduces mother-to-child transmission of HIV, was not reasonable under the standards set forth in _Soobramoney_ and _Grootboom_ and therefore violated the Constitution. The case has been described as the high-watermark globally in the treatment arena. For many, it is seen as a starting point for using the Constitutionally-guaranteed rights to health care, dignity, and the rights of children to further alleviate the HIV/AIDS epidemic in South Africa.

Constitution which expressly provides that the State is not obliged to . . . realise these rights immediately.”

123. _Id._ at paras. 95–96. Justice Sachs, a sitting justice in _Grootboom_, later stated that socioeconomic rights are “not like freedom rights, where every person is vested with the same rights under the Constitution. Rather, it is a question of appropriate utilization of resources . . . .” Albie Sachs, _Enforcement of Social and Economic Rights_, 22 Am. U. Int’l L. Rev. 673, 684–85 (2007).

124. Gloppen, supra note 84, at 167.

125. _Id._

126. _Id._

127. Heywood, supra note 33, at 182.

128. Novogrodsky, supra note 24, at 25.

Of the estimated 5.7 million people living with HIV in South Africa in 2008, 3.2 million were women and 280,000 were children under the age of fourteen. One of the primary ways in which young children are infected with HIV is mother-to-child transmission (MTCT), which can occur during pregnancy, during birth, and through breastfeeding. In 2003, 96,228 babies were infected in South Africa through MTCT.

The antiretroviral (ARV) drug nevirapine is highly effective at reducing MTCT. In 2000, drug trials demonstrated that nevirapine reduced the risk of MTCT by nearly 50 percent. The South African Medicines Control Council approved the drug. At the time of litigation, the cost of the drug was not an issue; in 2001, the manufacturer of nevirapine offered an unlimited supply of the drug to South Africa for five years at no cost.

In 1999, TAC pressured the government to accelerate its program to prevent MTCT, but the government hesitated, expressing concerns about the safety and efficacy of nevirapine. In 2000, the government finally announced a plan to use nevirapine nationally, but it was not a plan that made the drug widely available. Instead, two sites were selected in each of the nine provinces where the drug would be administered and further research would be completed. In 2001, TAC sent a letter to the Minister of Health, requesting specific reasons for the government’s failure to make the drug available to all patients in the public health sector. The Minister’s response raised issues about the efficacy of the drug, the cost of the medical infrastructure that would need to accompany the drug (testing, counseling, follow-up services), the cost of providing formula for breastfeeding mothers to avoid transmission through breast milk, and other problems. In explaining its decision to limit the distribution of nevirapine, the government stressed that the

129. UNAIDS, SOUTH AFRICA COUNTRY SITUATION REPORT, supra note 22. Prevalence rates in children have shown improvement. Id.
132. Id. at 168–69.
133. Id. at 169; Sachs, supra note 123, at 686.
135. Id. at para. 11.
136. Id.
137. Id. at paras. 11, 14–15.
introduction of ARV ... interventions needs to be accompa-
nied by a series of other interventions such as the delivery of
voluntary and confidential counseling and HIV testing, and
revised obstetric practices and infant feeding practices. These
require extensive capacity building, infrastructure develop-
ment, improved management and community mobilisation
efforts. 138

Dissatisfied with the government’s response, TAC sued the Minister
of Health and other governmental entities, framing its lawsuit under two
broad issues: 1) whether the government could refuse to make nevirapine
available to pregnant women when it is medically necessary for the wom-
en in the view of their doctors; and 2) whether the government is
obligated to establish a clear program for preventing MTCT, including
counseling, testing, antiretroviral therapy, and options for formula feed-
ing. 139 The case implicated two provisions in the Bill of Rights: the right
of everyone to have access to health care services, including reproductive
health care (Section 27(1)(a)), and the right of every child to basic health
services (Section 28(1)(c)). 140

In its opinion, the Court stated that the socioeconomic rights in the
Constitution are undeniably justiciable, but reaffirmed that there is no
minimum core obligation that the State must meet. 141 The Court held
that the State must take reasonable measures to progressively reduce socio-
economic deprivations in society, but that there are multiple ways in
which the State can meet its obligations. 142 The Court premised its re-
strained role on maintaining a balance of powers, finding that the rights
to health, housing, and other socioeconomic rights do not “give rise to a
self-standing and independent positive right enforceable irrespective” of
the considerations in the second part of these rights as they appear in the
Constitution. 143 The second part of these rights states that “[t]he state
must take reasonable legislative and other measures, within its available
resources, to achieve the progressive realisation of each of these rights.” 144

In evaluating the reasonableness of the State’s nevirapine dis-
tribution plan, the Court refuted the concerns raised by the government
related to the distribution of nevirapine. Notably, the Court found that
concerns about the safety of the drug were negated by the government’s
use of the drug at test sites and the broad availability of the drug in the

138. Id. at para. 16.
139. See id. at para. 18.
140. Id. at para 4.
141. Id. at para. 34.
142. Id. at para. 36.
143. Id. at para. 39.
private sector. After dismissing the concerns of the State, the Court held that the State's restriction of nevirapine to eighteen trial sites was not reasonable, stressing that those in most urgent need cannot be ignored by the very government action meant to realize their constitutional rights. Furthermore, the Court stressed that the importance of ongoing research does not mean that until the best program is developed, nevirapine must be withheld from mothers and children without access to a test site. "A programme that excludes a significant segment of the society cannot be said to be reasonable."

The Court ordered the government to devise and implement a plan to prevent MTCT and to remove restrictions keeping nevirapine from being widely available in the public sector. However, the Court declined to monitor compliance through supervisory jurisdiction. "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."

The Court noted that the government’s policy was already evolving in certain provinces for combating MTCT, and that the court order would facilitate further development. As a result, the Court removed itself from the frontline of enforcement, lessening the pressure on the government to comply with the order and making it more difficult for any parties to seek immediate relief upon any such governmental shortcoming.

B. Response to Treatment Action Campaign

The response to the Treatment Action Campaign case was mixed. On November 13, 2003, President Mbeki’s administration rolled out a new plan to fight HIV/AIDS, including $284 million marked specifically for antiretroviral treatment, a marked shift from Mbeki’s previous denialism stance. Some partially attribute the change to the Constitutional Court's willingness to challenge the executive branch in this area. Despite the positive changes in broad policy, the implementation of those changes on the ground has not been as positive.

146. Id. at para. 68.
147. Id.
148. Id.
149. Id. at para. 135.
150. Id. at para. 129.
151. Id. at para. 132.
152. Phillips, supra note 40, at 12.
153. Id.
154. Some of the slow implementation of new policies has been attributed to rumblings about judicial activism. See Forman, supra note 32, at 720.
Four days after the decision was handed down, TAC sent letters to the nine provinces in South Africa requesting information on what steps the provinces would take in complying with the order of the Court. Four of the provinces provided partial responses and five provinces did not respond at all.\textsuperscript{155} It was only after TAC threatened further legal action that some provincial governments responded.\textsuperscript{156} The province of Mpulamanga, which did not respond to the initial request, only started providing nevirapine in public health facilities after TAC applied for an order holding the province in contempt of court.\textsuperscript{157}

The difficulty of obtaining reliable information on how many pregnant women need nevirapine and related services and how many receive it at public facilities creates another obstacle to enforcement. Between 2004 and 2005, three different surveys yielded far different estimates: a South African Department of Health report stated that 80 percent of pregnant women needing the drug were receiving it; an independent report estimated 44 percent were receiving it; and the World Health Organization estimated that only 14.6 percent were receiving it.\textsuperscript{158} Such incongruous information makes it difficult to determine the impact of the ruling.

\textbf{C. A Perfect Storm}

There are different ways to understand the \textit{Treatment Action Campaign} decision, but many agree that there were certain circumstances that came together to make it an easy case for the Court to decide. For one, the budget concerns were attenuated; because the drug was being offered free of charge, the Court did not have to worry about impeding on budgetary decisions traditionally left to other branches of government.\textsuperscript{159} Furthermore, the government had already provided additional funds to combat MTCT during the course of the litigation and nevirapine was already partially included in the government's health policy through its availability at the pilot sites.\textsuperscript{160} In addition to the government's funding provision, the drug was safe; despite the objections raised by the govern-
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ment, nevirapine was being used at every private health facility in the country and it was already being used at the government's pilot sites.161 Perhaps more important to the Court's ability to rule against the government was the political climate and the subject matter of the case. "To contend that hundreds or thousands of babies can be born with a virus—when that [virus] can be easily, safely, and cheaply prevented—simply because one wants to understand better the program management, is not reasonable."162 Furthermore, the case was not just an isolated lawsuit. TAC had built a broader campaign aimed at targeting the epidemic.163 That campaign and the efforts of other groups advocating for HIV/AIDS patients, as well as upcoming political elections, played an important role in forcing the government to initiate a broader treatment plan even while the lawsuit was in progress.164 Broad frustration about the government’s response to HIV/AIDS supported the Court's decision. Much of this frustration stemmed from discontent with Mbeki's denialism:

This decision must be understood in the context of the South African government’s palpably inadequate response to the HIV crisis—a response bred partly by the irresponsible denial, among high-level officials, that HIV is responsible for AIDS at all. In these circumstances, it made sense for the court to do something other than rubber-stamp the government's failure to make a life-saving medicine available to young children.165

These factors combined to put pressure on the government and the Court at a unique time in South Africa's history. Had nevirapine not been offered for free, or had there not been a public outcry over denialism, it is possible the Court would have been more deferential to the State.

V. IMPACT OF HIV/AIDS LITIGATION

A. Reasonableness Standard

The Constitutional Court's continued deference to the legislature and the executive regarding socioeconomic rights raises concerns about the role of the Court in enforcing socioeconomic rights related to HIV/AIDS. For many, including human rights scholars, the Court's rejection of a minimum core content approach to socioeconomic rights

\[161.\] Sachs, supra note 123, at 686.
\[162.\] Id. at 692 (Justice Sachs participated in the decision).
\[163.\] See Heywood, supra note 33, at 182.
\[164.\] See Forman, supra note 32, at 724 n.129.
remains a central concern. A minimum core approach would empower individuals to bring claims and seek personal remedies when the State falls short of fulfilling the minimum core of the protection of constitutional rights. By favoring the deferential reasonableness standard instead, some believe the Court “failed to grasp a golden opportunity to ‘fast-track’ constitutional transformation by using the minimum core to set clear benchmarks for the legislature and executive, benchmarks that prioritize the welfare of the poorest of South Africa.”

In *Treatment Action Campaign*, the Court expressed concern with the idea of a minimum core because of the impossibility of giving “everyone access even to a ‘core’ service immediately.” Infrastructural deficiencies posed physical barriers to any remedy the Court could provide, and the deficiencies were not capable of being eliminated overnight.

The rejection of the minimum core approach also reflects caution with regard to the separation of powers in a young democracy. The concern is that judicial determination of socioeconomic rights undermines the political process and breaches the separation of powers in the government.

Questions regarding fairness in the distribution of scarce resources, and the adequacy of particular social policies, are at the heart of politics. To move these essential political questions into the courtroom is considered unacceptable on normative grounds, as well as imprudent. Judges are not particularly well-equipped to deal with issues involving economic and social policies, where the room for rational disagreement is wide.

An informed allocation of resources is especially relevant in the HIV/AIDS context. Combating the epidemic is not limited to treatment, but requires building a more equitable healthcare system and fulfilling other socioeconomic rights that impact the disease’s effects, such as education, water, and housing rights. The Court is reluctant to tell the legislature how to allocate its resources amongst all of these pressing concerns. Moreover, the Court’s concern for budgetary implications extends beyond allocation choices to concerns about bankrupting the State and interfering with important and popular programs.

167. *Id.* at 181.
169. *See id.*
171. *Id.* at 155.
also a concern that overreaching courts will fail to consider the actual mechanics of enforcement that the executive and legislative branches must deal with, including program details and administrative requirements.\footnote{174} All of these issues reflect South Africa’s position as a young democracy hesitant to encroach upon its separation of powers.

Arguably, the Court’s deferential approach also demonstrates an attempt to “gain the trust of the legislature and executive, thereby bolstering its own institutional legitimacy.”\footnote{175} By adopting the reasonableness standard, the Court avoids issuing any orders that extend beyond the means of enforcement; it thus avoids relegating itself to the role of moral authority without any actual bite. This practical approach arguably forecloses any idea that the Court foresees a more powerful role for itself in the future. However, if a restrained approach arises from a desire to appear cautious and not from any inherent unenforceability of health care rights,\footnote{176} perhaps the door is open for these rights to be enforced with greater independence at a future time.

While the reasonableness standard might be effective for building institutional legitimacy and mitigating separation of powers concerns, the collateral effects of such a standard may not be justified. Thousands die from a disease that is now affordably controlled—when does reasonableness no longer accept such suffering? Some argue that reasonableness can be an effective tool if the “government’s resource allocation decisions are not shielded from scrutiny.”\footnote{177} If resource allocations are scrutinized, there must be a point where not diverting more resources to HIV/AIDS treatment and prevention is no longer reasonable given the toll the disease is taking on the country.

The inconsistency inherent in the Court’s deferential approval of state programs provides another source of concern. Programs found reasonable today may not be reasonable in the future considering the State’s obligation to progressively realize socioeconomic rights. Some posit that giving constitutional approval to a particular program may leave the government “reluctant to try improving upon the judicially-approved standard or policy, particularly where positive results are not assured.”\footnote{178} This tendency runs counter to a core tenet of progressive realization, that even a constitutionally adequate state program is not certain to remain constitutional indefinitely.

Not all commentators view the rejection of the minimum core and the adoption of the deferential reasonableness standard as harmful to the

\begin{footnotes}
\footnote{174}{Id.}
\footnote{175}{Forman, supra note 32, at 720.}
\footnote{176}{Id.}
\footnote{177}{Liebenberg, supra note 85, at 189.}
\footnote{178}{Klein, supra note 96, at 383. However, this problem only increases with higher standards of review, and therefore may not be a strong argument against the reasonableness standard. Id.}
\end{footnotes}
development of socioeconomic rights, including HIV/AIDS related rights. The positive result in *Treatment Action Campaign* confirms that the deferential standard does not equate to an automatic stamp of approval for state programs, especially when the rights of those in most urgent need are implicated.\(^{179}\) When the interests being balanced become too disproportionate, the Court will no longer find a plan reasonable, especially when the "cost in human suffering and loss of life" outweighs any operational difficulties.\(^{180}\)

Alana Klein argues that there are two clear advantages to the reasonableness approach: (1) the legislature can set its own obligations, and (2) the court need not set complex policies, but at the same time judicial review is not entirely excluded.\(^{181}\) Others have made the argument that the reasonableness standard in the HIV/AIDS context can have a broader impact on the right to health. Lisa Forman contends that *Treatment Action Campaign* "effectively ensured that irrational science could no longer motivate government policy on mother to child transmission of AIDS, and this has had a powerful impact on how government has subsequently formulated broader AIDS treatment policy."\(^{182}\) In addition to ensuring a national MTCT plan specifically, the case also placed greater pressure on the government to implement a broader HIV/AIDS treatment plan, which it did, and which has improved health care services.\(^{183}\) "The reasonableness standard enforced in relation to gross violations of human rights may therefore have a powerful and positive knock-on effect on health care more broadly . . . ."\(^{184}\)

**B. Remedy**

The Constitutional Court refused to maintain supervisory jurisdiction in *Treatment Action Campaign*, which would have allowed the Court to monitor compliance with the court order.\(^{185}\) The Court does have the

\(^{179}\) See *Treatment Action Campaign*, 2002 (10) BCLR 1033 (CC) at para. 68 (S. Afr.), available at 2002 SACLR LEXIS 26 (SACLR 2002) ("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." (quoting *Grootboom* 2000 (11) BCLR 1169 (CC) at para. 44 (S. Afr.), available at 2000 SACLR LEXIS 126 (SACLR 2000))).

\(^{180}\) Forman, *supra* note 32, at 718.

\(^{181}\) Klein, *supra* note 96, at 376.

\(^{182}\) Forman, *supra* note 32, at 719.

\(^{183}\) Id.

\(^{184}\) Id.

\(^{185}\) *Treatment Action Campaign* 2002 (10) BCLR 1033 (CC) at para. 129 (S. Afr.), available at 2002 SACLR LEXIS 26 (SACLR 2002). The order of the High Court, which was then reviewed by the Constitutional Court, ordered a structural interdict requiring the government to revise their MTCT policy and to submit it to the Court for approval. Id.
authority to enforce the State’s obligations through declaratory, supervisory, or mandatory orders, but it has shown a reluctance to use supervisory orders in the past. This has fueled a second strand of criticism in addition to, and connected with, the criticism of the reasonableness standard.

The Court’s reluctance to retain a role in the enforcement of its judgment stems largely from the separation of powers concerns underlying the Court’s deferential reasonableness standard. In Treatment Action Campaign, the Court held that “[c]ourts are ill-suited to adjudicate upon issues where court orders could have multiple social and economic consequences for the community.” But Alana Klein has posited another reason for the Court’s reluctance: “Where the content of the right is constantly under development and where there is no clear end goal in sight, it will make less sense for a court to retain jurisdiction to hear reports. Courts cannot retain jurisdiction indefinitely.” However, the resistance of certain provinces against implementing the Treatment Action Campaign order suggests that retaining supervision may be the only effective way to ensure compliance in the HIV/AIDS context.

Cases like Treatment Action Campaign are arguably the cases best suited to supervisory jurisdiction. The inaccessibility of relevant information in these kinds of cases makes it difficult to monitor the State’s compliance with a court order. The inability to access important information—information that would necessarily be provided under court supervision—weakens civil society organizations that try to evaluate government compliance. After Treatment Action Campaign, for example, TAC and other organizations expended significant resources to determine what the government’s HIV policy consisted of, information that should have been widely available. Moreover, even if the State makes information available, without supervisory jurisdiction parties may be less likely to bear the costs of re-litigation. This problem is likely compounded in cases where parties would be forced to expend resources not only to monitor compliance, but also to return to court to enforce an earlier order.

186. Christiansen, supra note 73, at 376.
188. Klein, supra note 96, at 390.
189. Although some provinces had already enacted positive changes over the course of the Treatment Action Campaign litigation, other provinces refused to take any action until TAC sought to hold them in contempt of court. See Neff, supra note 131, at 170–72.
190. Id. at 179.
191. See id.
192. Id.
193. Klein, supra note 96, at 379–80; see also Neff, supra note 131, at 171–72 (explaining the burden of shifting monitoring to litigants in Treatment Action Campaign).
The Constitutional Court has not shut the door to the possibility of retaining a supervisory role in the future. In *Treatment Action Campaign*, the Court stated, "[t]he power to grant mandatory relief includes the power where it is appropriate to exercise some form of supervisory jurisdiction to ensure that the order is implemented." 194 Although it declined to do so in *Treatment Action Campaign*, there is reason to believe that the Court would consider this role should HIV/AIDS treatment be brought again before the Court. 195 The Court's willingness to reconsider its role in such cases may prove vital to enforcing the government's obligations as they relate to HIV/AIDS.

C. Further Burdens and Benefits for Future Litigation

Beyond the reasonableness standard and limited remedy, the Court's jurisprudence has yielded other burdens and benefits for future suits that confront the HIV/AIDS epidemic.

1. Burdens on Future Litigation

One result of the Court's socioeconomic jurisprudence is the "plaintiff problem." The Court's adjudication of the rights to health and housing, when extended to other socioeconomic rights, is limited to an analysis of the government program and not the circumstances of any individual plaintiff. 196 "This has enormous practical consequences for poor individuals or communities who want to use litigation as a tool to protect their socio-economic rights. It means they will not receive any direct individual relief, although they may indirectly benefit from a positive order handed down by the courts." 197 This problem may be heightened in the HIV/AIDS context when the immediacy of a remedy might be the difference between life and death, a difference that could deter potential plaintiffs who decline to litigate their rights because of the likelihood that any potential victory will come too late to alleviate the burdens of their disease.

On the other hand, the suitability of the reasonableness jurisprudence to larger organizations arguably offsets the obstacles to individual

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195. At least one commentator sees this process as a dialogue between the Court and the government as they establish their respective responsibilities and create "broader acceptance within government of the Court's appropriate role in relation to health ... . [T]he Court has clearly left the door open to increasingly retain supervisory jurisdiction and order more creative remedies in socioeconomic rights cases." Forman, *supra* note 32, at 720.
197. Liebenberg, *supra* note 85, at 176.
plaintiffs. These larger groups, like TAC, can challenge government programs that do not meet the needs of the poor. One benefit is that courts will not narrowly adjudicate the rights of a discrete group of individuals while declining to address a broader governmental failure and its impact across the country. The Court's approach also negates the need for those in similar circumstances to bring individual claims, a piecemeal approach that might save far fewer lives. This advantage is amplified by the fact that those whose social rights are most at risk often lack the knowledge or resources to voice their violations.

A second obstacle to using litigation to address HIV/AIDS comes in the form of sheer practicability. Any gains made are constrained by the apartheid-era conditions that still exist in many of the poorest regions of South Africa. Although improvements have been made, there are continuing "deficiencies in the public health sector, including poor availability of all types of health care personnel at a national level, limited access to critical services . . . negligible access to HIV/AIDS prevention and treatment services, and considerable inequities in . . . health expenditures and health care access." Finally, the Court's ability to retain independence when assessing government compliance hampers the potential benefits of future litigation. South Africa is largely a one-party state, with the African National Congress (ANC) holding much of the political power in the country. Because justices on the Court have commonly shared ideological ties with the ANC, there is concern that the Court is less likely to act contrary to the interests of the government.

2. Benefits

The Court's decisions have also highlighted factors that will be beneficial for the enforcement of socioeconomic rights addressing HIV/AIDS in future litigation. For example, the Court emphasized transparency as a factor to consider when assessing the reasonableness of government action in Treatment Action Campaign:

The magnitude of the HIV/AIDS challenge facing the country calls for a concerted, co-ordinated and co-operative national effort in which government in each of its three spheres and the panoply of resources and skills of civil society

198. Id. at 190.
199. Id.
200. Christiansen, supra note 73, at 377–78.
201. See id. at 377.
202. Gloppen, supra note 84, at 158.
203. Forman, supra note 32, at 716.
204. Gloppen, supra note 84, at 173.
are marshalled, inspired and led. This can be achieved only if there is proper communication, especially by government. In order for it to be implemented optimally, a public health programme must be made known effectively to all concerned, down to the district nurse and patients. Indeed, for a public programme such as this to meet the constitutional requirement of reasonableness, its contents must be made known appropriately.  

While the Court’s reluctance to provide ongoing supervision obstructs its ability to monitor compliance, the Court’s insertion of transparency into the reasonableness analysis facilitates monitoring by groups such as TAC or the South African Human Rights Commission. It has been suggested that the introduction of transparency was the Treatment Action Campaign Court’s greatest gift.  

The benefits of HIV/AIDS litigation are realized beyond the words of a final order. Even before litigation is commenced, “the passive threat of court involvement motivates government actors to legislate proactively and appropriately.” With limited litigation concerning HIV/AIDS and socioeconomic rights, the impetus for such proactive legislation has not been high; post-Treatment Action Campaign, however, the threat of further litigation may spur more immediate attention. Furthermore, even a loss in the courtroom can yield benefits to the overall campaign against HIV/AIDS. Courts can “provide a platform for voicing social rights concerns,” which can “generate or intensify popular debate and create a political momentum.” This may prove especially beneficial in the HIV/AIDS realm where stigma and stereotypes have hindered public debate.  

Litigation that improves access to effective treatment will save lives, but it will also change the “social nature of AIDS.” Justice Edwin Cameron has written that improving access to treatment “changes the perception of HIV as an inevitably deadly disease—thus significantly reducing stigma. Treatment also provides powerful incentives for voluntary HIV testing and openness about HIV infection.” It is hard to measure whether Treatment Action Campaign has had any such effect to

206. Liebenberg, supra note 85, at 189.
207. Cameron, supra note 11, at 87.
210. See discussion supra Part I.C.
211. Cameron, supra note 11, at 81.
212. Id.
date, but with the high levels of stigma associated with the disease, any efforts to encourage discourse and make testing and treatment a viable option are worthwhile.

VI. THE PATH FORWARD FOR HIV/AIDS LITIGATION

The promises of justiciable socioeconomic rights as they relate to HIV/AIDS have not given rise to a radical transformation in the lives of the people most in need in South Africa. Significant obstacles exist to using litigation to address the HIV/AIDS epidemic. The Constitutional Court's deferential approach to reviewing government compliance with socioeconomic rights created one of the largest obstacles. Other obstacles include the Court's reluctance to maintain supervisory jurisdiction, the difficulty of obtaining information on HIV/AIDS, the lack of remedies for individual plaintiffs, misconceptions and traditional practices that are contrary to preventing the spread of the disease, the lack of basic infrastructure in many parts of the country, and the political realities of a one-party state.

Nonetheless, constitutional litigation to enforce socioeconomic rights has an important role to play in addressing the HIV/AIDS epidemic. Some doors have been shut, but others have been opened. Creative lawyers have sufficient space to navigate the current jurisprudence and to place pressure on the government to provide for those in greatest need.

"HIV/AIDS is but one of many illnesses that require attention. It is, however, the greatest threat to public health in our country."213 The Court in Treatment Action Campaign acknowledged the enormity of the HIV/AIDS problem, and, in holding that the government was acting unreasonably in not distributing life-saving medications more widely, took a large step towards addressing it. South Africa has the largest HIV/AIDS epidemic in the world.214 Although there has been progress in slowing the growth rate of the disease, the massive rates of incidence and the rampant growth over the past decade suggest a failure by the government to contain the disease and provide treatment for those already infected.215 Given the statistics, it is hard to argue that what the government has done, and what it continues to do, is reasonable. Even under the deferential reasonableness standard, there is room to contest the government's response to the ongoing crisis.

Two years after Treatment Action Campaign, the Minister of Health stated that the use of ARVs was "accelerated by the judgment of the

215. See id. at 717.
Constitutional Court in the TAC matter.216 Further litigation can have similar effects, but few socioeconomic cases are taken through the judicial system.217 The difficulties discussed throughout this Comment have limited such cases. But the general trajectory of the cases that have been brought is arguably upward-moving. Although the Court rejected the minimum core approach and expressed a hesitancy to maintain supervision over cases, an understanding of these limitations facilitates the crafting of effective future litigation.

The Court has heard one major socioeconomic case since Treatment Action Campaign. In Khosa v. Minister of Social Development, the Court held that permanent residents, not just citizens, have the right to access social assistance.218 The ruling had potentially "grave budgetary implications" and was seen as a positive step in the use of further litigation to expand socioeconomic rights.219 The Court's willingness to issue judgments that implicate budgetary concerns is important to increasing pressure on the government to provide adequate HIV treatment, including developing the underlying healthcare system.

The burden on the government to progressively realize the right to health care is intertwined with the notion that the State's obligation is dynamic and fluid. Confronting this notion is the concern that once a government program receives a court's stamp of approval, the incentive is reduced to expand or alter that program to seek further progress. Litigation, however, can prove to be an effective tool in fighting such complacency. The constitutional formulation of the socioeconomic rights means the State's obligation "will change as circumstances change, and presumptively it will increase over time. Hence, the Court may revisit the reasonableness of static government programs."220

In addition to the internal development of government programs, South Africa looks to international law to determine what constitutes reasonableness.221 As international law develops in the arena of HIV/AIDS, so too can South Africa's approach to the epidemic. "[N]ational courts and administrative tribunals are increasingly finding that individuals have a human right to anti-retroviral treatment to combat HIV/AIDS."222 These international developments may prove crucial in

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216. Heywood, supra note 33, at 206.
217. Gloppen, supra note 84, at 166.
219. Gloppen, supra note 84, at 169 (citation omitted).
220. Christiansen, supra note 73, at 363.
221. See Treatment Action Campaign 2002 (10) BCLR 1033 (CC) at paras. 107–12 (S. Afr.), available at 2002 SACLR LEXIS 26 (SACLR 2002) (surveying law from the United States, India, Germany, Canada, and the United Kingdom and finding that none of the jurisdictions surveyed suggest that injunctive relief breaches the separation of powers).
222. Novogrodsky, supra note 24, at 5.
raising the bar for what passes as reasonable under the Court's jurisprudence. In addition to the domestic and international developments, there are areas of the law that have not been fully developed with regard to their impact on the HIV/AIDS epidemic.

One of the areas with the most significant potential to yield socio-economic advances is litigation involving children affected by the HIV/AIDS epidemic. Section 28 of the Constitution provides every child with the right to "family care or parental care, or to appropriate alternative care when removed from the family environment," and "to basic nutrition, shelter, basic health care services and social services."223 The rights of children are drafted as basic unqualified rights.224 Relying on these unqualified rights, the applicants in Treatment Action Campaign argued that a newborn child has a right to health care, including nevirapine, regardless of reasonableness or resource limitations. However, Grootboom previously held that the primary obligation to fulfill a child's rights under Section 28 belongs to the parent or family if they are caring for the child.225 The State only incurs an obligation to children no longer in the care of their families (for example, if they have been removed from their home by the State).226 Although the Court did not go as far as finding that children have a direct entitlement to basic health care when their parents cannot afford it, it did take their condition into account in the reasonableness analysis when it held that the nevirapine policy "was unreasonable in that it excluded a particularly vulnerable group with severe implications for them."227 As HIV/AIDS continues to disproportionately impact the poorest communities of South Africa, the considerations of children remain important in assuring that the government is actively and adequately combating the epidemic.

224. The rights of children are qualified by the general limitations clause in Section 36 of the Constitution, see supra Part III.A, but they are not qualified by the internal limitation placed on the rights to housing, health care, food, water, and social security. They are drafted as basic, unqualified rights, similar to the basic right to education and the rights of detained persons. See Liebenberg, supra note 85, at 162–63.
226. Id. ("[T]he Constitution contemplates that a child has the right to parental or family care in the first place, and the right to alternative appropriate care only where that is lacking."). Despite the Court's restricted reading, it emphasized that its interpretation does not mean that the State has no obligation to children who are still being cared for by parents or families. Treatment Action Campaign 2002 (10) BCLR 1033 at paras. 77–79 ("The State is obliged to ensure that children are accorded the protection contemplated by section 28 . . . that arises when the implementation of the right to parental or family care is lacking. Here we are concerned with children born in public hospitals and clinics to mothers who are for the most part indigent and unable to gain access to private medical treatment which is beyond their means. They and their children are in the main dependent upon the State to make health care services available to them.").
227. Liebenberg, supra note 85, at 185.
It was also argued in *Treatment Action Campaign* that it would be cost-effective in the long run to adopt a widespread nevirapine program. However, the Court did not address the argument, leaving it open for future use. The rationale for adopting a widespread program is that doing so “would result in significant savings in later years because it would reduce the number of HIV-positive children who would otherwise have to be treated in the public health system for all the complications caused by that condition.” The Court declined to deal with this argument because of improvements made by provincial and national entities since the time the suit was filed, including increased expenditures. “This means that the budgetary constraints . . . are no longer an impediment. With the additional funds that are now to be available, it should be possible to address any problems of financial incapacity that might previously have existed.” By writing off budgetary constraints it was easier for the Court to find the nevirapine program unreasonable. Not addressing the argument also allowed the Court to avoid the question of short-term versus long-term costs in the HIV/AIDS epidemic, where continued high rates of infection will continue to burden all aspects of the South African economy, including the public health sector.

Arguments around the rights of children are powerful and can be an effective tool in shaping successful litigation within the Court’s deferential approach to socioeconomic rights. Although an automatic right under Section 28 only arises when there is no parent or family present, an increasing number of children are in that position. With AIDS orphans and child-headed households on the rise, there is space for litigation and advocacy to ensure direct access to basic socioeconomic rights for those children. Furthermore, if HIV-positive parents are not receiving the care they need, their children will not only require medical treatment from the government, but the children might also require basic nutrition, shelter, and social services, as provided for in Section 28 of the Constitution. Despite the Court’s reluctance to directly evaluate resource allocation, future cases under different circumstances may force the Court to address these realities.

229. *Id.*
230. *Id.* at para. 117. The provinces of Gauteng and KwaZulu-Natal had already significantly expanded their distribution of nevirapine in public health facilities beyond the test sites. *Id.* at para. 118. Furthermore, the national government had made substantial additional funds available for the treatment of HIV. *Id.* at para. 120.
231. *Id.* at para. 120.
CONCLUSION

The promise of socioeconomic rights under the South Africa Constitution has been restricted from all sides, but space exists for the continued advocacy for HIV/AIDS patients and others affected by the disease. Treatment Action Campaign made a large step towards establishing the principle that the government has obligations related to HIV/AIDS, and both the litigation process, as well as the final court order, spurred government action. The governmental response has been insufficient given the impact of the disease on millions of South Africans and the country as a whole, but continued litigation can beget further improvements. As the country moves further away from the period of denialism fueled by President Mbeki, there is potential for litigation to change the nature of the disease and the way it impacts lives.

Litigation will not cure the disease, but as part of broader movements, it can play an important role in shaping government policy by realigning priorities and shifting public perceptions of the disease. Ensuring that the Constitution's promise of access to health care is aggressively enforced for HIV/AIDS patients is just one step in the process. The other socioeconomic rights promised under the Constitution will also change the impact of the disease on a personal, local, and national level. If the rights to food, water, housing, and a non-detrimental environment are protected and enforced, the lives of HIV/AIDS patients, who often populate the poorest communities in South Africa, will change for the better. The disease should not extract this high a toll on any country in the world, let alone one with such great promises of justice and equality.