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## Dealing with International AIDS: A Case Study in the Challenges of Globalization, 35 J. Marshall L. Rev. 381 (2002)

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# DEALING WITH INTERNATIONAL AIDS: A CASE STUDY IN THE CHALLENGES OF GLOBALIZATION

## INTRODUCTION

On January 2, 2002, through January 6, 2002, the Association of American Law Schools held its Annual Meeting in New Orleans, Louisiana. The Gay and Lesbian Legal Issues Section and the International Law Section conducted a joint program wherein speeches were given addressing a single topic: "Dealing With International AIDS: A Case Study in the Challenges of Globalization." The following articles are adaptations of the speeches that were given in the joint program.

## RECURRING NIGHTMARE: BARRIERS TO EFFECTIVE TREATMENT OF HIV IN THE UNITED STATES AND INTERNATIONALLY

JOHN G. CULHANE\*

This ten-minute presentation cannot cover my subject adequately. I am going to try to hit a few of the high points. The outline I have distributed expands on these remarks, and is more of a working paper for an article in progress. Anyone interested in discussing any of these matters more fully should contact me at my e-mail address.

As the first presenter, I think there is one thing that I must say at the outset: according to the latest estimates, forty million people in the world today are living with HIV and AIDS.<sup>1</sup> That doesn't need any elaboration. I just wanted to start there to establish a context for the magnitude of the problem with which we're dealing. What I want to do in the short time I have is to

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1. UNITED NATIONS PROGRAMME ON HIV/AIDS [UNAIDS] & WHO, AIDS EPIDEMIC UPDATE, at 1, UNAIDS Doc. UNAIDS/01.74E, W.H.O. Doc. WHO/CDS/NCS/2001.2 (Dec. 2001) [hereinafter AIDS EPIDEMIC UPDATE].

identify obstacles to successful prevention and treatment of HIV in the United States and explore parallels to other countries: What about our own successes and failures in treating the most marginalized groups is capable of being applied to other countries? In other words, are other countries making the same mistakes that we are making? And then I want to finish on a somewhat more optimistic note by talking about a range of ways to overcome obstacles to prevention and treatment. So, first, I want to talk about the obstacles.

The first of the obstacles is well known to women. And, in fact, it is important to look at particular countries. If you look at the developed world—by that I mean Western Europe and the United States—you will find that the infection rate among women is reasonably low. If you look at the developing and undeveloped countries, you will find just the opposite. In fact, in sub-Saharan Africa, fifty-five percent of those infected are women.<sup>2</sup> In the United States though, it is important not just to look at women generally, but to take a look at a more specific population, namely African American women who now account for about two-thirds of all new female HIV infections.<sup>3</sup> Why is this? I will talk about this in some depth in a moment when I talk about a different obstacle, but for now, we can note that this high percentage is closely related to questions of poverty, lack of healthcare and problems in terms of education.

Now look at another country that we typically regard as kind of a success story in the fight against HIV/AIDS, and that is Brazil. There, it turns out that the percent of increase in HIV and AIDS cases of women is seventy-five percent. Among men, it is only ten percent.<sup>4</sup> Why is that? The problem is complex, but the reasons have to do with the culture of machismo, which make it difficult for women to negotiate about condom use, and with women's lack of education about how to protect themselves.<sup>5</sup> So you've got a problem in the United States, which you can see is mirrored in another country that has had some success in fighting

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2. *Id.*; UNAIDS, REGIONAL HIV/AIDS STATISTICS AND FEATURES, END OF 2001, UNAIDS Doc. No. 00002-E-2 (Dec. 2001), available at [http://www.unaids.org/worldaidsday/2001/EPIgraphics2001/EPIgraphic2\\_en.gif](http://www.unaids.org/worldaidsday/2001/EPIgraphics2001/EPIgraphic2_en.gif) (last visited Mar. 20, 2002).

3. See Ann Carns, *Twenty Years of AIDS in America: Blacks Now Account for Half of All New HIV Infections; Homosexuality Still Taboo*, WALL ST. J., May 30, 2001, at B1 (stating that the United States' Center for Disease Control estimates that sixty-four percent of new HIV cases in America are African-American women).

4. Anthony Fiola, *Brazilian Women Ravaged by AIDS; Infection Rate Rises in Culture of Denial*, WASH. POST, Oct. 30, 2001, at A34.

5. See *id.* (stating that the Brazilian devastation is because of Brazil's "machismo" culture and uneducated women "who often don't see themselves with any risk factor") (quoting Paulo Roberto Teixeira, Brazil AIDS Program secretary).

## HIV/AIDS.

Another obstacle that is even more complex, and therefore more difficult to deal with and get around, is really a cluster of related problems having to do with religious, cultural and community questions or assumptions about sex, sexual behavior, sexual orientation and condom use. I can start with something obvious from the United States. As you know, there has been a move toward teaching only abstinence, and calling that "sex education." Some thirty percent of high schools are now teaching abstinence-only education.<sup>6</sup> This reality avoidance puts us in good company because in Kenya, President Daniel Arap Moi, declared himself embarrassed to talk about condoms. So instead of advocating condom use, he offered a "better idea": Kenyans should abstain from sex for two years!<sup>7</sup> Now, what kind of public policy is that? You know, a few weeks, sure, but two years—it certainly doesn't seem like a policy likely to be implemented. We can see unfortunate parallels and similarities between the United States and a place like Kenya.

There are more complex questions having to do with stigma, sexual orientation and social hostility, and I wanted to just use two examples here, one from the United States and one from China. The United States case returns us to the African American community, and here we have a toxic combination of circumstances. You have many men who are having sex with men but not identifying themselves as gay, for what will probably strike you as explainable reasons if you think about them. First, unlike white gay men, who may leave their neighborhoods and go out and seek a community, many men who have sex with men in the African American community stay in those communities. But there is a lot of stigma attached to homosexuality in these communities. Many church and religious groups do not want to talk about it, or if they do talk about it, it is to denounce homosexuality. So you have men having sex with men, not acknowledging themselves as gay, spreading HIV to each other and then spreading HIV to women with whom they are having sex. In some cases [these are] women that they are in long term relationships with—even married to—because it is a culture that simply won't talk about what is going on.

Similar forces of stigma, denunciation, and denial are also at work in China. Our information from China is not very reliable; there is a lot we do not know. The current estimate of 600,000 infected is widely thought to be a gross underestimate. But there

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6. See Sharon Lerner, *An Orgy of Abstinence*, VILL. VOICE, Aug. 7, 2001, at 34 (reporting the 1999 abstinence-only frequency in United States' schools at twenty-nine percent).

7. Tom Malati, Associated Press, *Kenyan President Shy to Talk About Condoms*, July 13, 2001.

again, you have stigma concerning sexual orientation, lack of education and local resistance.<sup>8</sup>

One other problem I want to talk about before discussing possible solutions and approaches has to do with the close connection between poverty, on the one hand, and poor health outcomes, on the other. This connection has been pointed out by many commentators, most notably the late Jonathan Mann.<sup>9</sup> It is very simple if you think about it for even a second. If you are poor, you probably have poor nutrition, less education, and less access to healthcare. These are all problems that you could call the components of poverty if not its sequel. So what do we do about that? Well, obviously, that is a complicated issue. Andy mentioned that one of the things we need to think about for HIV/AIDS is shuffling the wealth a little bit from the richer to the poorer. This is obviously very politically difficult to do.

Without diminishing the significance of the connection between poverty and poor health outcomes, there is a danger we should guard against. We should not assume that just because people are poor and people do not have education that they are incapable of heeding messages and incapable of taking steps to protect themselves if we are able to go out there and make the effort. And I want to very briefly talk about three examples that prove the point, or at least suggest that it has some validity.

One was a study on women in New York City that was reported in the *American Journal of Public Health*. These women were at a very high risk of all kinds of sexually transmittable diseases, including HIV. To qualify for this study, they either had to be crack addicted, had sold sex for money, or been in prison—those kinds of things. This was a study on vaccine efficacy to see whether these women could be followed up on in such a trial. It turns out ninety-two percent of those women were still showing up for their scheduled appointments one year later.<sup>10</sup> Obviously, this is not a group that you would think easy to reach.

In Haiti, which is widely regarded, and I think rightly regarded, as the poorest country in the Western Hemisphere, there was a pilot program conducted to see whether it would be possible to get Haitians to stick to HAART, Highly Active Anti-Retroviral Therapy. It turned out that it was possible. If the subjects taking

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8. Bates Gill & Sarah Palmer, *The Coming AIDS Crisis in China*, N.Y. TIMES, July 16, 2001, at A15.

9. See *The Body*, Jonathan Mann Award for Health and Human Rights, at [http://www.thebody.com/ghc/mann\\_award.html](http://www.thebody.com/ghc/mann_award.html) (last visited Mar. 20, 2002) (listing the Global Health Council's award criteria in remembrance of the late epidemiologist Johnathan Mann). The web site notes that Johnathan Mann "was able to clearly see the connection between poverty and ill health." *Id.*

10. Pamela Brown-Peterside et al., *Retaining Hard-to-Reach Women in HIV Prevention and Vaccine Trials: Project ACHIEVE*, 91 AM. J. PUB. HEALTH 1377, No.9 (Sept. 1, 2001), available at 2001 WL 11437680 (2001).

the drugs were monitored closely enough, they followed the regimen.<sup>11</sup> And, of course, in Brazil, we know we have a poor (although not extremely poor) country where they have been able to drop the number of deaths due to AIDS by fifty percent over the last few years.<sup>12</sup> So ways of dealing with poverty can be found. We should not let the assumption turn into a self-fulfilling prophecy where we just say, well, there is no money there and we should just give up. If we can target money, if we can target prevention efforts to people, it is very possible to make a big difference.

More broadly in terms of solutions, I want to just mention a few things very quickly. One is, of course, money again. We can see neglect of public health at all kinds of levels. George W. Bush went to the Center for Disease Control (CDC) and was practically hit by falling debris because the place was falling apart. Now, an anthrax scare is going to cause us to spend more money on public health. But you see this is public health neglect at the local, national and international level, where the seed fund for the Global AIDS Fund is supposed to be seven to ten billion [dollars], and right now, they have less than two billion [dollars]. So I think money is the indispensable cornerstone of any successful program.

Beyond that, we need initiatives at the international level, the national level, and the regional level and all the way down to the local level. And I would say if access is blocked at one point, we should seek another way of dealing with the problem. That is why in the outline I discuss vaulting over obstacles, going around them, sneaking under them—any way you can do it to get the needed help to people. On the international level, I think it is well to commend WHO and UNAIDS, who have been driving forces in pushing HIV/AIDS onto the global “front burner.” Their efforts bore plump fruit in June, 2001, when the UN General Assembly created a framework and got countries to commit to benchmark targets for HIV prevention, care, support and treatment.<sup>13</sup> This was a very big step for the international community, and if nothing else, it should get people to at least think about HIV on a national level. There is another example of a multi-national initiative from Southeast Asia that I discuss in the outline.<sup>14</sup>

Turning to the national level, we again begin with the United States. Unfortunately, any success we have had has come in spite of a continued failure of Presidential leadership. This is a

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11. Paul Farmer, *Community-Based Approaches to HIV Treatment in Resource-Poor Settings*, 358 LANCET 404 (Aug. 4, 2001).

12. Associated Press, *Brazil to Give Away 800,000 Condoms for Lovers' Day*, June 9, 2001.

13. *Declaration of Commitment on HIV/AIDS*, U.N. GAOR 26th Special Sess., Annex, Agenda Item 8, U.N. Doc. A/RES/S-26/2 (2001).

14. Emma Tinkler, Associated Press, *Tackling Growing Asian AIDS Epidemic to Cost Billions*, Oct. 6, 2001).

bipartisan indictment. First, we had the Reagan administration afraid, embarrassed, and more than a little judgmental. Reagan and his spokespeople were simply not willing to talk about HIV at all. It is fair to say that their silence was responsible for many thousands of infections and deaths. We had the Clinton administration, which would not federally fund needle exchange programs in spite of the good science supporting them. And now, we have got the George W. Bush administration distancing itself from a very good report by the Surgeon General, David Satcher, in which he discusses the need for real sex education and for destigmatizing gay and lesbian identity.<sup>15</sup> So the national leadership in our country has not been very good.

Compare this reaction to a country like Uganda, of all places, that has been the first country in Africa to really subdue its HIV/AIDS epidemic.<sup>16</sup> The reason for that has been good leadership at the national level,<sup>17</sup> willingness to talk openly about HIV, talk about disease, talk about condom use, and they have been extremely successful. In Cambodia, too, again there's a willingness to talk about sex, talk about homosexuality and condom use.<sup>18</sup>

Local efforts often are about the only option you have. If you are in a place where the national response has not been forthcoming, I think it is very important to look for other places. And the single best example of this is needle exchange programs that have been blocked from funding at the national level since the beginning of the HIV epidemic. But it turns out there are now some eighty-one cities that are running needle exchange programs of their own. In the year 1998, which is the most recent year for which data have become available, almost twenty million syringes

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15. See Karen S. Peterson, *Satcher Urges Sex Dialogue; Critics Urge Ouster*, USA TODAY, June 29, 2001, at 1A (noting the Bush administration's concerns with Clinton appointee Surgeon General David Satcher's self-described sex education agenda as more "science" than politics or religion).

16. AIDS EPIDEMIC UPDATE, *supra* note 1, at 15.

17. Although the Ugandan leadership has generally been good, it has been completely negative on the issue of homosexuality because the leadership mixes both the denial and persecution of gays. See Peter O'Connor, Associated Press, *Ugandan President Honored for AIDS Fight Says Nation Has No Homosexuals*, Mar. 3, 2002 (contrasting a March 2002 speech by Ugandan President Yoweri Museveni with Amnesty International's June 2001 report of homosexual torture in Uganda). In accepting an award for the nation's successful campaign against HIV/AIDS, Ugandan President Museveni stated that "[w]e don't have homosexuals in Uganda so this is mainly heterosexual transmission . . ." *Id.*

18. Center for Disease Control, Malaysian Nat'l News Agency (BERNAMA), *Cambodia Takes Measures Against HIV/AIDS* (Oct. 15, 2001), available at [http://www.thebody.com/cdc/news\\_updates\\_archive/oct18\\_01/cambodia.html](http://www.thebody.com/cdc/news_updates_archive/oct18_01/cambodia.html) (last visited Apr. 2, 2002).

were exchanged, which was up from about eight million in 1994.<sup>19</sup> It is a great public health success carried out at the grassroots level.

Another encouraging example is from Baltimore. You have the CDC, the State of Maryland and local activists all acting toward a common purpose. They have identified areas of high risk for HIV infection based on poverty, based on drug addiction, based on imprisonment, and they have sent mobile vans into those areas to deliver a package of health services. Not just HIV testing and treatment, but an entire package of health services.<sup>20</sup> Why is that important? Because people feel less stigmatized that way. People are not just going for HIV treatment and walking into this van saying, "oh, I am identifying myself," but rather they are looking at this as a whole package of services.

One final point is again from Kenya, now going from the grassroots level all the way down to what the first George Bush might have called one point of light. This is a story about a family in Kenya that broke the taboo on talking about HIV/AIDS. When a family member died, they put two red ribbons next to the death announcement to show that the person had died of AIDS, and the family said it was time to break the stigma.<sup>21</sup> That is in a country in which the president is embarrassed to talk about HIV/AIDS; and it is a family doing this. And I think these messages of hope can bubble up from the ground and yield good public health outcomes. Thank you.

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19. AMERICAN FOUNDATION FOR AIDS RESEARCH, NATIONAL SURVEY SHOWS MARKED INCREASE IN SYRINGE EXCHANGE PROGRAMS: AMFAR FUNDS SURVEY: PROGRAMS GAIN MOMENTUM AS MEANS FOR HIV PREVENTION (May 17, 2001), at <http://www.amfar.org/cgi-bin/iowa/news/press.html> (last visited Mar. 20, 2002).

20. AIDS ALERT, COMMUNITY-BASED EFFORTS TO CHALK UP SUCCESSSES: SITES IN NC AND MARYLAND HAVE TALE TO TELL (SUCCESS IN HIV PREVENTION), 16, No. 12, at 160 (Dec. 1, 2001), available at 2001 WL 11585715 (listing the health screening services such as counseling and testing for both AIDS and other health problems).

21. Matthew Green, Reuters NewMedia, *Kenyan Family Shatters AIDS Taboo with Death Notice*, (July 17, 2001), at <http://www.aegis.com/news/re/2001/RE010718.html> (last visited Apr. 2, 2002).



## BIOGRAPHY OF A NIGHTMARE: HIV/AIDS IN SOUTH AFRICA

PETER KWAN\*

### INTRODUCTION

"South Africa is experiencing an HIV/AIDS epidemic of shattering dimensions."<sup>22</sup> So begins a report from South Africa's Medical Research Council less than a year ago. It is as if the word "epidemic" alone has lost what force it once had to convey the enormity and tragedy of the health crisis. The fact that it is now the "single biggest cause of death" in South Africa seems to have lost its ability to shock.<sup>23</sup> HIV/AIDS in South Africa is not your garden variety "epidemic," these scientists and actuaries (not professions known for hyperbole) are telling us it is one of "shattering dimensions."<sup>24</sup>

The statistics are staggering and, after a while, mind-numbing. Reading and thinking about them is exhausting. But that experience pales into insignificance compared with the reality of those who have suffered and died and those who are suffering and living with it still. There is the reality for life partners and orphans of sufferers whose lives are shattered along with the victims, and all those who newly fall into those categories every day and whose numbers increase tirelessly.

The purpose of this Article is to present what is presently known about HIV/AIDS in South Africa. This includes the most educated and best scientific predictions of the future trends of this disease. It provides the empirical background and helps set up the background against which other speakers on this panel, notably Pierre de Vos, can describe and discuss the South African government's response to HIV/AIDS as well as recent human rights and constitutional challenges to that government's (in)action.<sup>25</sup>

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\* Peter Kwan, Visiting Professor of Law, Golden Gate University. Heartfelt thanks to Kelly Shindell for her invaluable assistance and to Pierre de Vos for his unfailing friendship and guidance.

22. ROB DORRINGTON ET AL., MED. RESEARCH COUNCIL OF S. AFR., THE IMPACT OF HIV/AIDS ON ADULT MORTALITY IN SOUTH AFRICA 5 (Sept. 2001).

23. MICHELLE ROTCHFORD GALLOWAY, MED. RESEARCH COUNCIL OF S. AFR., MRC REPORT REVEALS EXTENT OF EPIDEMIC AIDS: 'THE SINGLE BIGGEST CAUSE OF DEATH,' 10 AIDS BULL. 3 (Dec. 2001), available at <http://www.mrc.ac.za/aids/dec2001/mrcreport.htm> (last visited Apr. 19, 2002).

24. *Id.*

25. Pierre de Vos, *HIV/AIDS in South Africa: The Good, the Bad and the Ugly*, 35 J. MARSHALL L. REV. 386 (2002).

## I. BIRTH AND EARLY LIFE

The United States Center for Disease Control in Atlanta first described the Acquired Immunity Disease Syndrome as a syndrome in 1981.<sup>26</sup> A year later, two cases were reported in South Africa.<sup>27</sup> The first death from AIDS in South Africa was reported on January 20, 1989.<sup>28</sup> Although most of these first cases of infections were of white males, the profile of HIV/AIDS victims was swiftly to change both in terms of gender and race.<sup>29</sup> From 1982 to 1989, the victims were disproportionately homosexual or bisexual.<sup>30</sup>

The South African government's initial response to the emerging problem was to form an AIDS Advisory Group in 1985, whose task was both to advise and to formulate national programs to address HIV/AIDS. It took seven years before the government established a national AIDS program.<sup>31</sup> In 1994, various relevant individuals, organizations and groups created a National AIDS Plan under the umbrella of the National Coordinating Committee of South Africa, including local and national governments, the African National Congress Health Secretariat, businesses and unions.<sup>32</sup> Under that plan, and from 1998 to 2000, the government launched a national multi-media educational effort, the "Beyond Awareness Campaign."<sup>33</sup> By then, the epidemic had already matured and was firmly entrenched among the entire South

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26. United Nations Programme on HIV/AIDS, *Fact Sheets: Twenty Years of AIDS* (May 2001), available at [http://www.unaids.org/fact\\_sheets/files/AIDStwenty\\_en.html](http://www.unaids.org/fact_sheets/files/AIDStwenty_en.html) (last visited Apr. 19, 2002).

27. UNITED NATIONS PROGRAMME ON HIV/AIDS & WHO, EPIDEMIOLOGICAL FACT SHEET ON HIV/AIDS AND SEXUALLY TRANSMITTED INFECTION: 2000 UPDATE (REVISED) 6 (2000).

28. Four new AIDS cases were reported at the same time, one of which was a three-month-old baby. *South and Southern Africa in Brief: S. Africa AIDS Statistics*, (BBC broadcast, Jan. 23, 1989), available at [http://www.lexis.com/research/retrieve/frames?\\_m=220131fcabfaff73dda0ebba2f87850b&csvc=fr&cform=free&\\_fmtstr=XCITE&docnum=1&\\_startdoc=1&wchp=dGLSzV-LSIWS&\\_md5=7434d808eae6f0cd6cb873250b56c9a8](http://www.lexis.com/research/retrieve/frames?_m=220131fcabfaff73dda0ebba2f87850b&csvc=fr&cform=free&_fmtstr=XCITE&docnum=1&_startdoc=1&wchp=dGLSzV-LSIWS&_md5=7434d808eae6f0cd6cb873250b56c9a8) (last visited Apr. 19, 2002).

29. In 1989, 145 of the South African AIDS victims were white, forty-one were African, six were colored and three were Asian. From 1982 to 1989, there were twenty cases of women with HIV/AIDS in South Africa. *Id.*

30. Of the 195 victims that contracted HIV/AIDS from 1982 to 1989, 129 were either homosexual or bisexual, forty-five were heterosexual, nine were hemophiliacs, one was an intravenous drug user and seven victims were of unknown classification. *Id.* These victims' overall mortality rate was fifty-nine percent. *Id.*

31. National Coordinating Committee of South Africa, *AIDS in South Africa: Dynamics of the South African Epidemic*, at <http://www.aids.org.za> (last visited Apr. 19, 2002).

32. *Id.*

33. *Id.*

African population.

## II. ADULTHOOD

Securely established and without vigorous opposition in terms of a multi-faceted and concerted social and medical response, the epidemic has been able to wreak havoc in South Africa throughout the 1990's and up to the present. What one knows about the progression of HIV/AIDS through the South African population comes mainly from survey data collected through blood test results taken from pregnant women in public health antenatal clinics located throughout the country.<sup>34</sup> Over eighty percent of pregnant women in South Africa use the public antenatal care offered by the government.<sup>35</sup> At these clinics, pregnant women are routinely given blood tests for syphilis.<sup>36</sup> Although voluntary, few women refuse these tests.<sup>37</sup>

Each October, when testing for syphilis is administered, a test for HIV is also done anonymously, but with the consent of the woman.<sup>38</sup> This is the most reliable and consistent survey data available regarding HIV/AIDS in South Africa. There are no surveys or direct information on infection rates among non-pregnant women, men, infants or children.<sup>39</sup> Therefore, these figures do not present an optimum projection of the situation. Given the sample group, the survey data tracks only heterosexual transmission of HIV/AIDS. Even though eighty percent of all pregnant women attend public antenatal clinics, of these, 85.2 percent are African and therefore under-presents racially.<sup>40</sup> Nevertheless, it is international scientific practice to use pregnant women as the sentinel population for HIV/AIDS studies and represents the best data on the South African situation currently available.<sup>41</sup> In 2000, the antenatal survey included 400 public sector clinical sites where 16,607 pregnant women were tested for HIV.<sup>42</sup>

Notwithstanding these analytical reservations, the picture this data shows is grim. In 1990, less than one percent of the pregnant women being tested were HIV positive. In 2000, the rate

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34. Dorrington, *supra* note 22, at 7.

35. *Id.*

36. SOUTH AFRICAN DEPT. OF HEALTH, NATIONAL HIV AND SYPHILIS SERO-  
PREVALENCE SURVEY OF WOMEN ATTENDING PUBLIC ANTENATAL CLINICS IN  
SOUTH AFRICA: 2000, ¶ 3.6, available at  
<http://196.36.153.56/doh/docs/reports/2000/hivreport.html> (last visited Apr. 19,  
2002) [hereinafter DOH NATIONAL SURVEY OF WOMEN].

37. *Id.*

38. *Id.*

39. *Id.* ¶ 4.1.4.

40. *Id.* ¶ 3.6.

41. DOH NATIONAL SURVEY OF WOMEN, ¶ 3.4.

42. *Id.*

had increased to 24.5 percent,<sup>43</sup> up from 22.4 percent in 1999 and 22.8 percent in 1998.<sup>44</sup> Although there was an increase in the rate of infection in 2000, the good news is that the increase was not exponential.<sup>45</sup> Yet in 2000, the survey projects that South Africa had 4.8 million people infected with HIV, "most of them being at the prime of their age."<sup>46</sup>

The South African government estimates the current population to be 43,586,0997.<sup>47</sup> The mortality rate among young adult women (between twenty-five and twenty-nine years of age) rose 3.5 times between 1985 and 1999/2000.<sup>48</sup> Among men between thirty and thirty-nine years of age, the mortality rate nearly doubled in that time period.<sup>49</sup> These rises in mortality rate are consistent with actuarial predictions of deaths attributed to AIDS.<sup>50</sup> Notwithstanding the uncertainties regarding the data, the Medical Research Council's report estimates that

about 40% of the adult deaths aged 15-49 that occurred in the year 2000 were due to HIV/AIDS and that about 20% of all adult deaths in that year were due to AIDS. When this is combined with the excess deaths in childhood, it is estimated that AIDS accounted for about 25% of all deaths in the year 2000 and has become the single biggest cause of death.<sup>51</sup>

By some accounts, already South Africa has the highest number of HIV positive people of any nation,<sup>52</sup> and AIDS related illnesses are the "most common cause of death in the medical wards among adults aged 19-49 at teaching hospitals affiliated to the Universities of Cape Town, Natal and Witwatersrand."<sup>53</sup> In 2000, the South African government's own Department of Health estimated that 628,000, or twenty-five percent, of all public hospital admissions were for AIDS related illnesses.<sup>54</sup>

Since HIV/AIDS predominantly affects the younger, sexually

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43. Dorrington, *supra* note 22, at 7.

44. DOH NATIONAL SURVEY OF WOMEN, ¶ 4.1.1.

45. *Id.*

46. *Id.* ¶ 6.

47. U.S. CENT. INTELLIGENCE AGENCY, THE WORLD FACTBOOK 2001, available at <http://www.odci.gov/cia/publications/factbook/geos/sf.html> (last visited Apr. 19, 2002).

48. Dorrington, *supra* note 22, at 5.

49. *Id.* at 6.

50. *Id.*

51. *Id.*

52. Rachel Swarns, *A Bold Move on AIDS in South Africa*, N.Y. TIMES, Feb. 5, 2002, at A10.

53. Treatment Action Campaign, *Bredell Consensus Statement of the Imperative to Expand Access to Anti-Retroviral (ART) Medicines for Adults and Children with HIV/AIDS in South Africa* (Nov. 19, 2001), at <http://www.tac.org.za/Documents/Statements/bredell3.pdf>. (last visited Apr. 19, 2002) [hereinafter *Bredell Consensus Statement*].

54. *Id.*

active adult population, one of the effects of the epidemic has been an increasing shift in the ratio of deaths from those over fifty to those aged fifteen to forty-nine, between 1990 and 2000.<sup>55</sup> The effect on children is devastating. Under current estimates, 70,000 children are infected with HIV each year.<sup>56</sup> In Soweto, a Johannesburg Township, fifty percent of the pediatric admissions and two-thirds of the deaths of children are due to HIV.<sup>57</sup>

### III. THE FUTURE

If obtaining an accurate account of the current situation is fraught with methodological uncertainties, projections of future scenarios are even more hazardous. Some of these uncertainties include the commitment of the South African government to educational programs and the availability of anti-retroviral drugs for pregnant women. However, certain actuarial projections based on tested methods and relied upon by the insurance industry are available at least to provide a set of educated portrayals of the future landscape based upon different a set of variable factors. Under the most optimistic set of assumptions, the projections are catastrophic. In the next ten years, there will be between four and seven million AIDS related deaths and life expectancy will drop between five and sixteen years from the current age of fifty-five.<sup>58</sup>

The AIDS Unit of the Actuarial Society of South Africa has provided two charts projecting the future impact of HIV/AIDS on South Africa. These charts are appended to this Article. Like most data relating to HIV/AIDS, they are not without controversy. Although they are disputed by certain South African governmental officials, those figures are based on the South African government's own statistics from their antenatal clinics. They are also used by the government institutes like the Medical Research Council and by the insurance industry in South Africa.

The two charts differ only in that one of them is based on the assumption that there will be no change in the behavior and the response of the South African government regarding HIV prevention. The first chart is entitled "no change scenario." (Figure 1). The second chart assumes moderate changes in

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55. Dorrington, *supra* note 22, at 17.

56. *Bredell Consensus Statement*, *supra* note 53.

57. Glenda Grey M.D., *Fighting the Epidemic at Ground Zero: Combating HIV Infection in Soweto, South Africa*, HIV/AIDS Annual Update (2001), available at Medscape.com, <http://www.medscape.com/viewarticle/418662> (last visited Apr. 19, 2002).

58. Dorrington, *supra* note 22, at 24. The Dorrington report cites the United States Bureau of the Census as forecasting a higher rate of infection and a lower life expectancy rate in the United States compared to South Africa in 2010. However, the authors are skeptical about these figures because the World Health Organization estimated in 1999 that life expectancy in South Africa would decline from sixty to forty-three years.

governmental response and the population's sexual behavior. The second chart is entitled "change scenario." (Figure 2). Moderate change means that in five years, the government will provide intervention to prevent mother to child transmission in ninety percent of the cases, and that in five years there will be treatment to decrease sexually transmitted diseases by fifteen percent. In five years, there will also be a doubling of condom use and a decrease of new sexual partners by fifteen percent.

Under this moderate change scenario, one observes from the second chart that the total HIV infections will reach a peak in the year 2005. 7.086 million people will be living with HIV in South Africa out of a population of forty-seven million, which is about fifteen percent of the total population, or just over a quarter of the adults between twenty and fifty-five years old. That is, the Actuarial Society of South Africa predicts that three years from now, a quarter of the adults between ages twenty and sixty-five will be living with AIDS in South Africa. Deaths will reach a peak in the year 2010 when 712,535 people will die that year of AIDS related diseases. In the decade between 2000 to 2010, accumulated deaths are projected to be just under five million people. In that decade, there will also have been over one and a half million AIDS orphans.

In terms of life expectancy, by the year 2011, life expectancy will have dropped thirteen years to forty-three from the present life expectancy of fifty-six.

If there is no change in sexual behavior, or if there is no change in the government's response to HIV/AIDS, the total HIV infections will reach a peak in 2008. There will be 7.7 million people living with HIV in South Africa, which is 16.2 percent of the total population and 27.2 percent of adults between twenty and sixty-five. Deaths will reach a peak in the year 2011 when it is projected that 780,000 will die of AIDS related deaths that year. The accumulated AIDS deaths from the year 2000 to 2010 are projected to be 5.23 million. To put this in perspective, the difference in accumulated deaths between no change and moderate change is roughly fifty times the number of people who died in the World Trade Center on September 11, 2001. In that decade also, seven years from now, there will be 1,530,000 AIDS orphans. Life expectancy is projected to drop sixteen years.

These statistics mask several social facts. Firstly, HIV/AIDS is not a gay disease. The infection rates affect all sections of South African society. Secondly, HIV/AIDS is poverty and race related disease. There is an extremely disproportionate impact on poor and non-white communities in South Africa. There is also a city/rural gap. The health delivery infrastructure, while advanced compared to many developing nations, is heavily weighed in favor of urban areas and almost completely unavailable to rural areas.

While this gap is also interrelated to race and poverty issues, one needs to pay attention to this geographical disparity. This is important since much of the rhetoric opposing the provision of anti-retroviral drugs to developing countries is based on the lack of an effective healthcare infrastructure. That cannot be said of South Africa, where such an infrastructure does exist, but mostly for the urban privileged.

Why has it been so difficult then to address this catastrophe? The lack of political will stands out as a major obstacle. President Thabo Mbeki's ambivalence about the scientific link between HIV infection and AIDS translates to governmental apathy, confusion and paralysis.<sup>59</sup> Racism plays a role. Forced migrant labor is one of the many apartheid legacies that contributed to the spread of HIV/AIDS from the mainly white male population to the African male and female populations. Under this system, black laborers had to have special passes to work in jobs where the white population lived. Black men were segregated from their wives and often lived in huge hostels, leading to a break up of the family system. Numbers of sexual partners increased resulting in an increase in multiple transmission routes. Continued patriarchal attitudes towards women and women's right to control their bodies and reproduction also stand in the way of reducing transmission. State educational efforts have also been ill conceived.

The government in South Africa admonished the citizens through the so-called ABC Prevention Program. This program firstly stressed abstinence. As a secondary measure, the program urges citizens to "be faithful." Thirdly, if one is not or cannot be faithful, the program urges the use of condoms. The underlying message is that anyone who uses a condom or insists that one's partner use a condom is therefore either unfaithful, promiscuous or doesn't trust one's partners. These messages are, of course, highly resisted by women in South Africa.

Another obstacle standing in the way of addressing HIV/AIDS transmission is stigma. Like other cultures, AIDS is identified as

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59. de Vos, *supra* note 25. South African President Thabo Mbeki is not the only governmental impediment to effective HIV/AIDS policy implementation and treatment in the South Africa. Peter Mokaba has expressed similarly extreme views. Mokaba is a current South African member of Parliament and was also a former anti-apartheid leader. Mokaba has commented that "H.I.V.? It doesn't exist," and

The kind of stories that they tell that people are dying in droves? It's not true. It's not borne out by any facts . . . [W]e cannot allow our people to be guinea pigs . . . Anti-retrovirals, they're quite dangerous. They're poison actually. We cannot allow our people to take something so dangerous that it will actually exterminate them. However well meaning, the hazards of misplaced compassion could lead to genocide.

Rachel L. Swarns, *An AIDS Skeptic in South Africa Feeds Simmering Doubts*, N.Y. TIMES, Mar. 31, 2002, § 1, at 4.

a sexual and gay disease in South Africa. There is a strong cultural aversion to speak about sexually transmitted diseases. Combined with homophobia, those diagnosed with AIDS are closeted about their disease, and those who die from AIDS do not have the cause of death disclosed. This creates a culture of silence around HIV and AIDS, a silence that works against educational and consciousness raising efforts.



Figure 1

NO. CHANGE SCENARIO	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Numbers (total and infected)																
Total population	45,076,805	45,768,984	46,361,337	46,948,269	47,223,831	47,656,389	47,656,680	47,663,223	47,645,665	47,540,955	47,392,269	47,220,538	47,044,851	46,877,879	46,728,376	46,599,640
Total HIV infections	5,263,841	5,969,521	6,559,628	7,027,931	7,373,071	7,594,403	7,697,600	7,695,201	7,605,111	7,449,678	7,252,801	7,037,112	6,821,547	6,619,893	6,440,577	6,287,502
Total births	1,142,387	1,139,039	1,131,308	1,120,501	1,107,423	1,092,721	1,077,019	1,061,205	1,045,853	1,031,424	1,016,601	1,007,616	998,550	991,238	985,358	980,575
Births infected perinatally	56,048	63,880	67,994	70,844	72,135	72,693	72,524	71,815	70,748	69,492	68,193	66,962	65,890	64,989	64,293	63,771
Babies newly infected by mother's milk	16,259	19,289	19,790	20,794	21,417	21,724	21,783	21,651	21,385	21,036	20,653	20,273	19,826	19,630	19,392	19,210
AIDS sick																
Total AIDS sick (in the middle of year)	236,228	334,253	453,352	591,088	742,519	899,071	1,049,742	1,182,710	1,287,844	1,359,743	1,393,926	1,396,802	1,374,473	1,335,718	1,288,815	1,240,148
Deaths:																
Non-AIDS deaths	387,667	392,447	396,537	399,954	402,694	404,749	406,115	406,824	406,961	406,659	406,095	405,459	404,894	404,560	404,532	404,846
AIDS deaths	139,009	194,892	262,209	339,500	423,711	510,078	592,588	664,966	721,915	760,174	779,098	760,598	768,485	747,405	721,766	695,041
Accumulated Aids Deaths (to middle of the year)	298,845	482,642	668,428	987,061	1,367,429	1,834,484	2,387,587	3,019,659	3,717,519	4,463,489	5,237,887	6,021,684	6,799,064	7,558,853	8,293,873	9,002,186
Prevalence rates																
Minimum clinics	25.60%	27.30%	28.80%	30.10%	30.80%	31.40%	31.70%	31.70%	31.70%	31.50%	31.30%	31.10%	30.80%	30.60%	30.50%	30.40%
Women aged 15 - 49	21.50%	23.90%	25.80%	27.40%	28.30%	29.20%	29.60%	29.70%	29.50%	29.00%	28.30%	27.80%	27.60%	26.90%	26.10%	25.70%
Men	19.60%	21.80%	23.50%	24.80%	25.80%	26.50%	26.80%	26.80%	26.50%	26.00%	25.40%	24.70%	24.60%	23.40%	22.70%	22.90%
Adult men (ages 20 - 65)	20.50%	22.80%	24.70%	26.00%	27.00%	27.80%	27.70%	27.60%	27.20%	26.70%	26.00%	25.30%	24.60%	23.90%	23.20%	22.50%
Adults (ages 20 - 65)	20.10%	22.30%	24.10%	25.00%	25.40%	26.00%	26.20%	26.20%	25.80%	25.30%	24.60%	24.00%	23.90%	23.60%	23.00%	22.30%
Total population	11.70%	13.00%	14.10%	15.00%	15.60%	16.00%	16.20%	16.10%	16.00%	15.70%	15.30%	14.90%	14.50%	14.10%	13.80%	13.60%
Incidence rates																
Total new infections	692,241	851,175	610,891	774,173	741,169	711,646	685,766	663,514	644,632	629,237	616,824	607,430	600,370	595,344	591,954	589,791
Mortality statistics																
Life expectancy at birth	56	55	52	50	48	46	44	43	42	41	41	40	41	41	41	41
Minimal orphan statistics																
Total orphans (in middle of year)	493,860	555,684	636,876	739,676	865,270	1,011,785	1,174,110	1,339,615	1,506,396	1,660,812	1,794,735	1,902,852	1,982,896	2,036,255	2,064,075	2,070,546
Total AIDS orphans (in middle of year)	124,989	180,993	279,102	391,137	527,006	695,354	859,572	1,039,210	1,218,488	1,385,308	1,531,229	1,650,644	1,741,139	1,803,865	1,840,282	1,854,462

Figure 2

CHANGE SCENARIO	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Numbers (total and infected)																
Total population	45,078,805	45,768,894	46,363,319	46,855,936	47,241,158	47,518,461	47,685,361	47,757,797	47,751,189	47,687,869	47,591,166	47,466,622	47,394,750	47,330,179	47,301,669	47,311,669
Total HIV infections	5,263,641	5,968,621	6,491,179	6,844,911	7,040,721	7,096,851	6,994,937	6,824,732	6,592,727	6,320,107	6,030,022	5,746,036	5,466,206	5,264,560	5,086,439	4,959,359
Total births	1,142,367	1,199,039	1,130,754	1,118,538	1,103,628	1,086,973	1,069,428	1,052,099	1,037,197	1,023,635	1,012,419	1,003,579	997,063	992,804	989,600	988,237
Births indicated pernatally	50,048	57,247	50,563	46,456	42,771	38,362	35,171	33,002	31,955	30,573	29,387	28,412	27,655	27,111	26,759	26,571
Babies newly infected by mother's milk	16,259	17,560	17,063	15,932	14,938	13,782	12,634	11,846	11,291	10,786	10,343	9,970	9,672	9,447	9,283	9,199
AIDS sick																
Total AIDS sick (in the middle of year)	236,228	354,253	447,050	574,244	715,736	860,850	999,057	1,118,238	1,209,547	1,263,083	1,278,030	1,256,370	1,206,910	1,138,341	1,062,842	988,763
Deaths:																
Non-AIDS deaths	387,667	392,463	396,596	400,054	402,789	404,830	406,164	406,057	407,027	406,827	406,445	406,073	405,894	406,050	406,631	407,669
AIDS deaths	139,008	193,865	257,748	329,728	408,045	488,006	583,427	698,215	876,839	1,055,316	1,212,535	1,350,360	1,472,894	1,572,894	1,635,589	1,663,893
Accumulated AIDS Deaths (to middle of the year)	298,645	482,642	686,415	978,139	1,345,872	1,794,230	2,321,884	2,921,084	3,578,315	4,274,762	4,988,948	5,699,832	6,389,669	7,045,621	7,660,847	8,234,123
Prevalence rates																
Antenatal clinics	25.20%	27.30%	28.60%	29.10%	29.10%	28.60%	27.70%	26.80%	26.00%	25.30%	24.60%	24.10%	23.60%	23.30%	23.10%	23.00%
Women aged 15 - 49	21.90%	24.30%	26.10%	27.30%	27.90%	28.10%	27.70%	27.20%	26.40%	25.50%	24.80%	23.80%	22.70%	22.00%	21.40%	20.90%
Adult women (ages 20 - 65)	19.50%	21.70%	23.30%	24.40%	25.00%	25.20%	25.10%	24.60%	23.90%	23.10%	22.10%	21.00%	20.20%	19.40%	18.70%	18.20%
Adult men (ages 20 - 65)	21.20%	23.60%	25.20%	26.30%	26.70%	26.70%	26.30%	25.60%	24.70%	23.70%	22.70%	21.60%	20.70%	19.90%	19.20%	18.70%
Adults (ages 20 - 65)	20.30%	22.60%	24.20%	25.30%	25.80%	25.80%	25.30%	24.60%	23.70%	22.70%	21.70%	20.60%	19.70%	19.00%	18.30%	17.80%
Total population	11.70%	13.06%	14.00%	14.80%	14.90%	14.90%	14.70%	14.30%	13.80%	13.30%	12.70%	12.10%	11.60%	11.10%	10.80%	10.50%
Incidence rates																
Total new infections	892,241	816,342	714,460	630,869	561,434	501,711	471,445	467,260	464,621	463,247	463,019	463,814	465,499	467,928	470,915	474,279
Mortality statistics																
Life expectancy at birth	56	55	53	51	49	47	46	44	43	43	43	43	43	44	45	46
Maternal orphan statistics																
Total orphans (in middle of year)	493,860	555,664	636,876	739,572	865,216	1,011,457	1,172,985	1,338,483	1,499,424	1,647,293	1,770,870	1,863,845	1,923,378	1,950,266	1,948,560	1,917,719
Total AIDS orphans (in middle of year)	124,989	190,993	279,102	391,052	527,054	684,364	857,201	1,034,085	1,208,646	1,387,926	1,502,457	1,605,656	1,674,483	1,709,761	1,713,616	1,691,550

## INTRODUCTORY REMARKS: AIDS AND GLOBALIZATION—THE QUESTION PRESENTED

ANDREW L. STRAUSS\*

Welcome to our panel on International AIDS. Many of you are probably familiar with the chaos theorist, Edward Lorenz, who described what came to be called the butterfly effect, that the world of nature is so interdependent that a butterfly flapping its wings in Beijing could result in an eventual storm in New York City.<sup>60</sup> Globalization reinforces more than ever before that one aspect of nature, the human community, is interconnected, highly interconnected. In a largely borderless world, what one of us does, what one of us thinks, what happens to one of us affects all of us. And the topic of today's panel, the horror of AIDS, makes this much more than a mere abstraction. For what better demonstration really of the butterfly effect than the possibility that a monkey somewhere in the world bit one person and that this led to what eventually has become the AIDS crisis.<sup>61</sup>

The charge of the panel this morning is to specifically examine "International AIDS as a Case Study in the Challenges of Globalization." If the disease knows no borders, then shouldn't our solutions as well? This raises a host of questions for our panel to discuss. How do you create an effective strategy for dealing with the spread of a truly transnational pandemic? The question of subsidiary. What should be done at the level of the state and what should be done internationally? What is the role for international human rights? How intrusive should the international community be in countries where governments seem to be following wrong-headed or even wholly irrational policies? Do we at this point have the basic institutional infrastructure to accomplish an effective global strategy? Questions of distributive justice abound as well. Clearly, the disease knows no boundaries, but why is it that the poor, and the dispossessed, and the marginalized are its greatest victims? What are the obligations of specific industrial sectors such as drug companies or of wealthy citizens in general to help? What do ongoing debates about

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60. See JAMES GLEICK, *CHAOS: MAKING A NEW SCIENCE* 20-23 (Penguin Books) (1987).

61. For a discussion of this and other theories of the origins of the AIDS epidemic, see JAD ADAMS, *AIDS: THE HIV MYTH* 177-79 (St. Martin's Press 1989) (identifying the monkey bite theory as enjoying the most support).

intellectual property rights and economic theory have to contribute to this discussion?

These are the questions that our panel will turn to. Our first speaker, John Culhane, will look at how lessons learned in the United States can be adapted to the international fight against AIDS. Our next speaker will be Mark Wojcik who will discuss the applicability of the international human rights paradigm to the fight against AIDS. Following, Allyn Taylor will focus primarily on institutional and resource issues, specifically to what extent are international public, private partnerships called for in the fight against AIDS. Finally, Peter Kwan and Pierre de Vos will look at South Africa, one of the hardest hit countries in the world as a case study in the global fight against AIDS. First, Peter will lay the foundation by describing the problem, and then Pierre will discuss legal strategies for dealing with it.

I would like to now tell you a bit about our distinguished panel. John Culhane is a professor of law at Widener University School of Law, visiting professor of law at California Western School of Law for the Spring of 2002, and lecturer at Yale University School of Public Health. He teaches public health law at all three schools. He has written extensively on the subject of tort law, public health law and the rights of same sex couples, and is currently finishing work on an article on HIV in the workplace. Professor Culhane is a graduate of the William and Mary College and Fordham Law School.

Mark Wojcik is an associate professor of law at the John Marshall School of Law in Chicago. He is active in the ABA Section on International Law and Practice where he is a co-chair of the International Human Rights Committee and vice chair of the International Health Law Committee. He has written articles and book chapters on the legal aspects of HIV and AIDS for more than fifteen years. He is presently on sabbatical in Honolulu.

Allyn Taylor is a senior health policy advisor at the World Health Organization [WHO]. Her primary work at the WHO involves serving as the senior legal counsel on the WHO Framework Convention on Tobacco Control. She is also a member of the adjunct faculty at the John Hopkins School of Hygiene and Public Health. She currently serves as a chair of the International Health Law Interest Group of the American Society of International Law. Dr. Taylor holds a JD from the University of California, Berkeley, Boalt School of Law and a doctorate in public international law from Columbia University School of Law where she was a Ford Foundation Fellow.

Professor Peter Kwan studied law and philosophy at the University of Sydney where he completed his bachelor and masters degree in law, magna cum laude. He also has a masters degree in law from Columbia University where he was an article

editor for both the Journal of Transnational Law and the Journal of Chinese Law. Professor Kwan has served as chair of the Association of American Law Schools Section on Law and Humanities and is a chair elect of the AALS Section on Sexual Orientation and Gender Identity. Professor Kwan is currently teaching as a visitor at the University of Hong Kong, Department of Law.

Professor Pierre de Vos teaches constitutional law and international human rights at the law faculty at the University of Western Cape in South Africa. He holds degrees from Stellenbosch University, Columbia University and the University of Western Cape. He has published academic articles on a wide variety of topics including election law, the right to equality, same sex adoption and relationships, social and economic rights and legal philosophy. In 1994, he also published a novel, *Slegs Blanks/Whites Only* which was nominated for the CNA Literary Award.

As you can see our panel is uniquely qualified to help us at least begin to draw some conclusions on "International AIDS as a Case Study in the Challenges of Globalization."

## PUBLIC-PRIVATE PARTNERSHIPS FOR HEALTH: THE UNITED NATIONS GLOBAL FUND ON AIDS AND HEALTH

ALLYN L. TAYLOR\*

Today I will review some of the significant developments in global efforts to combat the AIDS pandemic during the last year, including the establishment of a new United Nations ("UN") Global Fund on AIDS and Health ("Global Fund"). Before I begin, I would like to express my appreciation to Professor Strauss for the opportunity to participate on this timely panel. I would also like to note that the views that I am presenting are my own and not necessarily those of the World Health Organization [WHO].

Despite the grim scenario of the AIDS pandemic, there have been critical developments in the last year that suggest that the global community has finally begun to recognize that universal access to prevention, treatment and care for HIV/AIDS is not only technically possible, but also a human rights imperative. A year ago AIDS drugs in Kenya and Ukraine cost the same as in the United States, around \$10,000 a year. Over the last year,

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however, there have been numerous and significant price drops for developing countries with one generic drug-maker now offering its triple-combination therapy for \$350 a year. Multinational pharmaceutical companies, responding to competition from generics and widespread public criticism, have slashed prices for poor nations, although—at a little over \$1,000 per year per person—still far out of reach for most poor states.

In addition, a year ago, many argued that unsophisticated patients in remote areas could not master a complex anti-retroviral regimen. Today, taking AIDS medicine is simpler and a number of small pilot clinics in poor countries have found a way to treat poor people successfully.

The global community has also, for the first time, put AIDS on the forefront of the international political agenda. The Declaration on the TRIPS Agreement [Agreement on Trade-Related Aspects of Intellectual Property Rights] and Public Health adopted at the World Trade Organization [WTO] Ministerial Summit in Doha on November 14, 2001, clarified and reaffirmed states' rights to declare national emergencies under the WTO TRIPS Agreement and institute compulsory licensing in the case of public health emergencies, including AIDS. In June 2001, the United Nations adopted a "Declaration of Commitment" on AIDS during a special three-day session of the UN General Assembly. Although lacking in teeth, the Declaration does set concrete targets and timelines at the national and international levels to fight AIDS.

Overall, this last year has marked an important shift in the global, technical, legal and political capacity to address the AIDS pandemic. Discussion about global prevention, treatment and care for those suffering from or affected by AIDS is no longer simply an academic debate. The critical challenge for 2002, therefore, is to enhance global financial capacity to provide comprehensive prevention, treatment and care services to fight AIDS. This struggle for money is no small feat and it is not simply about pills. The United Nations has estimated that seven to ten billion dollars is required annually to address the burden of AIDS in developing and middle income states.

The establishment of a well-endowed United National Global AIDS and Health Fund at the June 2001 Special UN AIDS Summit is, therefore, perhaps the most significant recent development in global AIDS policy. Although far short of the resources called for by the UN, the Global Fund will almost double the world's spending on AIDS this year as compared to last, with \$1.6 billion committed to the Global Fund thus far.

As reflected in the remarks of my colleagues on this panel today, academics and practitioners alike have high hopes that the Global Fund will be an effective mechanism to relieve the profound

impact of AIDS in developing states. However, little public information is available about the Global Fund and it has been subject to virtually no independent scrutiny, despite the fact that it is set to commence operations this month. Consequently, there are a number of outstanding questions regarding the potential and limitations of this new institution.

What we do know is that the Global Fund is a product of the personal vision of the UN Secretary-General Kofi Annan, who first proposed the creation of this new war chest last April as a vehicle whereby resources from public and private donors could be channeled quickly and effectively to address prevention, treatment and care of AIDS, malaria and tuberculosis in developing countries. The Global Fund is being designed to serve purely as a financial instrument, not an implementing agency. The Global Fund is intended to serve as a means for mobilizing, managing and disbursing new and additional resources. Trusteeship of the Global Fund has been entrusted to the World Bank, which manages numerous global funds, most notably in the environmental arena.

If utilized effectively, the Global Fund holds the promise of bringing anti-retroviral therapy as part of a package of comprehensive AIDS prevention, treatment and care services to poor people around the world. Indeed, the Global Fund could make major inroads against this disease by negotiating for the lowest possible prices for therapy on behalf of countries that are too small or poor to have clout with manufacturers. The Global Fund could also negotiate and pay for generic copies of drugs patented in rich countries to alleviate the suffering in poor countries.

However, as an effective instrument of health policy, the fund faces numerous external and internal obstacles. The external challenges, including the globalization of the AIDS pandemic, the continuing conflict between developed and developing countries on patented medicines and financial commitment are largely well known.

Less well appreciated are the internal challenges faced by the Global Fund. In design and operation, the Global Fund has been conceived as a unique hybrid of an increasingly popular institution known as a "global public-private partnerships." Although there are many definitions, global public-private partnerships are generally understood as involving some type of a collaborative relation between a corporation or industry organization and a public international organization that transcends national boundaries. Many of these partnerships also include other parties, including bilateral or civil society organizations.

The Global Fund has a distinct emphasis on public-private partnerships in both the organization of its management and its

operational policy. Indeed, the structure of the Global Fund is unprecedented. Although established by an intergovernmental organization, it is to be operated like a private foundation. The Global Fund has been created as an independent legal entity. In late January, the Permanent Board of the Global Fund, which is entrusted with making all financial commitments, will hold its first session. The Board will include an equal number of donor and developing countries, with seven seats each. In an exceptional move, the Board will also include two non-governmental organizations (NGOs) and two private sector voting seats. In addition, background information on the operation of the Global Fund specifically states that it will have an intense emphasis on public-private partnerships in targeting resources.

Although collaboration with the private sector on health matters was virtually unheard of a decade ago, in the last ten years public international organizations have entered into a remarkably diverse array of partnerships with the commercial sector; varying with regard to participants, legal status, governance, management, contributions and operational roles. A large variety of such partnerships have arisen to strengthen product development, product donation or distribution, and the general strengthening and coordination of health services. Donation/distribution ventures, such as for leprosy multi-drug therapy, are, perhaps, the most well known public-private partnerships in the health field. Contributions from pharmaceutical companies have also included involvement in supportive services to ensure appropriate distribution and effective use.

Other partnerships have focused on increased research and development of drugs and vaccines for diseases that disproportionately affect the poor. In the area of AIDS there have been a number of public-private partnerships aimed at strengthening health services and improving coordination, most notably the UNAIDS initiative, Accelerating Access to HIV Care, Support and Treatment, in partnership with five pharmaceutical companies.

There are about seventy public-private partnerships for health active today and there is clearly a wide spectrum of relationships embraced by the expression "public-private partnership" in the health context. However, to date, there has been little systematic evaluation of how these partnerships function and what constitutes good practice. Consequently, it is difficult to analyze the potential strengths and weaknesses of the Global Fund relative to other public-private partnerships for health.

In principle, the Global Fund's emphasis on public-private partnerships in resource allocation decisions at the country level



appears sound. Although a number of commentators have been highly critical of the idea of partnerships with the private sector in general, in international health it is widely recognized that intractable health problems require innovative collaborations of different sectors to achieve a synergistic combination of strengths, resources and expertise. Prevention, care and treatment of AIDS, as well as alleviating the impact of the epidemic, require large-scale multisectoral planning and coordination among diverse partners.

Public-private partnerships can also bring major resources into international public health efforts to combat AIDS at the country level and have the potential to benefit large populations. Health service delivery and other programs can clearly benefit if public sector agencies work in collaboration with the private sector in areas where the public sector lacks expertise and experience.

Notably, one of the first proposed projects being considered by the Global Fund provides a case in point for the potential benefits of collaboration with the private sector. The Transitional Working Group for the Global Fund has examined a proposal to provide anti-retrovirals to Africa's networks of hospitals, mission hospitals, health care centers and rural clinics. Clearly, corporations such as Coca-Cola, which sat on the Transitional Working Group for the Fund, may have better distribution networks throughout many poor countries than either the United Nations or national governments. Consequently, such a partnership between the private and public sectors may be able to administer drugs to people in need soon and without being hindered by complex governmental or intergovernmental bureaucracy.

However, cause for concern arises as to whether private industry is appropriately included on the Board of the Global Fund, which is charged with financial decision-making. Inclusion of corporations on the Board of the Global Fund gives private industry the exceptional right to participate in global public policy agenda setting, policy formulation and implementation.<sup>62</sup> It is

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62. The Board of the Global Fund will include an equal number of seats for donor and developing countries of seven seats each. The Board also includes two NGO and two private sector donor seats. WHO, UNAIDS and The World Bank will hold non-voting seats on the Board. In addition, the Board will include a person living with AIDS, tuberculosis or malaria in a non-voting seat. The decision making process includes an independent technical panel comprised of experts. These experts will review all proposals and make recommendations to the Board. Press Release, The Global Fund to Fight AIDS, Tuberculosis and Malaria, Planning Phase for Global Fund to Fight AIDS, TB and Malaria Concludes With Agreement on Basic Foundations (Dec. 17, 2001), at [http://www.globalfundatm.org/news\\_pr5.html](http://www.globalfundatm.org/news_pr5.html) (last visited Apr. 5, 2002). The Board will attempt to reach consensus in all cases. In the absence of consensus, the Board will utilize a voting procedure based on a two-thirds

certainly feasible that private sector efficiency and expertise could strengthen the planning targeting and implementation of the Global Fund as compared to the bureaucratic inefficiency of the United Nations and the specialized agencies. However, public health policymaking may not be an appropriate area of partnership.

As Buse and Waxman have noted, it must be kept in mind that ultimately the aims and values of public international organizations and corporations diverge.<sup>63</sup> The aim of the United Nations in general is to promote universal values of tolerance, freedom, justice, and equality found within the UN Charter. The core goal of the Global Fund is in particular to reduce infection, illness and death in countries in need. At the other end of the spectrum are the goals of private industry. The ultimate goal of a publicly held corporation is centered on maximizing profits to increase shareholder wealth.

Profit maximization may interfere with the goals of global public health in AIDS or in other contexts. Indeed, to return to the promise of the Global Fund described earlier, it is reasonable to question whether large industry participants on the Board would consider funding any projects involving the generic manufacture of patented drugs or which involve bulk purchase of anti-retrovirals to increase the market power of poor countries, even if consistent with the proscriptions of the WTO.

Ultimately, there may be a real concern that the goals of the United Nations in establishing the Global Fund could be subverted as policies, strategies and resource allocation decisions are either driven or subject to approval by industry. The structure of the Global Fund raises significant questions of global health governance. Traditional support for the United Nations could be undermined if this partnership erodes confidence in the credibility and impartiality of the Organization. As Buse and Walt have noted, the United Nations could be compromised if private sector collaboration undermines the goodwill of those states who believe in a multilateralism in which governments, not corporations, are

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majority from each of the two major groups represented on the Board. The two major groups on the Board are donors (including public and private sector participants) and developing countries (including NGOs). The Global Fund to Fight AIDS, Tuberculosis and Malaria, *Questions and Answers*, at [http://www.globalfundatm.org/questions\\_answers.html](http://www.globalfundatm.org/questions_answers.html) (last visited Apr. 5, 2002). As a consequence of the voting structure, private sector members of the Board do not have the voting power to block proposals supported by at least six of the donor countries. However, the potential significance of the voting power and the political influence of the private sector on the Board cannot be dismissed.

63. KENT BUSE & AMALIA WAXMAN, 79 BULL. OF THE WHO 748, PUBLIC-PRIVATE HEALTH PARTNERSHIPS: A STRATEGY FOR WHO 750 (No. 8, 2001), available at <http://www.who.int/bulletin/pdf.PDF> (last visited Apr. 5, 2002).

the decision-makers.<sup>64</sup>

The parameters of any public-private partnership should be situated within the context of the appropriate role of public international organizations. The inclusion of private industry on the Board of the Global Fund raises the question of whether the traditional distinction between the public and the private sector's aims and responsibilities have become or may become distorted. The goal of this presentation is not to answer this question, but to stimulate critical thought about the Global Fund as it commences its operations.

## HIV/AIDS IN SOUTH AFRICA: THE GOOD, THE BAD AND THE UGLY

PIERRE DE VOS\*

### INTRODUCTION

I want to start by thanking the sections for inviting me to this conference. It is a bit weird to be in the Versailles Room with all these opulent and expensive chandeliers speaking about HIV/AIDS in South Africa, but one must do what one must do. In my talk, I will try to highlight both the positive and the negative aspects of the [South African] government's reaction to the AIDS pandemic in the country. I will also try to show how the international human rights discourse might be used in conjunction with domestic constitutional law in South Africa to advance the cause of the prevention of HIV and the protection and treatment of people living with HIV/AIDS.

### I. CONSTITUTIONAL AND LEGAL PROTECTION FOR PEOPLE LIVING WITH HIV/AIDS

The good news is that South Africa has one of the most progressive Constitutions in the world.<sup>65</sup> It contains an equality clause that guarantees equality before the law and the right to equal protection and benefit of the law and also prohibits "unfair" discrimination on any ground, including those listed explicitly in section 9(3), which are, amongst others, race, sex, gender, sexual

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64. K. BUSE & G. WALT, 78 BULL. OF THE WHO 699, PUBLIC-PRIVATE HEALTH PARTNERSHIPS: PART II - WHAT ARE THE HEALTH ISSUES FOR GLOBAL GOVERNANCE? (No. 5, 2000), *available at* <http://www.who.int/bulletin/pdf.PDF> (last visited Apr. 5, 2002).

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65. S. AFR. CONST. (Constitution Act 108, 1996).

orientation and disability.<sup>66</sup> Although HIV/AIDS status is not explicitly listed in section 9(3), the Constitutional Court recently held that HIV/AIDS status was indeed a ground on which a person could be unfairly discriminated against.<sup>67</sup>

In *Hoffmann v South African Airways*, the court found that unfair discrimination in terms of section 9(3) results where the impact of the discrimination is such that it impairs the human dignity of the person concerned.<sup>68</sup> People living with HIV/AIDS are a minority group, exposed to intense prejudice and thus subjected to systematic disadvantage and discrimination. The court continued:

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 stigmatization 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 the right to earn a living. For this reason, they enjoy special protection in our law.<sup>69</sup>

This decision means that people living with HIV/AIDS now

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66. Section 9 of the South African Constitution states:

- (1) Everyone is equal before the law and has the right to protection and benefit of the law.
- (2) Equality includes the full and equal enjoyment of all rights and freedoms. To promote the achievement of equality, legislative and other measures designed to protect or advance persons, or categories of persons, disadvantaged by unfair discrimination may be taken.
- (3) The state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth.
- (4) No person may unfairly discriminate directly or indirectly against anyone on one or more grounds in terms of subsection (3). National legislation must be enacted to prevent or prohibit unfair discrimination.
- (5) Discrimination on one or more of the grounds listed in subsection (3) is unfair unless it is established that the discrimination is fair.

*Id.* ch. 2, § 9.

67. See Pierre de Vos, *Equality for All? A Critical Analysis of Equality Jurisprudence of the Constitutional Court*, 63 TYDSKRIF VIR HEDENDAAGSE ROMEINS-HOLANDSE REG. 62, No. 1 (2000) (explaining the South African Constitutional Court's equality jurisprudence).

68. *Hoffman v. S. African Airways*, 2000 (11) BCLR 1211, ¶ 28 (CC), available at <http://www.concourt.gov.za/judgments/2000/saa.pdf> (last visited Apr. 5, 2002).

69. *Id.*

have almost exactly the same constitutional protection against unfair discrimination as people who fear discrimination based on race, sex or gender.<sup>70</sup> People living with HIV/AIDS in South Africa are not only protected by the Constitution, which, after all, is difficult and expensive way of protecting one's rights.

The decision of the court was foreshadowed by several provisions in other legislation adopted since the advent of the South African Constitution explicitly protecting people living with HIV/AIDS from exploitation and discrimination. For example, labor legislation, which came into effect in 1999, explicitly mentions HIV status as a ground on which an employer may not discriminate when hiring, promoting or firing an employee.<sup>71</sup> The same act also prohibits the testing of an employee for HIV status unless the Labour Court, in strictly defined circumstances, determines that such testing is justifiable.<sup>72</sup> The National Department of Education has also issued a national policy on HIV/AIDS, which, amongst other things, prohibits unfair discrimination against learners, students and educators with HIV/AIDS,<sup>73</sup> while the National Department of Health has issued a national policy on testing for HIV.<sup>74</sup> Furthermore, the Medical Schemes Act obliges all medical schemes to provide at least a minimum cover for HIV positive persons.<sup>75</sup>

It is therefore clear that a strong legal framework exists to protect people living with HIV/AIDS from discrimination and exploitation. This protection extends beyond the protection against discrimination by state institutions, and also covers many

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70. de Vos, *supra* note 67, at 7. See also Harksen v. Lane, 1997 (11) BCLR 1489, ¶ 47 (CC), available at 1997 SACLX Lexis 20, at \*61 (stating that "in the case of discrimination on an unspecified ground, the unfairness must still be established before it can be found that a breach . . . has occurred."). People living with HIV/AIDS now have nearly the same constitutional protections against discrimination as that based on race or gender because a person living with HIV would have to carry the burden of proof to show that the discrimination against him or her was indeed fair, while a person who alleges discrimination on one of the grounds explicitly listed in section 9(3) will only have to show that a distinction was made on one of those listed grounds and it will then be assumed to constitute unfair discrimination.

71. § 6 (1) of Employment Equity Act 55 of 1998, available at <http://www.parliament.gov.za/acts/1998/act55-98.htm> (last visited Mar. 23, 2002).

72. *Id.* §§ 7(2), 50(4).

73. § 3(4) of National Education Policy Act 27 of 1996, available at <http://www.parliament.gov.za/acts/1996/act96.027> (last visited Mar. 23, 2002).

74. See Schedule of National Policy for Health Act 116 of 1990, available at <http://196.36.153.56/doh/docs/notices/1999/not99-1479.html> (last visited Mar. 23, 2002) (stating that the national policy on HIV testing is to balance informed consent with privacy).

75. § 29(1)(n) of Medical Schemes Act 131 of 1998, available at <http://www.polity.org.za.govdocs/legislation/1998/act98-131.html> (last visited Mar. 23, 2002).

instances of “private” or “semi-private” forms of discrimination. In this sense, South Africa’s approach to the HIV/AIDS pandemic can be viewed as commendable. Unfortunately, other aspects of the current government’s program are not nearly as laudable.

## II. PREVENTION OF HIV TRANSMISSION

The government has admitted that an extensive, culturally relevant and well-balanced HIV transmission prevention program would require the state to take several steps to limit the risk of HIV infection. Such steps would include steps to educate the population about the need to use condoms during sexual intercourse and to go for early treatment of other sexually transmitted diseases. It would also include medical interventions such as provision of anti-retroviral drugs to individuals after exposure to the HIV virus due to medical accidents or rape and sexual assault, and strategies to reduce the transmission of HIV from HIV positive mothers to their children through anti-retroviral programs.<sup>76</sup> While the government’s HIV/AIDS educational programs are quite comprehensive and generally viewed to be relatively effective, its approach to medical interventions to prevent HIV transmission seems less than logical.

The good news is that where healthcare workers in public health facilities are exposed to HIV in the course of their duties, and are therefore at risk in becoming HIV positive, the Department of Health will provide free access to anti-retroviral drugs. Although the risk is relatively low, the Department of Health has laid down clear guidelines to deal with this risk.<sup>77</sup> According to these guidelines, the most effective way to deal with such high-risk exposure is to administer a combination of anti-retroviral drugs within one or two hours after exposure.<sup>78</sup> To avoid delays in starting this treatment, the guidelines recommend that

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76. See SOUTH AFRICAN DEPARTMENT OF HEALTH, THE SOUTH AFRICAN GOVERNMENT’S RESPONSE TO THE HIV/AIDS EPIDEMIC; CONTROVERSIES AND PRIORITIES, §§ 1.1-1.3, available at <http://196.36.153.56/doh/aids/docs/gov-aids.html> (last visited Mar. 23, 2002) (identifying necessary guidelines in response to the South African HIV epidemic and other communicable diseases) [hereinafter THE SOUTH AFRICAN GOVERNMENT’S RESPONSE TO THE HIV/AIDS EPIDEMIC].

77. See SOUTH AFRICAN DEPARTMENT OF HEALTH, MANAGEMENT OF OCCUPATIONAL EXPOSURE TO THE HUMAN IMMUNODEFICIENCY VIRUS (HIV) (1999), ¶ 1.5, available at <http://www.doh.gov.za/aids/docs/management.html> (last visited Mar. 23, 2002) (identifying the “average risk of HIV infection from all types of reported percutaneous exposure” as approximately 0.3%).

78. *Id.* ¶ 3.4. The guidelines prescribe Zidovudine (AZT) administered in combination with Lamivudine (3TC). *Id.* at app. 1. It is recommended that Indinavir be added for very high-risk exposures, for example where high volumes of blood is involved or where a deep injury has occurred and if the source patient has been on Zidovudine for longer than six months. *Id.* ¶ 3.3, app. 1.

starter packs of the relevant drugs be made available in all healthcare settings. It is also recommended that the treatment should be continued for up to four weeks. Supportive counseling should also be made available to the exposed health care worker.<sup>79</sup>

The bad news is that this policy is not extended to individuals who are raped or otherwise sexually assaulted and who may have been exposed to HIV infection. Although it has been shown that the administering of anti-retroviral drugs immediately after the exposure and follow up treatment for two to six weeks after the assault may reduce the possibility of HIV transmission to the survivor of the rape or sexual assault, it appears that the official state policy prohibits the provision of anti-retroviral drugs in state hospitals to the survivors of sexual assault.<sup>80</sup> In at least one of the nine provinces, Mpumalanga, the member of the Executive Council ("MEC") for health has gone further by evicting a volunteer NGO [non-governmental organization] from the state hospital premises for providing anti-retroviral drugs such as AZT and 3TC to survivors of rape and sexual assault.<sup>81</sup>

The state has also refused to provide access to anti-retroviral drugs to all HIV positive pregnant mothers at birth to reduce the mother-to-child transmission of HIV. This is extremely perplexing given the fact that mother-to-child (MTC) transmission of HIV is the primary source of HIV infection in young children in South Africa. Over ninety percent of HIV infections in children are caused by transmission from mother to child.<sup>82</sup> In the absence of

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79. *Id.* ¶ 3.11.

80. See Mbulelo Baloyi, 'Sorry, No Drugs Here . . .', Independent Online, at [http://www.iol.co.za/general/news/newsprint.php?art\\_id=ct20011207202014981A6161856](http://www.iol.co.za/general/news/newsprint.php?art_id=ct20011207202014981A6161856) (last visited Mar. 19, 2002) (describing how a South African rape crisis center denied a young South African woman anti-retroviral drugs because the government prohibited such); Liz Clarke, *Ethical War Looms after Rape-Baby AZT Row*, Independent Online, at [http://www.iol.co.za/general/news/newsprint.php?art\\_id=ct2002011119551894P430282](http://www.iol.co.za/general/news/newsprint.php?art_id=ct2002011119551894P430282) (last visited Mar. 19, 2002) (describing the Northern Cape Health MEC's criticism of local physicians who gave a nine-month old baby anti-retrovirals after nine men gang-raped and sodomized her).

81. See Sizwe samaYende, *Health MEC Evicts Anti-Rape Activists*, Independent Online, at [http://www.iol.co.za/general/news/newsprint.php?art\\_id=ct20010512174013225R136168](http://www.iol.co.za/general/news/newsprint.php?art_id=ct20010512174013225R136168) (last visited Mar. 19, 2002) (quoting a South African MEC health official's "persecution" of rape crisis volunteers because they poison "black patients" and make "President Thabo Mbeki look like a fool"). The MEC also argued that the NGO, Greater Nelspruit Rape Intervention Project undermined the African National Congress and put her department in an awkward position because rape survivors elsewhere in their province also demanded anti-retroviral drugs. *Id.*

82. SOUTH AFRICAN DEPARTMENT OF HEALTH, PREVENTION OF MOTHER-TO-CHILD HIV TRANSMISSION AND MANAGEMENT OF HIV POSITIVE PREGNANT WOMEN, ¶ 3, available at <http://196.36.153.56/doh/aids/docs/mtct.html> (last visited Mar. 19, 2002). The transmission of HIV takes place during

breastfeeding, about two-thirds of infections occur around the time of delivery, with the majority of the remaining infections occurring during the last two months of pregnancy. But in populations where breastfeeding is the norm, it accounts for more than one-third of all transmission.<sup>83</sup>

It is common cause that the number of infants infected with HIV can be significantly reduced if certain steps are taken, most notably, by the provision of anti-retroviral therapy to a pregnant mother during childbirth and to the infant shortly after birth.<sup>84</sup> Although research has shown that some of these regimes are more effective than others, the most pertinent program for South African use is associated with the drug marketed under the name Nevirapine by the pharmaceutical company Boehringer Ingelheim.<sup>85</sup>

Nevirapine has been registered by the Medicines Control Council (MCC) of South Africa for use to reduce the risk of MTC of HIV intrapartum, that is, in the mother's womb before delivery. Moreover, there is ample evidence that the drug could have some success even without administering it in courses over weeks or even months. According to the MCC, administering a single dose of 200 milligrams to the mother during labor, preferably more than two hours before delivery and a single dose of two milligrams to the infant within forty-eight to seventy-two hours after birth

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pregnancy, labor, delivery, or even after childbirth during breastfeeding, but the vast majority of infections occur close to, or during, delivery and after childbirth because of breastfeeding.

83. *Id.* ¶ 4.4(a). Other factors, although less important, also increase the risk of mother-to-child HIV transmission, including the mother's immune status, viral load, vitamin A deficiency, placenta infections, and method of child delivery. *Id.* ¶ 4. In addition, behavioral risk factors during pregnancy include cigarette smoking, drug use and unprotected intercourse. *Id.*

84. See Edward M. Connor *et al.*, *Reduction of Maternal-Infant Transmission of Human Immunodeficiency Virus Type 1 with Zidovudine Treatment*, 331 *NEW. ENG. J. MED.* 1173, No. 18 (Nov. 3, 1994) (stating that "15 to 40 percent of infants born to infected mothers become infected in utero, during labor and delivery, or by breast feeding"); Mary Lou Lindegren, M.D. *et al.*, *Trends in Perinatal Transmission of HIV/AIDS in the United States*, 282 *J. AM. MED. ASS'N* 531, No. 6 (Aug. 11, 1999) (delineating statistical results that suggest "substantial declines in AIDS incidence were temporally associated with an increase in zidovudine use"); Laura A. Guay *et al.*, *Intrapartum and Neonatal Single-Dose Nevirapine Compared with Zidovudine for Prevention of Mother-to-Child Transmission of HIV-1 in Kampala, Uganda: HIVNET 012 Randomised Trial*, 354 *LANCET* 795 (Sept. 4, 1999) (providing controlled study results of HIV-1 infant transmission frequency during labor and the first week of life after Zidovudine and Nevirapine protocol).

85. *State Now Says No Problem to AIDS Drug*, allAfrica.com (Aug. 21, 2001), available at <http://allafrica.com/stories/200108210131.html> (last visited Mar. 21, 2002). This is so, because the manufacturers of Nevirapine offered to make the drug available to the South African government free of charge for a period of five years for the purpose of reducing the risk of mother to child transmission of HIV.



will have a marked effect on the rate of transmission from mother to child.<sup>86</sup>

Given these facts, the failure of the state to provide those HIV positive pregnant mothers who cannot afford private health care with access to Nevirapine at birth, seems inexplicable. The policy guidelines drawn up by the Department of Health and published in May 2000 fails to refer at all to the provision of anti-retroviral drugs to pregnant mothers during pregnancy and at delivery of the baby and shortly after delivery to the baby. After a meeting conducted on August [12-13], 2000, the Minister of Health and the MECs of the nine provinces took a decision to expand the existing "research sites" on Nevirapine to eighteen – two in each province.<sup>87</sup> It has been estimated that this pilot project, once fully operational, would reach about ten percent of pregnant mothers in South Africa.<sup>88</sup> The reason for launching these pilot sites, according to the minister, was to assess the operational challenges inherent in the introduction of anti-retroviral regimen for the reduction of vertical transmission in rural settings as well as in urban settings in South Africa. It has not been launched to investigate the efficacy of Nevirapine as it has been acknowledged "there is sufficient evidence confirming the efficacy of various anti-retroviral drug regimens in reducing the transmission of HIV from mother-to-child."<sup>89</sup> The Department of Health has forbidden doctors from prescribing Nevirapine to HIV positive pregnant mothers outside of the eighteen pilot sites. Medical personnel contravening this policy have been disciplined or even dismissed.

In December 2001, the Transvaal Provincial Division of the High Court declared the state's current policies, actions and omissions regarding the prevention of mother-to-child transmission of HIV to be in contravention of its duties in terms of section 27 of the Constitution.<sup>90</sup> In essence, the complaint in this

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86. Treatment Action Campaign v. Minister of Health, Founding Aff. ¶¶ 68-69 (Aug. 2001), available at <http://www.tac.org.za/> (last visited Mar. 19, 2002).

87. THE SOUTH AFRICAN GOVERNMENT'S RESPONSE TO THE HIV/AIDS EPIDEMIC, *supra* note 76, ¶ 1.3, available at <http://196.36.153.56/doh/aids/docs/gov-aids.html>; Charlene Smith, *Hospitals Participating in the Programme*, SANGONET (Jan. 26, 2001), at <http://www.sn.apc.org/wmail/issues/010126/OTHER39.html> (last visited Mar. 19, 2002); Charlene Smith, *Free Treatment for HIV+ Mums*, SANGONET (Jan. 26, 2001), at <http://www.sn.apc.org/wmail/issues/010126/OTHER38.html> (last visited Mar. 19, 2002).

88. Persons are increasingly being reached because provinces such as Guateng and Western Cape are now pilot sites for Nevirapine use. Smith, *Hospitals Participating in the Programme*, *supra* note 87.

89. SOUTH AFRICAN DEPARTMENT OF HEALTH, PROTOCOL FOR PROVIDING A COMPREHENSIVE PACKAGE OF CARE FOR THE PREVENTION OF MOTHER TO CHILD TRANSMISSION OF HIV IN SOUTH AFRICA, at (Q) (on file with author); *State Now Says No Problem to AIDS Drug*, *supra* note 85.

90. See *Treatment Action Campaign v. Minister of Health*, No. 21182/2001,

case was that the government continues to fail to “put in place a policy and to implement a programme that will in due course result in an integrated programme on a comprehensive basis, despite repeated undertakings to that effect.”<sup>91</sup> The government had already agreed in 1997 that pilot studies had to be done and that the end result should be to provide voluntary counseling and testing and anti-retroviral drugs to HIV positive pregnant women. But towards the end of 2001 the government had not yet budgeted or implemented any plans for voluntary counseling and testing, nor to provide the adequate information.<sup>92</sup> In fact, on October 9, 1998, the government withdrew its support for a pilot project to be launched in the province of Gauteng at five sites. Reasons were given as cost, toxicity and the non-registration of Nevirapine. The government policy also entailed a prohibition on all doctors in the public health sector outside of the eighteen pilot sites of prescribing Nevirapine to HIV positive pregnant mothers, even in cases where such drugs were available and affordable by the specific institution. The court found that the failure to act and the prohibition on all doctors on prescribing Nevirapine in public health facilities constituted an infringement on section 27 of the Constitution.

The state is currently attempting to appeal this judgment while the provinces of KwaZulu/Natal and Gauteng have announced that they will be extending the existing pilot programs.<sup>93</sup> At this time, however, it is clear that despite the pilot program, the Department of Health has no comprehensive, clearly defined, written down plan of action to ensure that in the shortest available time the treatment is made available to as many HIV positive pregnant women as possible. Although the Department

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at 60-61 (S. Afr. Transvaal Provincial Div. Dec. 2001) (holding that a health program “that leaves everything for the future” violates section 27(2) of South Africa’s Constitution because such program fails to provide “the right to health care”). Section 27 of South Africa’s Constitution states:

- (1) Everyone has the right of access to health care services, including reproductive health care; . . .
- (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.

S. AFR. CONST. (Constitution Act 108, 1996), ch. II (Bill of Rights), ¶ 27.

91. *Treatment Action Campaign, Founding Aff.*, ¶ 179 (Aug. 21, 2001), available at <http://www.tac.org.za/Documents/MTCTCourtCase/ccmfound.rtf> (last visited Apr. 5, 2002).

92. *Id.* ¶ 190.

93. *KZN HIV+ Moms to Receive Nevirapine*, iafrica.com (Jan. 22, 2002), at [http://www.iafrica.com/news/specialreport/aids\\_focus/881286.htm](http://www.iafrica.com/news/specialreport/aids_focus/881286.htm) (last visited Mar. 21, 2002).

seems to be slowly moving towards a position where they will expand the provision of Nevirapine to HIV positive pregnant mothers, there is no comprehensive plan in place to ensure that this happens as fast as possible.<sup>94</sup>

### III. PROVIDING ACCESS TO TREATMENT FOR PEOPLE LIVING WITH HIV/AIDS

While the Department of Health has prohibited state medical institutions from providing access to anti-retroviral drugs to people living with HIV/AIDS, it has instituted a policy in which they have agreed that in state hospitals people should be treated if they get opportunistic infections due to HIV infection.<sup>95</sup> In South Africa, as in many other developing countries, there is a big divide between those people who have access to private health care facilities and those who only have access to health care via the public health system. The public healthcare system, while relatively good compared to most developing countries, does not provide universal access, especially people living in rural areas that often do not have resources to reach hospitals in towns and cities. In such rural areas there are often no hospitals nearby and people live up to 200 or 300 kilometers away from a hospital. Where hospitals exist, there are not always the necessary drugs

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94. There seems to be a general reluctance on the part of government officials in the Department of Health to commit any plans to paper or to make public announcements about any intended actions relating to the prevention and treatment of HIV. Interview with Dr. S. Kariem, National Health Committee Secretary, African National Congress, in Western Cape, South Africa (Nov. 16 2001). Although Dr. Kariem was reluctant to speculate on the reasons for this reluctance, the only reasonable conclusion to be drawn is that the irrational antagonism displayed by President Thabo Mbeki regarding the nature of HIV and AIDS and the need and effectiveness of anti-retroviral drugs has scared officials into silence. The result is that officials are unwilling to divulge such plans to the public, even where they are formulating plans for the further extension of the provision of Nevirapine to HIV positive pregnant mothers.

95. Individuals living with HIV often require access to treatment for opportunistic infections caused or exacerbated by their diminished immune systems. This means that they need access to other medicines designed to treat the symptoms associated with AIDS, including Acyclovir, Cotrimoxazole or Fluconazole. According to the Department of Health's policy guidelines issued in August 2000, it is government policy to treat such opportunistic infections and to admit such patients to state hospitals in serious cases. SOUTH AFRICAN DEPARTMENT OF HEALTH, RECOMMENDATIONS FOR THE PREVENTION AND TREATMENT OF OPPORTUNISTIC AND HIV RELATED DISEASES IN ADULTS 12-13, available at <http://www.doh.gov.za/aids/docs/adult.html> (last visited Mar. 21, 2002). However, many individuals fail to gain access to such prescribed treatment for a variety of reasons. Individuals living with HIV/AIDS needing treatment in state medical institutions should have access to quality care. Care is often not available at many state hospitals due to a lack of trained staff, facilities and leadership.

available at such hospitals. Due to budget constraints, drugs run out and there are then not always additional funds to provide more drugs. Nevertheless, in principle, all HIV positive South Africans have access to care once they fall prey to opportunistic infections.

What people living with HIV/AIDS who cannot afford private health care have no access to is potentially life saving anti-retroviral drug therapy.<sup>96</sup> Even people with some access to the private health care facilities through medical aid and private funds can sometimes not afford to pay for these drugs because they are not covered by medical aid and because they are still too expensive.<sup>97</sup> At the moment, the government has no plans and has apparently not taken any action that would progressively make anti-retroviral therapy available to more and more HIV positive individuals in either the private or public health sectors.

One of the biggest stumbling blocks to providing more people with better access to appropriate treatment, other than lack of political will, remains high drug prices.<sup>98</sup> Moreover, the single biggest barrier to cheaper prices is the strict enforcement of patents.<sup>99</sup> Where patents are strictly enforced, drug companies are

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96. SOUTH AFRICAN DEPARTMENT OF HEALTH, HIV/AIDS/STD STRATEGIC PLAN FOR SOUTH AFRICA 2000-2005, ¶ 2.2, available at <http://www.doh.gov.za/aids/docs/aids-plan00-05.pdf> (last visited Mar. 21, 2002).

97. When these drugs were first introduced, the cost for South Africans who could afford it was around R4000 per month. The cost for such treatments is presently between R600 and R1000 per month. Dianne Black, *Cost of Living with Aids: When Theory Gives Way to Experience*, MAIL & GUARDIAN (Aug. 3, 2001), at <http://www.sn.apc.org/wmail/issues/010803/OTHER71.html> (last visited Mar. 18, 2002).

98. For a discussion of additional barriers, see Richard P. Rozek & Nicola Tully, *The TRIPS Agreement and Access to Health Care*, 2 J. WORLD INTELL. PROP. 813 (1999). The authors argue that “[i]n many instances, the prices of pharmaceuticals are not the cause of access problems. If the patient does not have access to a physician, or lacks accurate information, prices of pharmaceuticals are irrelevant.” *Id.* at 818. While the affordability of drugs is clearly not the only barrier to effective treatment, what remains clear is that for as long as drugs remain out of reach for most people with HIV/AIDS, governments have little incentive to put systems in place to deal with efficient distribution and strict compliance with often complicated drug-taking regimes. Further, for as long as drugs remain inaccessible, the debate about health system infrastructure remains purely academic. In addition, high drug prices are the only obstacle in the way of access to treatment for many people with HIV/AIDS in a country such as South Africa. One may also argue that any comprehensive and adequate program to progressively provide access to HIV/AIDS treatment and care programs will act as a catalyst to the development of health infrastructure. This is an important point, but cannot be discussed further in the limited space of this Article.

99. Brazil remains the clearest example of this point. See Tina Rosenberg, *Look at Brazil*, N.Y. TIMES, Jan. 28, 2001, § 6 at 26 (discussing the correlation between weaker patent protections and increased access to essential drugs).

free to charge prices they wish.<sup>100</sup> This, in turn, ensures that the prices of life-saving drugs, including anti-retroviral drugs, remain out of reach of most South Africans.

In 1997, the South African government took the first steps to begin to address this problem. By adopting the Medicines and Related Substances Control Amendment Act, amendments were made to the Medicines Act to allow for the introduction of three important measures that will bring down the prices of drugs [and] also anti-retroviral drugs.<sup>101</sup> Firstly, it allows for generic substitution of off-patent medicines and medicines imported and produced under compulsory licenses. This means that pharmacists are compelled by the Act to prescribe a cheaper generic version of a medicine, if one exists, when presented with a prescription by a patient.

Generic medicines are usually produced when the patent on a drug has lapsed and generic substitution will therefore usually not apply to patented drugs. As most anti-retroviral drugs are still protected by patent, this provision will not have any great effect on the cost of anti-retroviral drugs.<sup>102</sup> Secondly, the Act amends the

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The pharmaceutical industry argues that patents are not the problem with access to AIDS drugs in the developing world because the infrastructure is not available and circumstances are too chaotic to make drug delivery realistic. But this is a simplistic view, particularly in a country like South Africa where the required infrastructure does exist in many places.

100. Meaningful reductions in prices can be achieved even where patents are strictly enforced. For example, governments may seek agreements or obtain voluntary licenses from drug companies subject to a royalty payment for manufacturers to supply affordable medicines for the production, marketing and sale of generic alternatives.

101. § 22F of Medicines and Related Substances Control Amendment Act 101 of 1965, available at <http://www.gov.za/acts/1997/a90-97.pdf> (last visited Mar. 21, 2002).

102. *Id.*; Treatment Action Campaign, *An Explanation of the Medicines Act and the Implications of the Court Victory*, Q ONLINE, (Apr. 24 2001), available at <http://www.q.co.za/2001/2001/04/25-tacstatement.html> (last visited Mar. 19, 2002). While many key anti-retroviral drugs used in the fight against HIV/AIDS have had several years of patent protection, the patents are nearing expiration for Pfizer's Diflucan (Fluconazole) and Glaxo SmithKline's Retrovir (Zidovudine or AZT). According to the United States Food and Drug Administration's (FDA) Orange Book, Pfizer's United States patent on Diflucan expires on January 29, 2004. *Background Information on Fluconazole (Diflucan)*, Consumer Project on Technology, available at <http://www.cptech.org/ip/health/fluconazole/info.html> (last visited Mar. 19, 2002). Glaxo SmithKline's United States patent on Retrovir expires on September 17, 2005. *Background Information on Fourteen FDA Approved HIV/AIDS Drugs*, Consumer Project on Technology, available at <http://www.cptech.org/ip/health/aids/druginfo.html> (last visited Mar. 19, 2002). The online version of the FDA's Orange Book can be accessed at <http://www.fda.gov/cder/ob/> (last visited Mar. 23, 2002). Pfizer's South African patent on Diflucan is said to expire at the end of 2002. Letter from the Treatment Action Campaign, to William C. Steere, Chief Executive Officer, Pfizer, (June 20, 2000), available at

Medicines Control Act to allow for the parallel importation of patented medicines.<sup>103</sup> This allows the government to import patented Medicine from another country where it is sold at a lower price than in South Africa. Because pharmaceutical companies do not charge the same price for identical drugs in different countries, this section would allow the government to import drugs protected by patent from cheaper countries, like Indian and Brazil, than which the pharmaceutical company in South Africa would have provided it to them for. Thirdly, the amendments provides for a transparent medicine pricing system through the establishment of a pricing committee. This section requires pharmaceutical companies to justify the prices they charge and empower the pricing committee to make recommendations to the Minister of Health on the introduction of a transparent pricing system.<sup>104</sup>

All three of these provisions were challenged by thirty-nine pharmaceutical companies in the Transvaal Provincial Division of the High Court towards the end of 2000 in *The Pharmaceutical Manufacturers' Association v. The President of the Republic of South Africa*.<sup>105</sup> The pharmaceutical companies challenged the constitutionality of the three provisions of the Act set out above, *inter alia*, on the premise that it infringed on the right to property protected in section 25 of South Africa's Constitution. Under severe public pressure in South Africa and the rest of the world, the companies abandoned their case, and in effect agreed that the government had a right to implement the provisions set out above.<sup>106</sup>

At the time of writing, the government has not yet issued regulations to make these sections of the amendments operative and has therefore not been in a position to utilize this Act to import cheaper patented drugs from elsewhere or to regulate the pricing of drugs. Neither has [the government] taken any other tangible measures in any attempt to bring down the prices of anti-retroviral or other life-saving drugs. It has not shown any interest in issuing compulsory licenses to manufacture patented drugs to make use of the relaxation of the TRIPS [Trade Related Aspects of

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<http://www.tac.org.za/Documents/Other/pfifinlt.html> (last visited Mar. 23, 2002).

103. Medicines and Related Substances Control Amendment Act § 15C.

104. *Id.* § 22G.

105. *Pharmaceutical Mfr. Ass'n of S. Afr. v. President of the Republic of S. Afr.*, 1999 (4) SA 788 (S. Afr. Transvaal Provincial Div.).

106. *Id.* The "climb down" on the pharmaceutical companies was arguably a good tactical move because the amendments they challenged were not particularly threatening to their profits and interests, including the amendment that permitted the parallel importing of cheaper drugs. What pharmaceutical companies fear most is legislation that allows a state to issue compulsory licenses that permit manufacturers to make patented drugs. Rosenberg, *supra* note 36.

Intellectual Property Rights] agreement thrashed out at Doha, Qatar. The Ministerial meeting in Qatar decisively confirmed that countries have a right to make exceptions to the TRIPS agreement, including the issuing of compulsory licenses, if a national emergency exists. A national emergency includes a public health crisis, such as the one related to HIV/AIDS.<sup>107</sup> Despite this, the South African government has given no indication that they would exploit this gap provided to them.

#### IV. THE CONSTITUTION, THE RIGHT OF ACCESS TO HEALTH CARE AND HIV/AIDS TREATMENT IN SOUTH AFRICA

In order to get the government to change the way it is dealing with HIV/AIDS in South Africa, civil society, especially the Treatment Action Campaign, has been following a two-pronged strategy. On the one hand, they have been mobilizing international support as well as political support inside South Africa in order to put pressure on the government to take action on the prevention and treatment of HIV/AIDS. On the other, it has turned to the courts and has been using the provisions of the Constitution, especially those relating to the right of access to health care services, to embarrass the government into action. Why the Constitution? The right of access to healthcare services protected in section 27 of the Constitution is clearly justiciable.<sup>108</sup>

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107. See Agreement on Trade-Related Aspects of Intellectual Property Rights, Apr. 15, 1994, Marrakesh Agreement Establishing the World Trade Organization, Annex 1C, art. 31, 33 I.L.M. 81 (1994) [hereinafter TRIPS Agreement]; Ministerial Conference, *Declaration on the TRIPS Agreement and Public Health*, WT/MIN(01)DEC/2, 4th Sess., WTO Doc. No. 01-5860 (Nov. 20, 2001) [hereinafter TRIPS Declaration] (reading the TRIPS Agreement and TRIPS Declaration together means that a nation may grant compulsory licenses for the current HIV/AIDS crisis). The TRIPS Declaration states that:

Each Member has the right to grant compulsory licenses and the freedom to determine the grounds upon which such licenses are granted.

Each Member has the right to determine what constitutes a national emergency or other circumstances of extreme urgency, it being understood that public health crises, including those related to HIV/AIDS, tuberculosis, malaria and other epidemics, can represent a national emergency. Or other circumstances of extreme urgency.

The effect of the provisions in the TRIPS Agreement that are relevant to the exhaustion of intellectual property rights is to leave each Member free to establish its own regime for such exhaustion without challenge, subject to the MFN and national treatment provisions of Articles 3 and 4.

TRIPS Declaration, *supra*, at art. 5.

108. *In re Certification of the Constitution of the Republic of S. Afr.*, 1996 (4)

The question is how this right may be enforced in a given case. In a recent case, *Grootboom v President of the Republic of South Africa*, the Constitutional Court spelled out how these rights, including the right of access to health care services protected in section 27 of the Constitution, can be enforced.<sup>109</sup> It agreed that these rights engender both the negative and positive obligations for the state and other relevant role players.<sup>110</sup> In doing so, it made extensive use of the work of the United Nations Committee on Economic, Social and Cultural Rights, especially its General Comments issued by the Committee.<sup>111</sup>

The court stated that, on a negative level, section 27 places negative obligations on the state and other relevant role players to desist from preventing or impairing the right of access to health care services.<sup>112</sup> Any action by the state that would take away existing access to health care services or would make it more difficult for an individual to gain access to existing health care services would thus potentially result in an infringement of this right. In the context of the provision of providing access to anti-retroviral drugs for all people exposed to HIV or people living with

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SA 744, 800 (CC).

109. *South Africa v. Grootboom*, 2000 (11) BCLR 1169 (CC), available at 2000 SACLX Lexis 6. See also Pierre de Vos, *Pious Wishes or Directly Enforceable Human Rights?: Social and Economic Rights in South Africa's 1996 Constitution*, 1997 S. AFR. J. HUM. RTS. 67, 73 (discussing a general exposition on the duties engendered by social and economic rights in South Africa) [hereinafter de Vos, *Pious Wishes*].

110. *Id.* at 79, 83. According to section 8(2) of the South African Bill of Rights, certain circumstances may bind natural and juristic persons. S. AFR. CONST. (Constitution Act 108, 1996), ch. II (Bill of Rights), ¶ 8(2). Stephen Ellmann has argued that section 27(1) of the South African Constitution's Bill of Rights may bind pharmaceutical companies in the context of the South African HIV/AIDS crisis. Stephen Ellmann, *Post-Apartheid Constitutions: Perspectives on South Africa's Basic Law* 444-480 (Witwatersrand Univ. Press et al eds., 2001). This is because most South Africans are denied access (in the negative sense) to anti-retroviral drugs. The pharmaceutical companies' actions could be unconstitutional if their "legitimate interests" do not justify their continuous denial of access to anti-retroviral drugs. *Id.* at 461. Refusing to reduce the cost of anti-retroviral drugs could be unconstitutional if it is feasible for pharmaceutical companies to lower their prices without compromising their financial stability. *Id.* However, it is beyond this Article's scope to explore the duties of private institutions and individuals to provide access to healthcare services. See, e.g., de Vos, *Pious Wishes*, *supra* note 46, at 80 (discussing at length the South African Constitution's guarantee that "every person [has] the right . . . to housing, health care, sufficient food and water, social security and the right to basic education . . .").

111. See U.N. ESCOR, 5th Sess., Supp. 3, Nov.-Dec. 1990, U.N. Doc. E/1991/23 (1990) (discussing the general nature and scope of the state parties obligation in terms of a 2(1) of the Covenant on Economic, Social and Cultural Rights).

112. *In re Certification of the Constitution of the Republic of S. Afr.*, at 800 (CC); *Grootboom*, 2000 (11) BCLR, ¶ 34.



HIV/AIDS, any action of the state to, say, prohibit doctors in either the public or private health sector from dispensing a specific anti-retroviral drug would constitute a *prima facie* infringement of the right.<sup>113</sup>

On a positive level, this meant that section 27 of the Constitution also places a positive obligation on the state and other relevant actors to “protect, promote and fulfill” the right of access to healthcare.<sup>114</sup> At the very least, this means that the state must take steps, including the enactment of legislation, to ensure that individuals can acquire access to health care without interference from private actors and institutions. It furthermore means that the state has a duty to devise and implement, progressively and within its available resources, a comprehensive plan to ensure the full realization of the right of access to health care for all. This plan cannot merely be aimed at providing individuals with basic medicine, primary healthcare services and with access to hospital care.<sup>115</sup>

What is required is a holistic approach aimed at providing all South Africans with access to adequate, comprehensive health care that will enable an individual to live a healthier and more productive life.<sup>116</sup> This means that the state has a duty to foster conditions to enable citizens to gain access to health care services on an equitable basis.<sup>117</sup> What is required is for the state “to devise a comprehensive and workable plan to meet its obligations” in terms of section 27.<sup>118</sup> Implicit in this approach, is the understanding that the right of access to healthcare services does not entitle any applicant to individual relief because the state’s duty is not immediately to provide each and every South African with the best possible healthcare that money can buy, but to devise and implement a comprehensive plan that will achieve this goal over time.<sup>119</sup>

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113. Last year an NGO was evicted from a state hospital in Nelspruit because they provided voluntary counseling, testing and anti-retroviral drugs to rape survivors. Sizwe sama Yende, *supra* note 18. Pharmaceutical companies arguably act unconstitutionally when they deny individuals access to anti-retroviral drugs through their pricing policies. Smith, *Hospitals Participating in the Programme*, *supra* note 24.

114. S. AFR. CONST. (Constitution Act 108, 1996), ch. II (Bill of Rights), ¶ 7(2) (stating that the state “must respect, protect, promote and fulfill the rights in the Bill of Rights.”).

115. *Grootboom*, 2000 (11) BCLR, ¶ 35. (stating that the right of access to housing “requires more than brick and mortar”).

116. To achieve this in the context of HIV/AIDS, individuals would need primary health care services, information about HIV, voluntary testing and counseling facilities, anti-retroviral drugs, etc.

117. *Grootboom*, 2000 (11) BCLR, ¶ 93. (stating that a program was not reasonable if it “excluded a significant segment of society”).

118. *Id.* ¶ 38.

119. *Id.* ¶ 94-95.

When devising and implementing this plan, the state must take cognizance of the conditions and capabilities of people of all economic levels of our society.<sup>120</sup> Those who could afford to pay for health care should do so themselves, but where people have no money to pay, the state has a duty to take steps to unlock the system through legislation and other measures. What is required is that the state must address the needs of those who can afford healthcare and those who cannot. More importantly, the “poor are particularly vulnerable and their needs require special attention.”<sup>121</sup>

The crux of any inquiry about whether the state has met its obligations in terms of section 27(1) will depend on what constitutes such appropriate steps. Steps will be appropriate if they meet three key elements set out in section 27(2), namely (a) whether they are reasonable legislative or other steps; (b) to achieve the “progressive realisation of the right;” (c) within available resources.<sup>122</sup>

The obligation on the state is therefore firstly to act reasonably in pursuit of realizing the goal of providing accessible and affordable health care services for people from all economic spheres. To judge the reasonability of the steps taken it must be determined whether there is a comprehensive policy, encompassing all three tiers of government, to progressively realize the right of access to healthcare.<sup>123</sup> Legislation in itself will not be sufficient. What is required is for the state to act in order to achieve the intended result according to comprehensive policies and programs that are reasonable both in their conception and implementation.<sup>124</sup>

To determine whether such measures are reasonable, it will be necessary to consider health care problems in its social, economic and historical context and to consider the capacity of institutions responsible for implementing the program. The program must be “balanced and flexible” and a program “that excludes a significant segment of society cannot be said to be reasonable.”<sup>125</sup> More pertinently, those whose needs are the most urgent and whose ability to enjoy all rights are most in peril, must not be ignored by the measures aimed at achieving the realization of the goal. Where measures, though statistically successful, fail to respond to those most desperate, they may not pass the test of reasonability.<sup>126</sup> This signals the inter-related and mutually

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120. *Id.* ¶ 35.

121. *Id.* ¶ 36.

122. *Grootboom*, 2000 (11) BCLR, ¶ 41.

123. *Id.*

124. *Id.* ¶ 42.

125. *Id.* ¶ 43.

126. *Id.* ¶ 44.

supporting nature of the right of access to health care services and the right to equality and the overarching goal of striving for 'real' equality and a respect for dignity. State action or inaction that fails to take into account the structural inequalities in society; action that fails to take into account the impact of that action or inaction on the relevant groups who are most vulnerable and in greater need of state assistance, such actions will inevitably become difficult to be judged to be reasonable. As is the case in equality jurisprudence, the impact of the acts or omissions must be judged with reference to the very specific context in which the complainants find themselves, including the calamity of the HIV/AIDS crisis that South Africa faces.

The second requirement of progressive realization signals that the right cannot be realized immediately. What is required is that the state takes steps immediately to progressively facilitate access to health care services. The state has a duty to move expeditiously and effectively towards that goal. Any deliberate retrogressive measures in that regard would also require the most careful consideration and would need to be fully justified by reference to the totality of the rights provided in the Bill of Rights.<sup>127</sup> It is imperative to understand that the requirement of progressive realization of rights does not mean the state can sit back and do nothing. It must take steps immediately, even if those steps will not provide every South African with immediate access to adequate, humane and effective health care.

To determine whether the state's action or inaction is reasonable, one has to take into account the resources available to actually realize the right in question. There always has to be a balance between goal and means. The measures have to be calculated to attain a goal expeditiously and effectively but the availability of resources would always be an important factor in determining what was reasonable in a particular case.<sup>128</sup> Where resources are clearly insufficient to attain any meaningful access to certain forms of health care, a lack of action on the part of the state may be found to be more reasonable than in cases where the resource constraints are less severe. When considering resource constraints, it may be kept in mind that resources here refer to both the resources within the state and those available from the international community through international cooperation and assistance. In the HIV/AIDS arena this would include any assistance provided by the new global fund to combat HIV/AIDS or other international assistance.<sup>129</sup>

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127. *Grootboom*, 2000 (11) BCLR, ¶ 45.

128. *Id.* ¶ 46.

129. MICHAEL FLESHMAN, AFRICA RECOVERY, DRUG PRICE PLUNGE ENERGIZES AIDS FIGHT (U.N. Dep't of Pub. Info. vol. 15, no. 1-2 2001), available at

## V. CONCLUSION

The state's inexplicable inertia in expanding access to treatment and care for people living with HIV/AIDS is a major stumbling block in the way of a realistic and humane HIV/AIDS policy for South Africa. The only way to effectively challenge this inaction is probably through a combination of political mobilization and legal action. Regarding the latter, the constitutional provisions guaranteeing access to healthcare services could play a major role in challenging the policies of the government where they seem completely unreasonable or even irrational. While NGOs like the Treatment Action Campaign have had some success in this regard, there is still a very long way to go.

## AIDS AND INTERNATIONAL HUMAN RIGHTS LAW

MARK E. WOJCIK\*

Twenty years have passed since the U.S. Centers reported the first clinical reports of AIDS for Disease Control. The disease has touched every corner of the globe—it is our first global epidemic, a true pandemic. Since 1981, more than sixty million people have been infected with HIV. Twenty million of these persons have died, three million in the last year alone. This is an average of 8,200 deaths a day. Of the three million persons who died in 2001, an estimated 580,000 deaths were of children under the age of fifteen—almost 1,600 deaths of children every day. Africa has been hardest hit. An estimated 2.3 million Africans died of causes related to AIDS in 2001.<sup>130</sup> In many African countries, people are dying at a younger age than they did ten years ago.<sup>131</sup>

The reality of these deaths is often lost on many in developed countries where advanced pharmaceuticals are (or should be) available to prolong the lives of persons infected by HIV. For persons who have access to these “cocktail” drugs, HIV is a

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<http://www.un.org/ecosocdev/geninfo/afrec/vol15no1/15no1pdf/151aids1.pdf> (last visited Apr. 16, 2002). Fleshman reports that the Bill and Melinda Gates Foundation and the drug company Merck fund the anti-retroviral program in Botswana.

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130. THE ECONOMIST, Dec. 22, 2001, at 6.

131. *Terrorism Is Not the Only Scourge – It Is Also Time to Declare War on Disease in Poor Countries*, THE ECONOMIST, Dec. 22, 2001, at 10.

manageable disease, or at least it is perceived as such by members of the public and the politicians they elect. Death and its consequences are forgotten in the new epidemic of complacency—one fueled by magazine advertisements that purport to show handsome men with HIV climbing mountains or laughing with friends. Other publications and cultural influences that appear to glorify unsafe sexual practices reveal that we have learned nothing from the deaths of our friends.

Most of the forty million persons living today with HIV face a very different reality from that depicted in the magazine advertisements. Most people simply lack access to the drugs advertised in the magazines, although lawsuits in places as widespread as Costa Rica, Israel, and South Africa attempt to challenge that lack of access.<sup>132</sup>

New infections continue unabated. In the year 2001, an estimated 3.4 million persons in Africa contracted HIV.<sup>133</sup> Around the world an estimated five million persons were newly infected with HIV. That is 13,000 to 14,000 new cases every day last year. Women accounted for 1.8 million of those cases—almost 5,000 cases every day last year. And children under the age of fifteen accounted for an estimated 800,000 cases—almost 2,200 new cases every day.<sup>134</sup>

The global response to this crisis is disappointing in many aspects. But there has been some progress. In June, the United Nations General Assembly held a Special Session on HIV during which it promulgated highly optimistic goals to control the further spread of HIV. That conference set a framework for national and international accountability to fight AIDS. Governments pledged to aggressively pursue the targets relating to HIV prevention and care and agreed on specific strategies that must be developed by the year 2003.

I believe that the specific goals are very ambitious. I would be thrilled if they could be achieved, even partially. I welcome any progress. But I am worried that many countries will fall short of these national and international goals. For example, United

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132. See, e.g., Ravi Nessman, *Court Rules that South Africa Must Start Providing Key AIDS Drug*, HONOLULU ADVERTISER, Apr. 5, 2002, at A18 (reporting a ruling from the Constitutional Court upholding an order that the government must make available to pregnant women with HIV the drug nevirapine, which may reduce by fifty percent the chance of transmitting HIV during labor).

133. *The World This Year*, THE ECONOMIST, Dec. 22, 2001, at 6.

134. Analysis and current figures are available at [www.unaids.org](http://www.unaids.org), the website of UNAIDS, the United Nations Programme Against AIDS. That website also contains useful links to policy statements and background materials for many of the international issues relating to the AIDS pandemic. See also, e.g., Mark E. Wojcik et al., *International Human Rights*, 35 INT'L LAW. 723, 725 (2001).

Nations Secretary General Kofi Anan called for the establishment of a new global fund of seven to ten billion dollars to prevent and treat AIDS, tuberculosis, and malaria.<sup>135</sup> By the end of 2001, however, the Global AIDS and Health Fund had received pledges amounting to only 1.7 billion dollars.<sup>136</sup> Economic recession in the United States and other nations make it unlikely that governments or private corporations can fill this funding gap, particularly as there is as yet no consensus that money targeted for this fund will be an effective use of those funds.<sup>137</sup>

I am worried that countries lack the political leadership to meet the targets. In our own country, the national AIDS czar has all but vanished from the public eye. And the goals of the United Nations Global AIDS Conference—agreed to before the tragedies of September 11, 2001—may be forgotten by the public and our public leaders in favor of other concerns about anthrax and airline safety.

I am also concerned about countries where progress on these goals does not seem possible at all. The President of South Africa continues to deny that HIV is a problem and that HIV is its cause. This does tremendous harm to efforts there to combat the illness. In other countries, discrimination against men who have sex with men makes it impossible to provide public health information to them. In Malaysia, a leading politician is appealing his sodomy conviction and nine-year jail sentence. In Egypt, men charged with moral crimes have been sentenced to long prison terms at hard labor. And in Saudi Arabia, men accused of having sex with other men were publicly beheaded by sword.<sup>138</sup>

Persons with HIV and persons at risk of HIV face an amazing array of prejudice and discrimination in education, employment, family law, travel and immigration, housing, medical services, and even access to funeral and burial services.<sup>139</sup> These acts of prejudice and discrimination should be seen for what they are—violations of human rights and of international human rights law. Some violations are more serious than others. But all of them fall within the framework of customary and conventional international human rights law. This is often forgotten where concerns about

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135. *The Health of Nations - Will a New Report Persuade Rich Countries to Spend Another \$27 Billion a Year on Other People's Health?*, THE ECONOMIST, Dec. 22, 2001, at 83, 84.

136. *Id.*

137. For its part, the United Nations is optimistic about enticing a wide range of donors to the Global AIDS and Health Fund. *See, e.g., Global AIDS Fund to Be Disbursed*, 38 U.N. CHRON. 77 (2001-2002).

138. *Saudis Execute 3 Men for Sodomy*, THE ADVOCATE [Baton Rouge, La.], Jan. 2, 2002, at 2A; Katie Szymanski, *U.S. Silent on Saudi Sodomy Execution*, BAY AREA REPORTER, Jan. 10, 2002, at 14.

139. *See, e.g., Mark E. Wojcik, Discrimination After Death*, 53 OKLA. L. REV. 389 (2000).

persons with HIV is viewed by an “us” versus “them” mentality—a balancing of rights rather than a recognition that legitimate concerns can be mutually accommodated to promote both human rights and public health.

The traditional human rights instruments, including for example, the Universal Declaration of Human Rights (UDHR),<sup>140</sup> the International Covenant on Civil and Political Rights (ICCPR),<sup>141</sup> and the International Covenant on Economic, Social,

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140. G.A. Res. 217, U.N. GAOR, 3rd Sess., U.N. Doc. A/810 (1948), *also reprinted in* BARRY E. CARTER & PHILLIP R. TRIMBLE, *INTERNATIONAL LAW: SELECTED DOCUMENTS* 381 (1995). Although the Universal Declaration on Human Rights is not a treaty, nations “have endowed it with great legitimacy through their actions, including its legal and political invocation at the national and international levels.” Jonathan M. Mann et. al., *Health and Human Rights in HEALTH AND HUMAN RIGHTS: A READER* 9 (Jonathan M. Mann et al., eds. 1999). The Declaration provides in article 1 that “[a]ll human beings are born free and equal in dignity and rights” and in article 2 that “[e]veryone is entitled to all the rights and freedoms set forth in this declaration, without discrimination of any kind, such as race, colour, sex, language, political or other opinion, national or social origin, property, birth or other status.” Language such as “everyone,” “without discrimination of any kind,” and “other status” makes the document broad enough to cover persons affected by HIV. Similarly broad language is found in article 3, which recognizes that “[e]veryone has the right to life, liberty and the security of the person,” and article 7, which provides in part that “[a]ll are equal before the law and entitled without any discrimination to equal protection of the law.” Article 12 recognizes a right of privacy, article 16 recognizes a right to marry, and article 23 recognizes a right to work. These protections are important to recall as nations from time to time have attempted to restrict the right of persons with HIV to marry or to work. Article 22 provides that “[e]veryone, as a member of society, has the right to social security and is entitled to realization, through national effort and international cooperation and in accordance with the organization and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality.” And article 25(1) recognizes that “[e]veryone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.” Many of these rights obviously apply to persons affected by HIV.

141. 999 U.N.T.S. 171 (1966), *also reprinted in* BARRY E. CARTER & PHILLIP R. TRIMBLE, *INTERNATIONAL LAW: SELECTED DOCUMENTS* 387 (1995). Among the protections that might apply to persons with HIV are the inherent right to life in article 6(1), freedom from inhuman or degrading treatment or punishment in article 7, the prohibition on non-consensual medical or scientific experimentation also found in article 7, the right to liberty and security of the person under article 9, and in article 10, the right for persons who are deprived of their liberty to “be treated with humanity and with respect for the inherent dignity of the human person.” Article 16 recognizes that “[e]veryone shall have the right to recognition everywhere as a person before the law”; and article 17 recognizes that “[e]veryone has the right to the protection of the law against . . . interference or attacks” on the individual’s right to privacy. The right to marry is recognized in article 23, and article 24

and Cultural Rights (ICESCR),<sup>142</sup> apply to persons affected by HIV. In these major human rights declarations and conventions the full spectrum of rights apply to all persons, including persons affected by HIV. Rights such as the right to life, the right to privacy, and the right of the individual to be treated with respect and dignity all apply to persons living with HIV. Other applicable international human rights instruments include the International Covenant on the Elimination of All Forms of Racial Discrimination (CERD),<sup>143</sup> the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW),<sup>144</sup> the Convention

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provides special recognition for the protection of children. The United States has ratified the ICCPR, albeit with a reservation that articles 1 through 27 are not self-executing and therefore cannot be independently used in domestic courts as a source of legal obligation. See 138 Cong. Rec. S4781 (1991), *also reprinted in* BARRY E. CARTER & PHILLIP R. TRIMBLE, *INTERNATIONAL LAW: SELECTED DOCUMENTS* 404 (1995).

142. 99 U.N.T.S. 3 (1966), *also reprinted in* BARRY E. CARTER & PHILLIP R. TRIMBLE, *INTERNATIONAL LAW: SELECTED DOCUMENTS* 410 (1995). The Covenant provides in article 2(2) that the rights it recognizes are to be exercised "without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, or other status." This language is broad and includes non-discrimination based on a person's HIV status. The rights recognized in the convention are the right to work in article 6(1), the right to safe and healthy working conditions in article 7(b), and the right to social security, including social insurance, in article 9. Article 10(2) and 10(3) recognizes that special protection should be given to mothers and to children and young persons. And Article 12(1) provides that parties to the convention "recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." Achievement of this right to health requires the parties to take steps necessary for "the prevention, treatment and control of epidemic, endemic, occupational and other diseases."

143. 660 U.N.T.S. 195 (1966), *reprinted in* BARRY E. CARTER & PHILLIP R. TRIMBLE, *INTERNATIONAL LAW: SELECTED DOCUMENTS* 423 (1995). Among its many protections, CERD recognizes in article 5 "[t]he right to housing" and "[t]he right to public health, medical care, social security and social services."

144. 1249 U.N.T.S. 13 (1979), *reprinted in* 19 I.L.M. 33 (1980), *also reprinted in* BARRY E. CARTER & PHILLIP R. TRIMBLE, *INTERNATIONAL LAW: SELECTED DOCUMENTS* 432 (1995). CEDAW is particularly important in the fight against AIDS because of the increased vulnerability of women. It contains a number of broad general protections, such as article 3 which requires states to "take in all fields . . . all appropriate measures . . . to ensure the full development and advancement of women, for the purpose of guaranteeing them the exercise and enjoyment of human rights and fundamental freedoms on a basis of equality with men." In addition to the broad general rights identified in the convention, article 10(h) of CEDAW identifies "[a]ccess to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning." Similarly, article 11(1)(f) identifies "[t]he right to protection of health" and article 12(1) requires states to "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." Article 14(2)(b) identifies the right of "access to



Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment,<sup>146</sup> and the Convention on the Rights of the Child<sup>146</sup> and its Protocol on Child Prostitution.<sup>147</sup> Many regional agreements and regional human rights instruments also relate to the discrimination faced by persons with HIV, including instruments such as the American Declaration on the Rights and Duties of Man,<sup>148</sup> the American Convention on Human Rights,<sup>149</sup>

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adequate health care facilities, including information, counseling and services in family planning.”

145. G.A. Res. 39/46, U.N. GAOR, 39th Sess., Supp. No. 15, at 197, U.N. Doc. No. A/RES/39/708 (1984), *reprinted in* 23 I.L.M. 1027 (1984), *as modified* 24 I.L.M. 535 (1985), *also reprinted in* BARRY E. CARTER & PHILLIP R. TRIMBLE, *INTERNATIONAL LAW: SELECTED DOCUMENTS* 444 (1995). Inclusion of the Torture Convention in a list of documents relating to the rights of persons with HIV may be surprising until one considers the Convention's definition of torture in article 1(1), which defines “torture” to include “any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as . . . punishing him for an act he or a third person has committed or is suspected of having committed, . . . or for any reason based on discrimination of any kind . . . .” The definition requires that the acts alleged must be “inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity.” *Id.* at art. 1(1). The definition of torture also excludes “pain or suffering arising only from, inherent in or incidental to lawful sanctions.” *Id.*

146. 28 I.L.M. 1448 (1989), *also reprinted in part in* BARRY E. CARTER & PHILLIP R. TRIMBLE, *INTERNATIONAL LAW: SELECTED DOCUMENTS* 455 (1995). The treaty has been ratified by every nation in the world except Somalia (which has no functioning central government) and the United States. It requires in Article 3(2) that nations “undertake to ensure the child such protection and care as is necessary for his or her well-being” and in Article 19(1) that nations “take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the case of parent(s), legal guardian(s) or any other person who has the care of the child . . . .”

147. Optional Protocol to the Convention on the Rights of the Child on the Sale of Children, Child Prostitution and Child Pornography, G.A. Res. 54/263, U.N. GAOR, 54th Sess., Agenda Item 116(a), U.N. Doc. No. A/RES/54-263 (2000), *reprinted in* 8 INT'L HUM. RTS. REP. 293 (2001). For a discussion of the history and application of this protocol, see Mark E. Wojcik, et. al., *International Human Rights*, 35 INT'L LAW. 723, 726-28 (2001).

148. O.A.S. Res. XXX, O.A.S. Off. Rec. OEA/Ser. L/V/I.4 Rev. (1965), *also reprinted in* BURNS H. WESTON, ET. AL., *SUPPLEMENT OF BASIC DOCUMENTS TO INTERNATIONAL LAW AND WORLD ORDER* 368 (1997) [hereinafter O.A.S Res. XXX]. See also Mark E. Wojcik, *Using International Human Rights Law to Advance Queer Rights: A Case Study for the American Declaration on the Rights and Duties of Man*, 55 OHIO ST. L.J. 649 (1994).

The American Declaration of the Rights and Duties of Man was agreed upon before the Universal Declaration of Human Rights. Rights recognized in the American Declaration include the recognition in article 11 that “[e]very person has the right to the preservation of his health through sanitary and social measures relating to food, clothing, housing and medical care, to the extent permitted by public and community resources.” O.A.S. Res. XXX, *supra*.

149. 9 I.L.M. 673 (1970), *also reprinted in* BARRY E. CARTER & PHILLIP R.

the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social, and Cultural Rights,<sup>150</sup> the European Convention for the Protection of Human Rights and Fundamental Freedoms and its protocols,<sup>151</sup> and the African (Banjul) Charter on Human and Peoples' Rights.<sup>152</sup> There are, of

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TRIMBLE, INTERNATIONAL LAW: SELECTED DOCUMENTS 488 (1995). Article 1(1) of the Convention obligates states to "ensure to all persons subject to their jurisdiction the free and full exercise" of rights and freedoms recognized in the Convention. Those rights include "the right to have his physical, mental, and moral integrity respected" under article 5(1); "the right to personal liberty and security" under article 7(1); "the right to have his honor respected and his dignity recognized" under article 11(1); the right to privacy under article 11(2); and the right "without discrimination, to equal protection of the law" under article 24. The Convention also confirms in article 32 that "[e]very person has responsibilities to his family, his community, and mankind" and that "[t]he rights of each person are limited by the rights of others, by the security of all, and by the just demands of the general welfare, in a democratic society." While this last language might be seen as justifying discrimination against persons with HIV, it should be read in support of the idea that the key to promoting public health is the protection of individual human rights.

150. 28 I.L.M. 156 (1989), *also reprinted in* BURNS H. WESTON, ET. AL., SUPPLEMENT OF BASIC DOCUMENTS TO INTERNATIONAL LAW AND WORLD ORDER 535 (1997). Among protections recognized in this document are the obligation of non-discrimination in article 3, the right to work in article 6, the right to social security in article 9, and in article 10(1), "the right to health, understood to mean the enjoyment of the highest level of physical, mental and social well-being." The parties agree in article 10(2) to "recognize health as a public good," to adopt measures that provide education "on the prevention and treatment of health problems," and to satisfy "the health needs of the highest risk groups and of those whose poverty makes them the most vulnerable."

151. 312 U.N.T.S. 221 (1950), *also reprinted as amended by protocols in* BARRY E. CARTER & PHILLIP R. TRIMBLE, INTERNATIONAL LAW: SELECTED DOCUMENTS 464 (1995). Article 8 provides a right of privacy that may not be interfered with except "for the protection of health or morals, or for the protection of the rights and freedoms of others." A similar caveat accompanies the right to freedom of expression in article 10. Under article 14, other rights in the Convention, including the right to marry in article 12, are to "be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth, or other status." The "other status" language is broad enough to include a person's HIV status as a basis for non-discrimination.

152. 21 I.L.M. 58 (1981), *also reprinted in* BARRY E. CARTER & PHILLIP R. TRIMBLE, INTERNATIONAL LAW: SELECTED DOCUMENTS 509 (1995). Article 2, for example, provides that "[e]very individual shall be entitled to the enjoyment of the rights and freedoms recognized and guaranteed in the present Charter without distinction of any kind such as race, ethnic group, color, sex, language, religion, political or any other opinion, national and social origin, fortune, birth or other status." Words such as "every individual," "without distinction," and "other status" are broad designations that include persons affected by HIV. Similar phrases can be found elsewhere in the document. Article 3(1), for example, provides that "[e]very individual shall be equal before the law." Article 4 provides in part that "[e]very human being shall be entitled to respect for his life and the integrity of his person." And

course, many other conventions and instruments that might be cited, including ones that specifically identify the problem of HIV and AIDS.

Although there is a large number of documents that can be invoked when creating protections for persons affected by HIV, the international human rights framework is not always seen as coming into play because the instruments do not expressly mention AIDS or HIV. I recall an incident in 1993 in the week when the final declaration of the World Conference on Human Rights had been issued in Vienna.<sup>153</sup> In those days we did not have instant Internet access to such documents. I asked a colleague who just read a copy of the Final Declaration before I did if there was anything in there about protecting the human rights of persons with AIDS. He said there was "nothing in it relating to AIDS." But when I looked at the document, I saw throughout that document an array of general and specific human rights guarantees that could be applied to persons with AIDS, such as "the rights of everyone to a standard of living adequate for their health and well-being, including food and medical care, housing and the necessary social services,"<sup>154</sup> or the call for effective measures against child prostitution and other forms of sexual abuse,<sup>155</sup> or the recognition that "[t]he speedy and comprehensive elimination of all forms of racism and racial discrimination, xenophobia and related intolerance is a priority task for the international community"<sup>156</sup> and that "[r]espect for human rights and for fundamental freedoms without distinction of any kind is a fundamental rule of international human rights law."<sup>157</sup>

I admit, of course, that there was no explicit mention of HIV or AIDS in the final document itself, but I deny that there is "nothing in it relating to AIDS." Therein lies the continuing challenge for international human rights law (and national human rights laws). We must identify the human rights norms that apply to persons with HIV, and we must show that protecting those norms is not

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article 5 provides that "[e]very individual shall have the right to the respect of the dignity inherent in a human being and to the recognition of his legal status." The Charter also guarantees the right to information about health in article 9, which provides that "[e]very individual shall have the right to receive information." And article 16 provides first that "[e]very individual shall have the right to enjoy the best attainable state of physical and mental health," and second that nations who are parties to the Charter "shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick."

153. Vienna Declaration and Programme of Action, 32 I.L.M. 1661 (1993), also reprinted in BURNS H. WESTON, ET. AL., SUPPLEMENT OF BASIC DOCUMENTS TO INTERNATIONAL LAW AND WORLD ORDER 625 (1997).

154. *Id.* at art. 31.

155. *Id.* at art. 48.

156. *Id.* at art. 15.

157. *Id.*

only a laudable goal in itself, but necessary to protect and promote public health in general.

Adopting references to international human rights instruments in our scholarship and teaching on AIDS will have many benefits. First, acts of prejudice and discrimination against persons affected by HIV will be seen as infringements or violations of human rights. These are not violations that should simply be ignored. Remedies should be pursued in national courts and before international tribunals. Second, our scholarship and advocacy will support persons in this country who are affected by HIV or who might be at risk of becoming infected with HIV. The current levels of new infection are unacceptable. Our scholarship and advocacy will also help persons in other countries. It has long been known that AIDS cannot be cured in any country until it is cured in all countries. We need to strengthen the international law framework so that it can be used to help individuals and organizations in other nations. We also need to learn from their experiences. Many legal advances for persons living with HIV are entirely unknown in the United States. While we have much to offer others, we also have much to learn. Finally, we must remember to put people back into the equation. When we say that this disease has affected sixty million people over twenty years, it obscures the fact that each of those cases is an individual story.

The process of identifying various human rights norms that apply to persons living with HIV is only the first stage, however. The second stage after identification of human rights norms is to provide for enforcement of those norms. This is an issue not only for persons affected by HIV, but also for all aspects of international human rights laws. Norms may be recognized as unenforceable aspirations rather than legal rights. The international human rights norms must develop into rights that are enforceable in local, national, and international tribunals. They must be enforceable in common law and civil law systems. We have seen already some evidence of increased enforcement of human rights norms, but enforcement is still often more of an exceptions rather than a rule.

The third stage, after identification of norms and providing opportunities for their enforcement, is to provide remedies for those whose rights have been violated. As Professor John Van Dyke of the University of Hawaii recently noted, “[t]he right to obtain financial compensation for a human rights abuse and to have the perpetrator of such an abuse prosecuted and punished is itself a fundamental human right that cannot be taken from a victim or waived by a government.”<sup>158</sup> Remedies are important not

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158. John M. Van Dyke, *The Fundamental Human Right to Prosecution and Compensation*, 29 *Denver J. Int'l L. & Pol'y* 77, 77 (2001).

only for violations of civil and political rights, but also for violations of economic and social rights, to the extent that national and international resources are available.

The fourth and final stage is to prevent violations of rights. Avoiding a violation of human rights in the first place is more important than providing an opportunity for redress.

We are still to a large extent only in the first stage of this process. That there is more work to be done does not diminish the importance of the work being done now. But we see that we cannot become complacent or despondent. Twenty years again from now we will still be looking at AIDS and the human rights of persons affected by HIV. We may not then have arrived at full implementation of the fourth stage of preventing violations, but we will hopefully have reached it in many cases. Let us see how close we can come to fully achieving that goal.