

**LITIGATING ON THE RIGHT TO HEALTH FOR PEOPLE LIVING WITH HIV IN
SOUTH AFRICA AND COLOMBIA**

**Submitted in partial fulfilment of the requirement of the fulfilment of the degree LLM
(International Human Rights Law and HIV in Africa)**

BY

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DEDICATION

I dedicate this work to the poorest and vulnerable people in quest of their right to health and dignity.

ACKNOWLEDGMENT

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List of abbreviations and acronyms

ACHPR: African Charter on Human and Peoples' Rights

AIDS: Acquired Immunodeficiency Syndrome

ARV: Antiretroviral

ART: Antiretroviral Treatment

CBO: Community Based Organizations

CCC: Constitutional Court of Colombia

CRSA: Constitution of Republic of South Africa

ECSR: European Committee of Social Rights

ICESCR: International Covenant of Economic, Social and Cultural Rights

NGO: Non-Governmental Organization

PIL: Public Interest Litigation

PLHIV: People living with HIV

TAC: Treatment Action Campaign

HIV: Human Immunodeficiency Virus

UDHR: Universal Declaration of Human Rights

UNAIDS: Joint United Nations Programme on HIV/ AIDS

UNESCO: United Nations Educational, Scientific and Cultural Organization

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CHAPTER I: INTRODUCTION

1.1 Background to the research and problem statement

The right to health as defined in different international instruments is not the same as the right to be healthy. Rather, the right to health is the right to enjoy the highest attainable standard of health taking 'into account both individual's biological and socio-economic preconditions...'¹The right to health is a fundamental part of human rights and of our understanding of life with dignity.²Article 25(1) of the Universal Declaration of Human Rights (UDHR) affirms that everyone has the right to an adequate standard of living for the health of him/her self and for his/her family, including underlying determinants of health such as 'food, adequate housing, water, sanitation and the right to health'.³Article 12(1) of the International Covenant on Economic, Social and Cultural Rights (ICESCR) recognizes the right to health as a right of everyone to enjoy the highest attainable standard not only physical but also mental health. In addition, General Comment 14 of the Committee on Economic, Social and Cultural Rights (Committee on ESCR) clarifies the relationship between those underlying determinants which is food, adequate housing, water, sanitation and the right to health. The Committee on ESCR goes further in its General Comment 15 to include the right to a healthy environment as one of the underlying determinants of the right to health.⁴

The Committee on ESCR has noticed that despite the fact that many countries around the world have signed and ratified different international human rights instruments addressing the right to health such as the International Convention on the Elimination of All Forms of Racial Discrimination⁵, the Convention on the Elimination of All Forms of Discrimination against Women⁶, the Convention on the Rights of Child⁷, millions of people, especially poor and vulnerable people, do not fully enjoy the right to health.⁸

Why do the poor and vulnerable not enjoy the right to health fully? One of the reasons may be the fact that for a long time there has been a rigid separation in human rights doctrine between civil and political rights on the one hand and social, economic and cultural rights on the other. Scholars and jurists in their writing and application have in a sense legitimized this separation thus entrenching it.

¹ General Comment no14 (2000) at 9, [http://www.unhchr.ch/tbs/doc.nsf/\(symbol\)/E.C.12.2000.4.En?Open Document](http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En?Open Document) (accessed 12 November 2012).

² General Comment no14 (2000) at 1.

³ Universal Declaration of Human Rights (Universal Declaration), http://www.ohchr.org/EN/UDHR/Documents?UDHR_Translation/eng.pdf (accessed 15 November 2012).

⁴ General Comment no 15 (2002) 11 at 29, <http://www.unhchr.ch/tbs/doc.nsf> (accessed 15 November 2012).

⁵ International Convention on the Elimination of All Forms of Racial Discrimination, article 5e (iv), <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CERD.aspx> (accessed 12 November 2012).

⁶ Convention on the Elimination of All Forms of Discrimination against Women, article 11(1) (f), 12 and 14 (2) (b), <http://www.un.org/womenwatch/daw/CEDAW> (accessed on 15 November 2012).

⁷ Convention on the Rights of Child, article 24, <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx> (accessed on 20 November 2012)

⁸ General Comment no14 (2000) at 5.

Within this way of thinking, civil and political rights or first generations rights are seen as placing an obligation of restraint on the state (negative obligations). Socio-economic rights or second generation rights are seen to generate obligations on the state to act and do certain things to achieve some positive benefits (positive obligations).⁹

Another reason is that in many countries, socio-economic rights are not enshrined in the national laws or international law is not incorporated into domestic law.¹⁰

A further reason is that litigation on the right to health has focussed very narrowly on access to medicines and health care services. The right to health is broadly considered as the right to receive only health care services while thus far not much judicial attention has been given to the underlying determinants of the right to health.

General Comment 14 of the UN Committee on Economic, Social and Cultural Rights has clarified the scope of the right to health in order to avoid the misconception that the right to health is only about having access to medicines, doctors, nurses and hospitals. It instead emphasises that there are certain factors that are essential for the right to health to be enjoyed which include safe food, safe water and adequate sanitation, adequate nutrition and housing, healthy working and environmental conditions, health related education and information and gender equality.¹¹ Schuftan argues that the full enjoyment of the right to health is dependent upon the realization of these factors as the denial of the right to the underlying determinants of health, for example the right to food, may ultimately lead to malnutrition which in turn increases morbidity and mortality.¹² Every human being needs a house to live in and adequate sanitation to stay in good health. Lack of those underlying determinants of health has an adverse impact on the health of people in general and on the health of vulnerable people in particular such as PLHIV. The ESCR Committee recognised the indivisibility of rights and in General Comment 14 made it very clear that the highest attainable standard of health cannot be enjoyed without these underlying pre-conditions being in place.

However, some analysts suggest that litigation on the more narrow concept of the right to health described above has been used successfully partly because the chances of winning a case are great when each issue is addressed separately.¹³ Whereas, basing a claim on the right to food, water, housing, sanitation and the environmental rights can be more difficult to address through litigation.

A wide range of litigation strategies throughout the world forced the government to be accountable and succeeded in producing changes in national health policies while at the same time improving

⁹ N Ntahiraja & N Nkurunziza 'The State and social rights of her citizens: The right to health in Burundi' (2011) 2.

¹⁰ S Verma 'Justiciability of economic social and cultural rights' (2005) 2.

¹¹ Office of the United Nations High Commissioner for Human Rights (OHCHR) *The right to health*, fact sheet no.31 (2006) 1, <http://www.ohchr.org> (accessed 15 November 2012).

¹² C Schuftan et al; *The right to health: A people's health movement perspective and case study* (2010) 505.

¹³ S Gloppen 'Litigation as a strategy to hold governments accountable for implementing the right to health' (2008) 21 *Health and human rights journal* 36.

the life of millions of people. For example in the group of cases of the *Treatment Action Campaign v. Minister of Health* (TAC cases)¹⁴ concerning the issue of access to medicines for people living with HIV/AIDS, many commentators have argued that those cases demonstrated an effective and manageable approach to the right to health specifically and they have demonstrated that socioeconomic rights are in fact justiciable.¹⁵

HIV/AIDS has helped to show that the right to health can be used efficiently when an innovative and creative approach is developed by litigants or by jurists in that such strategies can result in concrete and real change in socioeconomic rights.

Other commentators have raised the question whether the narrow focus on treatment in the TAC cases has resulted in the dilution of the normative content of the right to health.¹⁶

1.2 Research questions

The main research questions that I address are: What makes litigation on the right to health for PLHIV possible and what strategies can be adopted to make it successful? What kind of strategies have been put in place by jurists and litigants in countries such as South Africa and Colombia where cases on the right to healthcare have been taken to the court and have been successful?

1.3 Research methodology

The methodology of the study is desktop research using judgments, books and articles. I analyse whether domestic litigation on the right to healthcare has been effectively used as a key for the full realisation of international treaty obligations on the right to health. Moreover, I analyse whether it has been used as a key to unlock the underlying determinants of health. To that end I review and analyse a pool of carefully selected cases from South Africa and Colombia on the matter of the right to healthcare. Colombia has been chosen because it is the country with the highest number of right to health cases in the world.¹⁷ South Africa is interesting due to the fact that it has adopted a new Constitution in 1996 and has recognized social and economic rights as justiciable fundamental rights and not simply as directives of state policy as in many other African states.¹⁸ The richness of the right to health and health related human rights jurisprudence lead us to be focused mainly on those countries.

I compare litigation strategies; look at the obstacles encountered and the factors that contributed to the success of the litigation. Recommendations are made and a conclusion drawn.

¹⁴ *Treatment Action Campaign v. Minister of Health* 2002 10 BCLR 1033 (CC)

¹⁵ E C Neff 'From equal protection to the right to health: Social and Economic Rights, Public law litigation, and how an old framework informs a new generation of advocacy' (2009) 168 *Columbia Journal Law and Social Problems* 181.

¹⁶ B M Meir & A E Yamin 'Right to health litigation and HIV/AIDS policy' (2011) 82 *Journal of Law, Medicine and Ethics* 84.

¹⁷ C Gianella 'Does the Colombian Constitutional court undermine the health system?' (2011) 1 *CMI Brief* 4.

¹⁸ O L Ferraz 'Between usurpation and abdication? The right to health in the Courts of Brazil and South Africa' (2010) 2.

The Global Health and Human Rights Database is my tool to study the litigation strategies adopted so far. It is a web site which has compiled, summarized and categorized health-related human rights judgments which deal with international and regional instruments and national constitutions.

1.4 Literature review

Efficient litigation on the right to health has been debated by many authors. Some have argued that an explicit right to health within a country's constitution is vital for the implementation of the international human right to health and some have argued that right to health litigation is possible even in countries where the judiciary has created a right to health or interpreted it within other rights, such as the rights to life, dignity, and non-discrimination.¹⁹

In South Africa, the Constitution contains the right to health and has been used several times by advocacy groups to litigate for PLHIV like the Treatment Action Campaign. In the case of Colombia, the Constitution contains an explicit right to health but the Constitutional Court has had a shifting interpretation on the nature of the right to health's justiciability. Despite the shifting interpretation Colombia has produced a significant amount of jurisprudence on the right to health.²⁰

*Hogerzeil et al*²¹ studied whether a right to essential medicines is enforceable or not through the court. They engaged in systematic research to identify completed court cases in low-income and middle-income countries in which individuals or groups had claimed access to essential medicines with reference to the right to health. Their study concluded that the success of the cases was mainly linked to the existence of constitutional provisions on the right to health or the right to life, which were supported by the international human rights treaties. In addition, they established that the role of non-governmental organisations was also crucial to the success of the strategy.

*Birn*²² suggests that the right to health has been distorted and misinterpreted by some actors who have argued that the improvements in the broad domain of the underlying determinants of the right to health may be less easily realized than the right to healthcare. She believes that the move to enforceable economic, social, and cultural rights, including the rights to food, shelter, and freedom from discrimination in health services will create many new possibilities for using human rights treaties as a legal tool to improve health conditions, country by country.²³

The same author argued in the same journal that litigation on the right to health may be successfully undertaken under circumstances where there are enforceable legal instruments combined with effective and willing judiciaries. In addition chances of success are increased when such litigation is

¹⁹ J M Zuniga et al ; *Advancing the human rights to health* (2013) 31.

²⁰ Zuniga (n 2 above) 31.

²¹ H V Hogerzeil et al; 'Is access to essential medicines as part of the fulfilment of the right to health enforceable through the courts?' (2006) 305 *Lancet Journal* 368.

²² A E Birn 'Health and human rights: Historical perspectives and political challenges' (2008) 29 *Journal of public health policy* 37.

²³ Birn (n 2 above) 35.

supported by social justice movements, political parties, and representatives of worker and peasant interests. It also helps when the political systems of the country do not privilege elites over majority interests.²⁴

*Porter*²⁵ looks more broadly at the role of litigation within the wider framework of socio-economic rights advocacy. He suggests that the support of a strong social movement makes litigation on those rights more effective and efficient. He believes that law and legal practice should be treated with a healthy degree of scepticism. However, with the involvement of strong social movements, he suggests that we can look forward to an evolution in the understanding of socioeconomic rights as more claims based on socio-economic rights are made.

1.5 Outlines of the chapters

My dissertation topic has four chapters. Chapter one is the introductory chapter. Chapter two introduces the concept of the right to health and its link with HIV. It also analyses the obligations of states under international human rights with respect to the right to health. The third chapter studies litigation on the right to healthcare and analyses the specific cases chosen that have been brought before the courts in South Africa and Colombia on the matter of health by PLHIV. The last chapter defines and compares strategies that have been adopted. It looks also at factors that had contributed to the success or failure of particular strategies and what lessons can be learned from. It finally makes recommendations and draws conclusions.

²⁴ Birn (n 3 above) 36.

²⁵ B Porter 'Toward a progressive framework for the ESC rights' (2005) 29.

CHAPTER TWO: THE RIGHT TO HEALTH AND THE LINK WITH HIV

2.1 Introduction

In every development process, there are three types of actors that may intervene when states do not respect its commitments. They are claim holders, duty bearers and agents of accountability. When the state does not respect human rights, claim- holders have to demand their rights directly from the duty bearers in government. Claim holders should interact with agents of accountability who oversee the procedures being put in place by government and make sure duty bearers fulfil their obligations.²⁶

Thirteen years ago, the UN Committee on Economic, Social and Cultural Rights (ESCR Committee), which monitors compliance with the ICESCR, adopted General Comment 14 on the right to health which states that the right to health extends not only to timely and appropriate health care but also includes fulfilment of the underlying determinants of health. The ICESCR provides the most comprehensive article on the right to health in international human rights law. And the scope and content of the right to health has been defined by the General Comment 14.

The African Commission on Human and Peoples' Rights (African Commission) has held that the enjoyment of the right to health is vital to all aspects of a person's life and wellbeing, and is crucial to the realisation of all other fundamental human rights and freedoms.²⁷ Article 16(1) and 16(2) of the African Charter on Human and Peoples' Rights (Africa Charter) obliges state parties to provide health care services to their nationals at all times without any limitations or distinctions.²⁸

The right to health like all human rights imposes three types of obligations on state parties which is the obligation to protect, respect and fulfil and requires states to meet a minimum essential level of the right often referred to as the core content of the right.

2.2 Obligations of states with respect to the right to health under international law

2.2.1 International obligations

The ESCR Committee in its General Comment 14 emphasised various aspects of the right to health. As can be seen below it saw respect of the right to health as central to a state's obligations under international law.

States parties have the obligation to take steps towards the full realization of the rights recognized in the ICESCR to the extent of its maximum available resources.²⁹ In the spirit of article 56 of the

²⁶ Schuftan (n 2 above) 505.

²⁷ J A Oder 'Litigating the right to health before the African Commission on Human Rights and Peoples' Rights: the record so far' (2008) 129.

²⁸ African Charter on Human and People's Rights, article 16.

²⁹ International Convention on Economic, Social and Cultural Rights, article 2.

Charter of the United Nations, state parties should recognize the importance and the role of being part of an international community and cooperate in its commitment to the full realization of the right to health.³⁰ States have to respect the enjoyment of the right to health in their country but also have to respect the enjoyment in other countries. ‘Depending on the availability of resources, states should facilitate access to essential health facilities, goods and services in other countries, wherever possible, and provide the necessary aid when required’.³¹

2.2.2 Core obligations

The ESCR Committee, in its General Comment 14 requires state parties to ensure the satisfaction of minimum essential levels of the right to health³². The core obligations of state parties are to ensure that its population have the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups. States have to ensure at the same time that its population has the basic needs such as the minimum essential food which is nutritionally adequate and safe, a house which has an adequate supply of safe and potable water and sanitation. Plus, they have to provide essential drugs, ensure equitable distribution of all health facilities, goods and services. In addition, states must adopt and implement a national public health strategy. Moreover, the state is required to develop a plan of action on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action should be periodically reviewed on the basis of a participatory and transparent process.³³

‘The core obligations emphatically include both timely and appropriate healthcare and the underlying determinants of health such as access to safe and potable water and adequate sanitation, and adequate supply safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information including on sexual and reproductive health. A further important aspect is the participation of the population in all health-related decision-making at the community, national and international levels’.³⁴

Aware that conditions differ from state to state, the ESCR Committee requires state parties to ensure that health facilities, goods and services are available, accessible, acceptable and of good quality. Availability means that health care services and facilities must be in sufficient quantity within the state party. Besides, underlying determinants such as safe and potable drinking water and adequate sanitation facilities must be available in hospitals, clinics and other health related buildings. Accessibility means that health facilities, goods and services have to be accessible for everyone without any discrimination of any kind and must be accessible within the whole country including in rural areas. Health facilities and services must be affordable for everyone including socially

³⁰ General Comment no14 (2000) at 38.

³¹ General Comment no14 (2000) at 39.

³² General Comment no 14 (2000) at 43.

³³ General Comment no14 (2000) at 43.

³⁴ General comment no14 (2000) at 11.

disadvantaged groups like PLHIV, prisoners and other vulnerable people. This expression includes also the right to seek, receive and impart information and ideas concerning health issues. Acceptability means that all health facilities, goods and services must be respectful of medical ethics and culturally appropriate, as well as being designed to respect confidentiality and improve the health status of those concerned. As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality.³⁵

However the reality of many poor, marginalised and vulnerable people in Africa is very different. PLHIV, sexual minorities and other marginalised groups are routinely discriminated against in the health sector. Moreover, while many countries are now providing free medication for PLHIV, there is little if any attention given to the underlying determinants of health. Despite these realities, the number of cases litigated in Africa concerning the right to health does not match the serious socio-economic circumstance faced by its population.³⁶

2.2.3 Specific obligations

As stated earlier, we have three types of specific obligations for states parties. The obligation to respect, protect and fulfil its engagements.

2.2.3.1 Obligation to respect

The obligation to respect is of immediate effect and not subject to progressive realization. It entails three components which are: refraining from interfering with the existence and enjoyment of economic and social rights, refraining from impairing access to economic and social rights or mitigating the impact of interference in the enjoyment of those rights.³⁷

To refrain from interfering directly or indirectly with the right to health means that states should not participate directly or indirectly in harming the health of its own population. Directly, for example, in polluting the environment or water or in providing unsafe water to its population, a factor which will increase their vulnerability to sicknesses. *Social and Economic Rights Action Centre (SERAC) v. Nigeria*³⁸ is one of the cases which illustrate the government of Nigeria interfering directly with the right to health through the use of force by government's forces on the Ogoni community while the petroleum companies were contaminating the air, water and soil.

2.2.3.2 Obligation to protect

'The obligation to protect requires states to prevent third parties from interfering with the right to health'³⁹ which means that states should adopt measures that guarantee the safety of everyone

³⁵ General Comment no14 (2000) at 12.

³⁶ Oder (n 2 above) 142.

³⁷ M F Prada 'Empowering the poor through human rights litigation'(2001) 39.

³⁸ Social and Economic Rights Action Centre (SERAC) and Another v. Nigeria (2001) AHRLR 60 (ACHPR).

³⁹ OHCHR (n 2 above) 25.

against a third party who could be or is a threat to the enjoyment of the right to health. The African Commission in the *SERAC* case, after hearing the allegations and arguments of both sides, stated that the government of Nigeria failed to protect the population from the harm caused by the petroleum companies and failed also to provide or permit studies of potential or actual environmental and health risks caused by the oil operations in the area. Third parties or non-state actors include individuals, groups, landlords, corporations, other states or entities as well as agents acting under their authority.⁴⁰ Here the third party was the petroleum companies.

This obligation to protect not only entails protecting individuals and communities from violations, but it also requires the investigation of perpetrators of such violations and the provision of remedies to victims.

2.2.3.3 Obligation to fulfil

‘The obligation to fulfil requires states to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures to fully realize the right to health.⁴¹ The obligation to fulfil obliges states to progressively realise the right to health by taking steps towards that goal⁴² and moreover states must take the abovementioned appropriate steps to ensure that everyone also gets access to the underlying determinants of health such as food, safe and clean water, proper sanitation, an adequate house. States may adopt policies to provide antiretroviral treatment to all individuals in need, yet due to resource constraints, be able to cover only a small percentage of the population.

When a government ratifies a treaty, it agrees to ensure that its laws, policies and actions are compatible with the rights defined in the treaty and cannot use the having insufficient resources as an excuse to not implement human rights, especially if there has been mismanagement of state funds. In *Free Legal Assistance Group and Others v. Zaire*,⁴³ owing to the mismanagement of public finances, the government had failed to provide basic services to the populace and consequently there was a shortage of medicines in hospitals. The African Commission found that the failure of government to provide basic services such as safe drinking water and electricity and shortage of medicine as alleged in the communication constitutes a violation of article 16 of the African Charter.

2.3 The concept of the right to health under the African Charter

The right to health in Africa is recognised under the African Charter of Human and Peoples’ Rights (African Charter) in language similar to the International Covenant on Economic, Social and Cultural Rights (ICESCR). The African Charter recognized in its preamble that civil and political

⁴⁰ Prada (n 2 above) 40.

⁴¹ OHCHR (n 3 above) 27.

⁴² Oder (n 3 above) 134.

⁴³ *Free Legal Assistance Group and Others v. Zaire* (2000) AHRLR 74 (ACHPR).

rights cannot be dissociated from economic, social and cultural rights. They emphasised the principle of universality in their conception and noted that the satisfaction of economic, social and cultural rights is a pre-condition for the enjoyment of civil and political rights.⁴⁴

The African Commission on Human and Peoples' Rights adopted a set of guidelines for the implementation of the economic, social and cultural rights under the African Charter. While these guidelines include many of the issues mentioned by the ESCR Committee's General Comment 14, it goes further to suggest certain specific issues that are important in the African context. To highlight a few, the guideline suggests that state parties develop national health insurance systems for the benefit of the poor and vulnerable. The guidelines warn state parties to ensure that privatisation of the health sector does not negatively affect accessibility of health services to the poor. It further provides specific guidelines to states on addressing malaria, HIV and the health needs of women, children and the disabled.

Apart from the other very detailed guidelines regarding healthcare services, it also emphasises the need to address the determinants of health;⁴⁵ health facilities, infrastructure, goods and services which should be distributed to everyone without any kind of discrimination and monitored on the accessibility of those health facilities and services particularly to members of vulnerable and disadvantaged group.⁴⁶ Underlying determinants such as housing and sanitation and adequate supply of safe and potable water is also part of obligations to fulfil the right to health.⁴⁷ The guidelines and principles did not forget to highlight a category of disadvantaged people who needs particular attention by virtue of their conditions of life. Prisoners and other persons deprived of their liberty, under any form of detention, may have access to conditions of detention consistent with human dignity and the highest attainable standard of health. Measures taken must ensure adequate food, clothing, exercise, physical security, reading material, rehabilitation programmes and medical treatment for them.⁴⁸

2.4 Connection between the right to health and HIV

To understand the link between the right to health and HIV, I will first demonstrate the link between human rights and HIV and then look at the link between the right to health and HIV. There is an inter-connection between all three concepts which is briefly looked at below.

⁴⁴ Preamble to the African Charter on Human and Peoples' Rights.

⁴⁵ Principles and guidelines on economic, social and cultural rights in the Africa Charter on Human and Peoples' Rights, <http://www.achpr.org/instruments/economic-social-cultural/> (accessed on 17 October 2013).

⁴⁶ Section III, C, xiv, Principles and guidelines on economic, social and cultural rights in the Africa Charter on Human and Peoples' Rights.

⁴⁷ Section III, C, xlv, Principles and guidelines on economic, social and cultural rights in the Africa Charter on Human and Peoples' Rights.

⁴⁸ Section III, C, lxi, Principles and guidelines on economic, social and cultural rights in the Africa Charter on Human and Peoples' Rights.

2.4.1 Link between human rights and HIV

'Human rights are inextricably linked with the spread and impact of HIV on individuals and communities around the world. A lack of respect for human rights fuels the spread and exacerbates the impact of the disease, while at the same time HIV undermines progress in the realisation of human rights'.⁴⁹ This link is apparent in the disproportionate incidence and spread of the disease among certain groups which include women and children, and particularly those living in poverty. Most of the time, people infected and affected by HIV are living in poverty because they do not have enough energy to work and gain money to buy food or to cultivate for themselves. They can neither build nor afford to buy a proper house, access safe water and have adequate sanitation. This increases their vulnerability. People infected with HIV may also suffer from violations of their rights when, for example the government discriminates against them in relation to access to health facilities and social services or access to information. The realization of rights by people living with HIV would require non-discriminatory access within a supportive social environment.⁵⁰

HIV/AIDS concerns many fundamental human rights such as: the right to life, the right to non-discrimination, equal protection and equality before the law; the right to the highest attainable standard of physical and mental health; the right to equal access to education; the right to an adequate standard of living etc.

HIV/AIDS demonstrates the indivisibility of human rights since the realisation of economic, social and cultural rights, as well as civil and political rights, is essential to an effective response to the epidemic.

2.4.2 Link between HIV and the right to health, including the underlying determinants to health

In 2001, the Office of the High Commission on Human Rights alarmed by the fact that over 36 million people were infected with HIV by the end of 2000 adopted a resolution in which it is stated that the right to the highest attainable standard of health includes access to antiretroviral therapy for HIV.⁵¹ Through legislation and litigation, many countries have recognized that their people have the right to HIV treatment as part of their human rights, confirming that economic, social and cultural rights was indeed justiciable.

The importance given to the underlying determinants of health, that is, the factor and conditions which protect and promote the right to health beyond health services, goods and facilities, show that the right to health is dependent on, and contributes to, the realization of many other human rights

⁴⁹ <http://www.ohchr.org/EN/Issues/HIV/Pages/HIVIndex.aspx> (accessed on 10 September 2013).

⁵⁰ <http://hivinsite.ucsf.edu> (accessed on 10 October 2013).

⁵¹ International Guidelines on HIV/AIDS and human rights (2006) 4.

such as the right to food, right to water, to an adequate standard of living and to an adequate house.⁵²

The human right to adequate food is recognized in many international instruments but the ICESCR deals with it more comprehensively than any other instrument and that goes for the right to water and sanitation and the right to adequate housing as well. ‘The right to food is realized when every man, woman and child, alone or in the community with others, has physical and economic access at all times to adequate food or means for its procurement’.⁵³ The right to health is closely linked to the right to food. The human right to food is not merely about everyone being fed. It is about the entitlement to have food, to have access to food but also to have sufficient and nutritious food to stay healthy. In the context of HIV, the right to food and the need for food becomes even more pertinent because it is difficult to take medication without food due to the risk of developing side effects. Food insecurity is a common and an important barrier to accessing medical care and Anti-retroviral (ARV) adherence.⁵⁴ Good nutrition helps maintain and improve the health of people living with HIV and delays the progress from HIV to AIDS related diseases.

‘Water is a limited natural resource and a public good fundamental for life and health. The human right to water is indispensable for leading a life in human dignity’.⁵⁵ The right to water is recognized in several international documents, including treaties, declarations and other standards. The right to water and sanitation must also be taken seriously particularly in the context of HIV because diseases related to unsafe water and inadequate sanitation such as diarrhoea and various types of skin diseases are some of the common infections from which PLHIV suffer and at times die.

Virginia Shubert and Nancy Bernstine in their article supported the fact that housing was part of HIV prevention plans and at the same time contributed to healthcare. They found strong correlations between improved housing status and reduced HIV risk behaviours. Firstly, improved access to healthcare outcomes for persons living with HIV/AIDS; and secondly, ultimately better health outcomes.⁵⁶ The Commission on Human Rights in its resolution 1993/77 affirmed that the practice of forced evictions constitutes a gross violation of human rights, in particular, the right to adequate housing.⁵⁷

A minimum standard has to be fulfilled in all time by states no matter what kind of constraints it may be facing and policies must be put in place to ensure the enjoyment of the right to health.⁵⁸

⁵² Office of the United Nations High Commissioner for Human Rights (OHCHR) *The right to health*, fact sheet no.31 (2006) 25.

⁵³ General Comment no 12 (1999) 2.

⁵⁴ <http://www.plosone.org> (accessed on 11 October 2013).

⁵⁵ General Comment no15 (2003) at 1.

⁵⁶ V Shubert & N Bernstine ‘Moving from fact to policy: housing is HIV prevention and health care’ (2007) 172.

⁵⁷ http://www.unhabitat.org/downloads/docs/1341_66115_force%20evic%20chr1.htm (accessed on 4 November 2013).

⁵⁸ Prada (n 3 above) 43.

When the government does not comply with its obligations, litigation has been used as one strategy to force governments to comply with the international human rights instruments that they have ratified. In the next chapter, I will go through different cases that have been litigated in Colombia and in South Africa on the matter of the right to healthcare and HIV and I will analyse the strategies that have been used.

CHAPTER THREE: LITIGATING FOR THE RIGHT TO HEALTHCARE

3.1 Introduction

Anyone who had their human rights violated has the right to go to the court to claim a remedy.⁵⁹ Remedies can be obtained if the case is brought before a competent jurisdiction which can either be a national court or an international tribunal under appropriate circumstances such as if all domestic remedies have been exhausted and the state concerned is a party to the relevant international instrument. Complaints can be brought before the court by states or by individuals for different concerns but those that are brought in the context of human rights are complex and it must be recognized that a judicial approach for the realization of human rights will never be sufficient.⁶⁰

But despite those difficulties, different international human rights instruments such as the Universal Declaration of Human Rights (UDHR), the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights, International Convention on the Elimination of All form of Racial Discrimination and others have contributed to setting an international normative standard for health policy and formed the basis for health litigation.⁶¹

Health litigation can play an important role for the realisation of the right to health and also for other related rights. It has led courts to order the government to address the health needs of its people and at the same time advances the right to health and promotes health equity.

The legal recognition of the right to health is important because it allows individuals and groups to claim their rights when government violates them or when government is not willing to assume responsibility for guaranteeing that people can enjoy the benefits of the right to health.

In recent years, litigation has emerged as the chosen strategy to push for state accountability particularly for realizing international treaty obligations and for the fulfilment of national legal commitments to health-related human rights. Litigation has provided specific causes of action for individual health needs thus empowering individuals to pursue human rights claims for the health of the public.⁶²

Experience has shown that where socio-economic rights are justiciable before the court, litigating the right to health before national, regional, or international courts (or quasi-judicial bodies, such as the United Nations Human Rights Committee and Inter-American Commission on Human Rights)

⁵⁹ M Killander *International law and domestic human rights litigation in Africa* (2010) v.

⁶⁰ Killander (n 2 above) 1.

⁶¹ Zuniga (n 3 above) 26.

⁶² B M Meier et al ; *Bridging international law and rights-based litigation: Mapping health-related rights through the development of the Global health and human rights database* (2012) 4.

allows individuals to seek impartial adjudication from a formal institution with remediation authority. Cases based upon international and regional human rights instruments and national legal provisions, have begun to show tangible gains in national health policy, with tribunals around the world expansively exercising their authority to interpret human rights, clarify individual claims, and prescribe national policies in response to leading threats to health.⁶³

This chapter will go on to look at different mechanisms that can be used to litigate on the right to health. It will start at the United Nations level, move to the regional level and end with the domestic level.

3.2 Right to health litigation before United Nations mechanism

The Committee on Economic, Social and Cultural Rights (ESCR Committee) is an independent body of the United Nations Economic and Social Council that is empowered to oversee the ICESCR and monitor compliance of States.

Litigation on the right to health at an international level is possible by virtue of the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights, one of the mechanisms, which creates an individual complaint procedure through which litigation under the ICESCR can occur. Interights suggests that the mechanism cannot be used to address systematic violations as cases must be presented by people or groups that are victims.⁶⁴ Litigants must have exhausted all the available local remedies before getting to the international mechanism.

3.3 Regional health litigation

In Africa, the three key regional human rights mechanisms are the African Court on Human and Peoples' Rights, the African Commission on Human and Peoples' Rights and the African Committee on the Rights and Welfare of the Child (the Children's Committee). Some African countries have been taken to the African Commission on the matter of the violation of health rights, where complainants asked their governments to comply with their obligations under the international and regional human rights instruments that they have ratified.

For example in *Purohit and Moore v. The Gambia*,⁶⁵ the complainants advocated for patients who were detained at Campana, a psychiatric unit of the Royal Victoria Hospital, alleging among other things that the legislative regime in the Gambia for mental health was in violation of the right to enjoy the best attainable state of physical and mental needs stipulated under article 16 of the African Charter but also the right of disabled people to have special measures of protection in keeping with

⁶³ Meier (n 2 above) 4.

⁶⁴ 'Right to health litigation in Africa Consultative meeting: 2012 Meeting report, <http://www.interights.org/document/283/index.html> (accessed on 16 October 2013).

⁶⁵ *Purohit and Moore v. The Gambia* (2003) AHRLR 96 (ACHPR 2003) .

their physical and mental health under article 18(4).⁶⁶ The African Commission found that the Government of The Gambia failed to comply with its obligations to provide healthcare for vulnerable people and urged the state to provide adequate medical and material care for persons suffering from mental health problems.

In the Americas, there is an Inter-American system which is responsible for the protection of human rights. The system has a normative basis made of several instruments like the American Declaration of the Rights and Duties of Man and the American Convention on Human Rights, the Protocol to the American Convention on Human Rights on the Abolition of Death Penalty, the Inter-American Convention to Prevent and Punish Torture etc.⁶⁷ Another instrument that sets forth economic, social and cultural rights is the Inter-American Charter of Social Guarantees. The Inter-American Commission was recognized as the supervisory organ while the Inter-American Court was recognized as the second supervisory organ by the American Convention. The Inter-American Court and the Inter-American Commission which are both competent for the matters relating to the fulfilment of the commitments made by the state parties have already given judgments related to the right to health. For example, in *The Xákmok Kásek Indigenous Community v. Paraguay* case,⁶⁸ the Inter-American Commission filed before the Court an application against the Republic of Paraguay alleging that the state failed to ensure the right to life of the indigenous community by depriving them of their territory. The Commission argued that regarding access to healthcare services, children suffered from malnutrition and other members, from many other diseases due to the long distance from medical centres resulting in them not being able to easily access healthcare services. The Court declared the Republic of Paraguay responsible for many deaths of indigenous people as a result of the lack of medication and ordered the state to ensure that positive measures are taken to prevent violations of and avoid the risk to the right to life.

In Europe, the European Social Charter which was adopted in 1961 was revised in 1996 and came into force in 1999. It guarantees various fundamental rights and freedoms and, through a supervisory mechanism based on a system of collective complaints and national reports, ensures that state parties are implementing those rights. The European Committee of Social Rights (ECSR) has the role to ascertain whether countries have honoured the undertakings set out in the Charter. The function of the ECSR is to judge the conformity of national law and practice with the Charter.⁶⁹

⁶⁶ <http://www.achpr.org/files/sessions/33rd/communications> (accessed on 10 October 2013).

⁶⁷ Human right centre, Circle of rights Economic, social and cultural rights activism: Training program, University of Minnesota.

⁶⁸ *The Xákmok Kásek Indigenous Community v. Paraguay* (24 August 2010) Ser L/ Doc 8 Rev1.

⁶⁹ 'The right to health under the European Social Charter' (2009) 1, <http://www.coe.int/socialcharter> (accessed on 10 October 2013).

3.4 How can litigation contribute on the domestic level?

Litigation can contribute to hold governments accountable with respect to both policy and implementation gaps. Litigation plays an important role in bringing national health laws and policies in line with the health rights obligations created by human rights norms. 'Implementation or enforcement gaps are discrepancies between *stated policy* and *implemented policy*. Health rights litigation may serve to hold governments accountable to their laws and policies and aid implementation by empowering individuals and groups to enforce the laws more directly'.⁷⁰

Domestic litigation remains a primary accountability tool in most regions, albeit that its effective use is contingent on a number of factors, including the existence of independent judiciaries. The past decade has seen an exponential rise in right to health litigation globally, including in low and middle income countries. These cases have focused on a wide range of issues, such as access to health services, discriminatory labour practices and various aspects of the basic determinants of health.⁷¹

Some African countries even though they do not include in their constitutions health as a right have made significant progress to make human rights litigation possible while others are still finding their way. Through progressive interpretation and litigation, the right to health has been recognised as a component of civil and political rights, particularly the right to life and freedom from cruel, inhuman and degrading treatment. But despite these developments, the litigation on the right to health issues across Africa remains complex. While many states are parties to regional and international human rights instruments with economic and social rights, the place of the right to health in national legal frameworks remains precarious.⁷²

Particularly for PLHIV, domestic litigation has become a principal strategy for realizing international treaty obligations for the enjoyment of the human right to health. Advocates have laid the groundwork on which a rapidly expanding enforcement paradigm has arisen at the intersection of human rights litigation and HIV policy. Consequently, many countries have transformed aspirational declarations into justiciable obligations and implemented human rights through national policies and programs.⁷³ Taking up the jurisprudential challenges in enforcing the rights based approach to HIV/AIDS, some Courts have relied on international human rights standards related to

⁷⁰ S Gloppen et al 'Right to health through litigation' unpublished, Harvard law school, (2008) 24.

⁷¹ A D Pinto & R E G Upshur *An introduction to Global health ethics* (2013) 50 .

⁷² [http://www.interights.org/right to health Africa](http://www.interights.org/right%20to%20health%20Africa) (accessed on 27 September 2013).

⁷³ Meier (n 3 above) 81.

health while others have been largely divorced from the interpretations of international human rights instruments and have instead focused on interpretations of national standards.⁷⁴

In South Africa, the court has resolutely rejected the minimum core idea and has preferred an approach that assesses the reasonableness of government conduct while in Colombia the Constitutional Court has chosen to entrench a minimum core of the right to health. The Constitutional Court of South Africa has been focusing mainly on the fact that the right to health requires only reasonable measures on the part of state within its available resources. Despite this approach, the right to health has gained substantive meaning in explicit scenarios in South African jurisprudence particularly in relation to the HIV/AIDS pandemic.⁷⁵

3.5 Litigation on health and related rights in the context of HIV

‘As equal human beings, the right to health belongs to every one of us. Our chances of enjoying good health must not be unfairly disadvantaged because of our sex, race, religion, age, language, colour, disability, health status (e.g. HIV/AIDS), national or social origin, sexual orientation, political or other opinion, property, birth, civil, political, social or other status as this is incompatible with our right to health’.⁷⁶

States are obliged through international and regional treaties or national constitutions to respect, protect and fulfil the human right to health. ‘In the vast majority of cases, the right to health has not been an enforceable legal right. However, cases regarding the right to healthcare are increasingly brought before the courts. In a number of low and middle income countries in Latin America and later in Africa have granted access to certain forms of medical treatment’.⁷⁷

‘The advent of antiretroviral treatment (ART), and its success in prolonging the lives of people living with HIV/AIDS, drove rights advocates to expand their efforts beyond asserting equality rights to framing access to anti-retroviral (ARV) drugs as a human rights issue’⁷⁸ and through domestic litigation empowered individuals to raise human rights claims for HIV prevention, treatment and care. Litigation has helped to make human rights a reality, giving meaning to state’s responsibility to realize the highest attainable standard of health for all. Litigation has been used as part of an advocacy strategy that can help in promoting and protecting the rights of people living with and affected by HIV.

However, it must be noted that the right to healthcare for PLHIV has been claimed through litigation more than the underlying determinants of health. The right to access to healthcare only is

⁷⁴ Meier (n 4 above) 82.

⁷⁵ K G Young & J Lemaitre ‘The comparative fortunes of the right to health: Two sales of justiciability in Colombia and South Africa’ (2013) 211-212 *Harvard human rights journal* 216.

⁷⁶ A Es & P Hunt ‘Our right to the highest attainable standard of health’ 4 (2007) 7,

http://www.ifhro.org/images/stories/ifhro/Right_to_health/3_2_2_factsheet_our_rth_2007.pdf (accessed on 10 September 2013).

⁷⁷ Gloppen (n 2 above) 1.

⁷⁸ Zuniga (n 4 above) 26.

not enough if the other components are not respected, protected and fulfilled. The right to access to healthcare cannot stand alone in the HIV context if the other rights are not also respected, protected and fulfilled as has been discussed earlier in the preceding chapter.

When a case is filed, taken to the court and won, a positive outcome is often to ensure that the state develops and implements policies which result in a suitable and equitable social environment for those who are already infected or affected by HIV/AIDS and who also live in poverty.

3.6 Cases litigated on the matter of health rights in South Africa and Colombia

The right to health needs the participation of the government to realize it by for example, providing medicines for PLHIV who do not have the means to afford it, and for people who are convicted, imprisoned and living with HIV. South Africa and Colombia are two countries whose judgements on the right to health I have chosen to study. I have noted that courts asked states to provide healthcare, treatment and services and to implement health plans for the wellbeing of their citizens. States also have the obligation to ensure that progressive measures are being taken in implementing those rights.

I have chosen South Africa because of its progressive constitution and Colombia because of the large number of cases decided and the special *tutela* process which will be discussed in more detail later.

3.6.1 Cases on the right to healthcare of PLHIV in Colombia

The right to health was introduced in Colombia in 1991 in its new Constitution and is elaborated in its article 49 and states that:

‘Public health and environmental protection are public services for which the state is responsible. All individuals are guaranteed access to services that promote, protect, and rehabilitate public health’.⁷⁹

The new Constitution establishes the Constitutional Court of Colombia (CCC) and introduces the *tutela* which is enshrined in article 86.⁸⁰ The *tutela* is an action which enables individuals to bring any constitutional claim before any court for the immediate protection of its fundamental human rights. Since then, Colombia has the highest number of right-to-health cases in the world.⁸¹ Between 1999 and 2010 there have been 2,725,361 *tutela* decisions.⁸² Its experiences illustrate how judicial claims can reflect structural problems of a health system. It also shows how, by exercising oversight and holding governments to their promises and obligations, courts can provide policy makers with

⁷⁹ Constitution of Colombia, article 49, http://www.confunder.richmond.edu/admin/docs/colombia_const2.pdf (accessed on 23 October 2013).

⁸⁰ Constitution of Colombia, article 86.

⁸¹ Gianella (n 2 above) 1.

⁸² Young (n 2 above) 186.

evidence to evaluate current policies and to discover structural problems.⁸³ Jurisprudence has evolved during the years and the CCC has adopted different approaches. Here are some cases that had been litigated on the matter of health issues by PLHIV in Colombia.

3.6.1.1 Case T-484/92⁸⁴

The CCC decided its first case in 1992 which considered the content and enforceability of the right to health in the context of a claim by person living with HIV challenging the discriminatory denial of healthcare coverage.⁸⁵ The first case was of a Colombian named Munoz living with HIV who filed an appeal in 1992 to the Constitutional Court against the Colombian Social Security Institute. He made a complaint seeking an order allowing him to continue to receive necessary medical treatment when he was informed by his doctor that his treatment would cease in 30 days. He got an extension from the Tulua Social Security Institute but he further requested the Court to order the government to go beyond those 180 days. The petitioner argued that the state would be in failure of the constitutional right to health which requires the state to ensure special protection of health for population groups facing economic, physical or mental vulnerabilities.

The Constitutional Court of Colombia held that the government was not required to provide free treatment for everyone but just for vulnerable people who were living with HIV. According to the Court the right to health is a fundamental right when related to the protection of life. The Court ordered the Social Security Institute to continue providing the treatment while the competent authorities determined how best to proceed in line with Court's ruling.

In stressing the fundamental status of the right to health, the Colombian Court did not look at further detailed analyses of how the right was set out in the international treaty, how it has been interpreted by other bodies. Unfortunately, the Court did not lay out more of its thinking on further interpretation of what the right to health entails which could have been helpful in advancing the right to health in Colombian law. It only focused on two human rights provisions in the national Constitution particularly the obligation to protect and promote free access to health services for those in need.⁸⁶

In 1993, one year after the decision, Colombia passed Law 100 with the purpose of transforming the public health system to one which required compulsory health insurance provided by both private and public companies.⁸⁷ This law was restrictive because it contained a scheduled list of benefits. The CCC tied its jurisprudence to the various aspects of this Law 100. Due in part to its

⁸³ Gianella (n 3 above) 1.

⁸⁴ Case T-484/92, <http://www.globalhealthrights.org/health-topics/health-care-and-health-services/munoz-ceballos-alonso-v-instituto-de-seguros-sociales-iss-t-48492/> (accessed on 20 October 2013).

⁸⁵ Young (n 3 above) 186.

⁸⁶ 'Courting rights: case studies in litigating the human rights of PLHIV' 2006 UNAIDS.

⁸⁷ Young (n 4 above) 188.

understanding of the new health care system under Law 100 and as a result of the large number of *tutelas* during the economic crisis, the CCC, in 1997 decided to limit its jurisprudence on the right to health setting two bases for justiciability. The first was if the claimant was *improperly* denied a service that was on the scheduled list of benefits. The second was if the services or treatment were not on the list, described as an “excluded benefit” but if it relates to a “high cost” illness such as HIV/AIDS. In these latter cases, the CCC decided that the claim was justiciable if there was a threat to life or dignity.⁸⁸

3.6.1.2 Case SU-480/97⁸⁹

In 1997 six writs of *tutela* against the Institute of Social Security were combined into one record and after different outcomes in each, a combined appeal to the CCC was made. Among the six writs, there was one which was brought by PLHIV that sought the inclusion of a protease inhibitor to treat HIV/AIDS which was excluded from the list. These medicines were needed for the treatment of HIV and AIDS. The institute refused to provide those inhibitors simply because they were not listed on the Ministry of Health’s manual of essential medicines at the time they complained. A further *tutela* within the group of six was filed by a PLHIV against a private company called the Health Promoting Entities (HPE). The plaintiff’s doctor prescribed a particular antiretroviral and the private company, HPE, refused to reimburse the plaintiff claiming that the medicines were not in the manual authorized by the Ministry of Health. HPE also claimed that the plaintiff’s case lay against the state, not a private provider. Finally, in what may seem unrelated but was in fact part of the group of *tutelas*, a complaint was brought by a group of PLHIVs, that their freedom of association had been breached as their support group, the Club of Happiness, were no longer allowed to hold their meetings at a particular clinic.⁹⁰

The CCC considered all these issues on appeal in one combined record as stated above and found that the right to health and social security were fundamental rights that created specific obligations for the state which the state delegated to HPE. One of these obligations was the provision of basic treatment. The court therefore found that ‘prescribed treatments and medicines needed to be provided in its totality’. It did however qualify its ruling in stating that, ‘... prescribed medicines would only be funded if they were essential, the prescription was for the generic form, and the prescription came from the patient’s treating physician’.⁹¹

Consequently, the Court stated that even if the medicine was not on the list the HPE should have provided the medicine free of charge and reclaimed the cost from the state if the patient’s life was at stake. On the issue of the claim for reimbursement from the private provider, the court also held that

⁸⁸ Young (n 5 above) 189.

⁸⁹ Case SU-480/97, <http://www.globalhealthrights.org/health-topics/health-care-and-health-services/case-su-48097/> (accessed on 20 October 2013).

⁹⁰ <http://www.globalhealthrights.org> (accessed on 06 November 2013).

⁹¹ As above.

doctors are free to prescribe medicines even if they were not on the list but that they consider necessary for “catastrophic diseases” such as HIV and AIDS. Finally it found that the Club of Happiness should be allowed to continue meeting and based its decision on Decree 1543 of 1997 which provides for a right to counselling.⁹²

In 2003, while the CCC took a step and accepted the minimum core principle and clarified the right to health for some level of consistency in Decision T-859/03, the criticism of this case is that it did not address the fundamental issues within the healthcare system which was leading it to a crisis point.⁹³

3.6.1.3 Decision T-760⁹⁴

In 2008, the CCC adopted *Decision T-760* which was the first to establish structural litigation guidelines to specifically order the government to address the major issues in the healthcare system. In this case, the Court analyzed 20 claims brought by individuals and 2 claims by insurance companies to determine whether regulatory failures represented a violation of the constitutional obligations of the competent authorities to respect, protect and fulfil the right to health and its effective enjoyment. In those different cases, the main issue was about the access to health services which was denied.

The Court held that the right to health was violated and that the state needed to take necessary measures to ensure sustainable universal coverage. However, the decision coincided with the coming of many cases related to the right of health and created instability in the health insurance system.⁹⁵

In January 2010, the government, instead of improving the health system, adopted decrees which only addressed the budget crisis. They, among other things, limited services that were not on the list to the extent of available resources and limited doctor’s ability to prescribe services and medicines, those decrees resulted in substantial regression from the progress that was made with respect to the health system. It consequently gave rise to protest and crisis in Colombia with many doctors, medical students, patients, trade unionists and marching for medicines and services mainly on an HIV platform.⁹⁶ Eventually, the CCC declared the decrees unconstitutional and in June of 2010 a new president was elected namely President Juan Manuel Santos. Some argue that his coming to power was a result of the protest described above and not surprisingly he very quickly introduced a new schedule which expanded the list of benefits services to include most of those ordered by courts

⁹² <http://www.globalhealthrights.org> (accessed on 6 November 2013).

⁹³ Young (n 6 above) 190.

⁹⁴ Decision T-760/08.

⁹⁵ Young (n 7 above) 192.

⁹⁶ Young (n 8 above) 194.

in the past.⁹⁷ In 2011, Law 1438 was introduced to reform the healthcare system and among those reforms were the improvement of the accountability and functionality of the healthcare provider, the availability of resources for primary and preventive care and free healthcare coverage for children.⁹⁸

3.6.2 Cases on the right to healthcare for PLHIV in South Africa

South Africa included the right to health in its constitution even though it has only signed and not yet ratified the ICESCR. The right to health is elaborated in section 27 of the Constitution of the Republic of South Africa (CRSA) which states that:

- ‘1) Everyone has the right to have access to
 - a. health care services, including reproductive health care;
 - b. sufficient food and water; and
 - c. social security, including, if they are unable to support themselves and their dependants, appropriate social assistance.
- 2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of these rights.
- 3) No one may be refused emergency medical treatment’.⁹⁹

However, its realization is difficult to secure. Poverty, gross income disparities, extremely high burden of disease are some of the obstacles in South Africa which can hardly unlock the right to health to make significant progress.¹⁰⁰ But despite those obstacles, South Africa has built a strong jurisprudence around the social and economic rights and especially in protecting the right to healthcare for vulnerable people. Under the CRSA, organizations such as the Treatment Action Campaign (TAC) have the *locus standi* to bring cases on behalf of people who can’t afford to pay fees for a lawyer.

I will describe the fact and outcome of each case and thereafter analyse some aspects of the cases.

3.6.2.1 Cases of HIV prisoners

3.6.2.1.1 Van Biljon and Ors. v. Minister of Correctional Services¹⁰¹

In 1996, the transformative CRSA inspired many human rights activists by incorporating the justiciable economic and social rights. In 1997, four prisoners living with HIV complained against the Minister of Correctional Services to the High Court because they were not accessing the ARV treatment while they were convicted. Their arguments were based on an order that the South

⁹⁷ Young (n 9 above) 195.

⁹⁸ Young (n 10 above) 196.

⁹⁹ Constitution of South Africa, chapter 2, section 7, article 27(2).

¹⁰⁰ C Ngwena ‘The recognition of access to health care as a human rights in South Africa: Is it enough?’ (2000) 26 *The president and fellows of Harvard college* 44.

¹⁰¹ Van Biljon and Ors. v. Minister of Correctional Services and Ors. 1997 6 BCLR 789 (C).

African government had made when it declared that prisoners living with HIV who had reached the symptomatic stage of the disease and whose Cluster of Differentiation 4 (CD4) counts was less than 500 per millilitre of blood was entitled to receive antiretroviral treatment for free. But at that time, the Department of Correctional Services was providing only monotherapy to prisoners, rather than the recommended triple combination therapy, and only prisoners with a CD4 count of less than 200 were receiving ARV treatment because of budgetary constraints. ARV treatment was provided by the department when HIV had developed into AIDS. The department argued that they did not have at that time, guidelines establishing when antiretroviral treatment was needed.

The Court held that the budgetary constraints did not justify the failure to realize a prisoner's right to adequate medical treatment which was an infringement of the Constitution and also that the government failed to give special assistance to prisoners who were vulnerable regarding their conditions of life and moreover their health status.

The Court ordered the Government of the Republic of South Africa to take on a greater responsibility than progressive realization of the highest attainable standard of health as recognized in article 12 of the International Covenant on Economic, Social and Cultural Rights and other international human rights treaties and created an important precedent for future advocacy for the health of all prisoners. Even if the case appeared to be a major victory for prisoners living with HIV in South Africa, it turned out to be less of a practical victory because there was no follow up with further lobbying.¹⁰²

3.6.2.1.2 EN and Ors. v. South Africa¹⁰³

Fifteen prisoners living with HIV from the Westville Correctional Centre (WCC) in KwaZulu-Natal province and TAC which was acting in the public interest filed an urgent application to the High Court in 2006. The applicants were acting in their individual capacities and as representatives of the class of prisoners incarcerated at WCC. They claimed that the government of the Republic of South Africa was not providing medical treatment and thereby was in breach of their constitutional obligations in ensuring that prisoners living with HIV were receiving adequate medical treatment. The applicants were asking the government to remove as quickly as possible impediments to accessing the treatment and at the same time avoid much delay which was compromising their health. The respondents alleged that they were not in breach but that they were taking reasonable steps in ensuring access to adequate treatment for prisoners at Westville Correctional Centre.

The High Court of Durban after examination of all facts held that the government has not taken reasonable steps and ordered it to remove immediately the restrictions preventing the prisoners from accessing the ARV treatment and to make it available for all other prisoners living with HIV who

¹⁰² 'Courting rights: case studies in litigating the human rights of PLHIV' 2006 UNAIDS.

¹⁰³ EN and Ors. v. South Africa 2007 1 BCLR 84 (D).

were convicted. The implementation of this decision was not easy. It took a long period of negotiations between TAC and the state's representatives; it was complicated further because there was no willingness on the part of the state to implement the order. But after long negotiations, the government did recognize the need to make the drugs available and also to develop and implement specific plans related to the improvement of the health of prisoners living with HIV.¹⁰⁴

3.6.2.2 Treatment Action Campaign v Minister of Health (TAC)¹⁰⁵

Treatment Action Campaign (TAC) a non- governmental organization lobbying for universal access to antiretroviral drugs and other members of civil society filed a case against the government of South Africa in the High Court. They complained about a national program which has been developed with the purpose of offering nevirapine, a drug which prevents the transmission of HIV from mother to child, to pregnant women living with HIV. Unfortunately, the drug, which was free of charge, was only accessible for a small number. It was available at research and training sites through the country. But in the meantime, mothers and babies who could not access the research and training sites and who could not afford private healthcare were not accessing the drug because public hospitals and clinics other than research sites were not enabled to prescribe nevirapine to reduce the risk of transmission.

The High Court found that the government had not taken reasonable steps to address the need to reduce transmission of HIV among pregnant women to their child and thereby violated the Constitution in its section 27 and 28 which guarantee the right of everyone to have access to public healthcare services and the right of children to be afforded special protection. The government did not agree with the decision of the High Court and launched an appeal before the Constitutional Court.

The Constitutional Court of South Africa (CCSA) after examining whether socio-economic rights were enforceable ordered the government to remove those restrictions that prevent nevirapine from being made available at public hospitals and clinics and obliged it to ensure that children are receiving the protection contemplated by section 28 that arises when parental or family care are lacking. Finally, the Court ordered the government to make available resources in order to implement the program efficiently and to coordinate the program to progressively realize the right of pregnant women and their newborn children to access health facilities. Nevirapine is now provided in all government hospitals and medical practitioners are entitled and empowered to decide whether or not to prescribe it.

¹⁰⁴ http://www.tac.org.za/Documents/Court_Cases/Westville_Prisoners/Alp2007.pdf (accessed on 1 November 2013).

¹⁰⁵ Treatment Action Campaign v. Minister of Health 2002 10 BCLR 1033 (CC).

Since 2000, the right to health has been litigated more indirectly through duties to regulate the healthcare system and to provide for the social determinants of health through other economic and social goods. For example, cases on the right to adequate housing has been brought in South Africa such as *Government of the Republic of South Africa and others v. Grootboom and others* (*Grootboom case*) where Mrs Grootboom and other homeless people filed a complaint requiring the government to provide adequate basic shelter. In the *Grootboom case*,¹⁰⁶ the complainants applied to the High Court in 2002 asking for an order which will require the government to provide them with basic shelter. The homeless complainants were illegally living on someone's private land and they were evicted from their informal homes built on this land. The High Court held that the government was obliged to provide to children and their parents immediate shelter but rejected the argument of providing minimum shelter to everyone. The government appealed to the Constitutional Court (CC) but the CC extended the right to housing to everyone including those without children. The Constitutional Court declared that the government had failed its constitutional obligations and ordered it to devise, fund, implement and supervise measures to provide relief for all.

Other cases have been brought on the matter of water and sanitation like in *Nokotyana and others v. Ekurhuleni Metropolitan Municipality case* and *Mazibuko, Lindiwe v. City of Johannesburg and others case*. In *Nokotyana and others v. Ekurhuleni Metropolitan Municipality*,¹⁰⁷ the members of the Harry Gwala Informal Settlement filed in 2009 a complaint against the Ekurhuleni Metropolitan Municipality. The applicants were asking the Municipality to install communal water taps and refuse removal services at their Settlement and the High Court did in fact order the government to provide for some of those services. But they failed to get an order from the High Court to provide for the sanitation services and decided to appeal to the Constitutional Court. The Constitutional Court also held that the Municipality did not have an obligation to provide for sanitation services.

The same year, in *Mazibuko, Lindiwe and others v. City of Johannesburg and others case*¹⁰⁸ five residents of Soweto brought a complaint before the High Court against the City of Johannesburg challenging the legality of a project which will charge consumers for the use of water and challenged also the legality of the installation of pre-paid water meters by the City of Johannesburg. They failed and decided to appeal before the Constitutional Court. The Constitutional Court held that the project was respecting laws and found that the city had done diligence in reviewing and evaluating its water policy.

¹⁰⁶ *Government of the Republic of South Africa and others v. Grootboom and others* 2000 11 BCLR 1169 (CC).

¹⁰⁷ *Nokotyana and others v. Ekurhuleni Metropolitan Municipality* 2010 4 BCLR 312 (CC).

¹⁰⁸ *Mazibuko, Lindiwe and others v. City of Johannesburg and others* 2009 4 SA 1 (CC).

The approach that have been adopted by the South African Courts regarding adjudication on those socio-economic rights, was based on the reasonableness of the state's legislative and other measures within its available resources.¹⁰⁹

¹⁰⁹ K Mc Lean *Constitutional Deference, courts and socio-economic rights in South Africa* (2009) 126.

CHAPTER IV: STRATEGIES FOR LITIGATION ON THE RIGHT TO HEALTH

4.1 Introduction

The best way to empower people to cope with HIV and AIDS is to protect their dignity and human rights. And the best way to enforce these rights is to advocate and litigate for their fulfilment in their respective countries which leads to an effective HIV response.¹¹⁰

Litigation in Colombia and South Africa has become an attractive and often chosen human rights advocacy tool. All the cases discussed in the previous chapter have been litigated either by an organization on behalf of PLHIV or by themselves for their wellbeing, and for their dignity but mostly for their basic health. Jurists were called upon to interpret international law and national laws regarding the right to health and in most cases, and all the cases mentioned above, the litigants claiming their rights were successful. At times they successfully challenged the government on its failure to implement national programs and policies like in the *TAC* case for example. Supporting the implementation of human rights, these cases have resulted in tangible outcomes in some instances, like the provision of essential medicines to the sick.

Before looking at the different strategies used to litigate on the right to health, I first look at some of the obstacles to litigation and how some of these obstacles have been overcome in South Africa and Colombia.

4.2 Obstacles to litigation on the right to health

4.2.1 Non ratification of the international treaties

Non ratification of international treaties in general and of International Covenant of Economic, Social and Cultural Rights in particular is an obstacle to litigation on human rights. In monist countries for example, according to international law theory, once the international treaties are ratified, it is automatically incorporated in national law and provisions of those treaties are enforceable by the court. 'But in practice, judges have denied applicability of ratified treaties when it has not yet been published at the national level'.¹¹¹

Most important, non ratification of the ICESCR means not having the opportunity to benefit from the provisions its Optional Protocol which opens the door to individual complaints when local remedies are all exhausted.

¹¹⁰ 'Courting rights: case studies in litigating the human rights of PLHIV' 2006 UNAIDS.

¹¹¹ Killander (n 3 above) 6.

South Africa is one of the countries that has only signed the ICESCR, on 3 October 1994,¹¹² but has not yet ratified it. It follows that South Africa has also not signed the Optional Protocol. If South Africa ratifies the ICESCR, it will be bound by the obligations, goals and standards that arise from the ICESCR and it will also be obliged to ensure that it does not infringe upon the spirit of the ICESCR. It would also be subject to the reporting procedures of the ESCR Committee.

4.2.2 Non domestication of the international laws

Non domestication of international law is also an obstacle to litigation on socio-economic rights in general and the right to health in particular. In dualist countries where ratification is not sufficient to enforce any international human rights provision, domestication of those provisions is required. Lawyers need a basis on which to litigate.

Specific provisions like the right to health need to be incorporated in a state party's constitution. South Africa, even though it has not yet ratified the ICESCR, is more advanced than some countries regarding the incorporation of socio-economic rights in its domestic legislation.¹¹³ It has included a range of socio-economic rights in its constitution and the right to health is also enshrined in article 27. 'Moreover, a significant body of case law has emerged from the South African Constitutional Court defining the scope of these rights'¹¹⁴. The right to healthcare as I have mentioned in the previous chapter has been addressed by the Constitutional Court several times. Hence, it can be concluded that it is important to ensure that domestic constitutions include provisions regarding socio-economic rights in general and the right to health in particular, as litigation is impossible in some countries without it.

4.2.3 Limited knowledge of international human rights law

The complexity of litigating socio-economic rights needs special education and special legal training. In Francophone Africa, many lawyers are not trained and qualified in human rights laws.¹¹⁵ It is a serious handicap when such lawyers are called upon to interpret provisions contained in the ICESCR and worse still when they are called upon to litigate based on international human rights. Lawyers and judges must be familiar with international human rights laws and have enough knowledge in terms of litigation on human rights issues.

Lawyers who litigate for the enforcement of human rights norms and standards need to be knowledgeable regarding both national laws and international laws in both monist and dualist system. Lawyers involved in this type of litigation also need to be aware of the relevant judgments under international law on the matter of human rights and specifically with respect to the right to

¹¹²D Petherbridge 'South Africa's pending ratification of the ICESCR: What are the implications?' 1 (2013).

¹¹³E Wiles 'Aspirational principles or enforceable rights? The future for socio-economic rights in national law' (2006) 37 *AM.U.INT'L L.REV.* 64.

¹¹⁴Wiles (n 2 above) 37

¹¹⁵Killander (n 4 above) 19

health. Jurisprudence is particularly important in common law jurisdictions where precedent plays an important role in the decisions handed down by the court.

Ordinary people also need to have knowledge of their rights, even if it is just basic knowledge, as without such knowledge they will not be able to recognise when their rights have been violated and consequently are less likely to seek help to enforce their rights.

4.2.4 High cost of litigation

Taking a case to the court is an expensive exercise including in some cases the cost of lawyers. Free legal assistance may be provided for those who cannot afford the fees of lawyers but this is not the case everywhere and certainly not in every country in Africa. Consequently, although vulnerable people need assistance, many of them are unable to access the court due to the lack of legal aid, especially in civil law and human rights matters, and especially in the poorer countries in Africa.¹¹⁶

To address this problem, Colombia has enshrined in his constitution a *tutela* action which allows individuals to take their complaints to every court in Columbia. When people perceive that their fundamental rights have been infringed upon by the government, they may bring this type of simple *tutela* with or without the assistance of trained lawyers. It is a popular mechanism which has been used by poor people to claim their constitutional rights.

4.3 What factors have contributed to litigation on the right to health in South Africa and Colombia?

4.3.1 Purposive interpretation of law

‘Purposive approach is an approach to statutory and constitutional interpretation under which common law courts interpret an enactment in light of the purpose for which it was enacted’.¹¹⁷ Interpreting a constitution or a provision may not change the substance or create a new provision.

Jurists in Colombia have interpreted the right to health, which is enshrined in the constitution, and have used that right in a way that it is related to the protection of life. For example in the *Case T-484/92*, the Court held that the right to health was fundamental when related to the protection of life. The Court explained that the right to health constitutes a fundamental right to be protected for health threats and also that it is a social right which implies positive obligations binding on the state. It also declared that the right to health was connected to the right to be free from any discrimination and required to provide health services for marginalized groups.

¹¹⁶ F Viljoen *International human rights law in Africa* (2007) 451.

¹¹⁷ http://www.wikipedia.org/wiki/Purposive_approach (accessed on 29 October 2013).

4.3.2 Locus standi

South Africa has in its constitution a provision which specifically addresses the issue of *locus standi*. This provision has been an important tool in the enforcement of the right to health specifically and more generally in the public interest. Section 38¹¹⁸ of the South African Constitution states that:

‘anyone listed in this section has the right to approach a competent court, alleging that a right in the Bill of Rights has been infringed or threatened, and the court may grant appropriate relief, including a declaration of rights. The persons who may approach a court are:

- a) anyone acting in their own interest;
- b) anyone acting on behalf of another person who cannot act in their own name;
- c) anyone acting as a member of, or in interest of, a group or class of persons;
- d) anyone acting in the public interest; and
- e) an association acting in the interest of its members’.

Hence in the *TAC case*, the TAC brought the case as organization acting in the public interest and in the interest of its members. In situations where individuals are afraid or unable to litigate in their own name, and are ignorant of their rights, provisions such as these which expand the grounds for *locus standi* are particularly important.

4.3.3 Knowledgeable and organised community

A case which is brought by a litigant without any knowledge of human rights is less likely to succeed than a case brought by litigants who have greater knowledge of their rights. Moreover, cases brought by an organised group have greater chances of success during the litigation and importantly after the judgment as this group can help apply pressure on government to implement the court’s decision. TAC in South Africa, in the *TAC case* and in other cases, was able to succeed and save many lives because their members are knowledgeable about human rights litigation and they are organized. This suggests that those who wish to bring a claim to court should ensure that they are an organised and well equipped group if they want to get a good result from their case.

4.3.4 Public interest litigation

‘Public interest litigation means a legal action initiated in a court of law for the enforcement of public interest or general interest in which the public or class of the community have pecuniary interest or some interest by which their legal rights or liabilities are affected’.¹¹⁹ Public interest

¹¹⁸ Constitution of South Africa, chapter 2, section 38

¹¹⁹ <http://www.newindialaw.blogspot.com/2013/04/public-interest-litigation.html>, (accessed on 29 October 2013)

litigation also means many related cases which are brought before the court for the same remedies. It is a very specialist type of litigation strategy.

It has been argued that courts by themselves cannot bring about social reform without some form of public interest litigation.¹²⁰ Courts can bring about social change but to be more effective it needs to be in conjunction with public litigation. This has been clearly demonstrated in the cases analysed in the previous chapter. One of the main contributing factors for successful public interest litigation has been the effective mobilisation and organisation at the community level.¹²¹ 'Public interest litigation is successful when some factors are taken into consideration such as a proper organisation of clients, overall long term strategy, co-ordination and information sharing, timing, research, characterisation and follow-up'.¹²² Clearly, like in every court case but even more importantly in public interest litigation, thorough research and preparation is essential. In the context of public interest litigation, however, the preparation extends beyond what is normally expected of an ordinary commercial lawyer.

4.3.5 Committed and dedicated organisational representatives and social justice lawyers

Vulnerable people and organizations acting for the wellbeing of the poor are the ones that need to benefit from public interest litigation, particularly litigation to protect their right to health. These vulnerable people need first and foremost, organisational representatives who are trustworthy, skilled and committed to their cause. In addition, they need lawyers who are also committed to their cause. An independent lawyer who is not committed to the cause of his/her client or client community is less likely to go the extra mile for a successful outcome. Such lawyers need to have a healthy balance between commitment to the cause and the ability to objectively assess the case, its strengths and weaknesses and ultimately develop a good strategy.

4.3.6 Other factors

Apart from the support and assistance of committed organizations, there is another factor that can and has in fact contributed to the success of some cases. Effective litigation on health issues for marginalized groups needs to consider *all* dimensions and aspects of the case and needs to be focused on one specific issue that can realistically be achieved through litigation and capture the attention of the judges. For example, in the *TAC case*, litigants could have chosen to address many different issues such as demanding the provision of AZT. However, after examining all the dimensions, including the contextual issues, they chose to focus on addressing the very pertinent subject of prevention of mother to child transmission through the provision of nevirapine for pregnant women living with HIV.¹²³ The judges were convinced and the Court asked the

¹²⁰ G Marcus & S Budlender *A strategic evaluation of public interest litigation in South Africa* (2008) 116.

¹²¹ Marcus (n 2 above) 126.

¹²² Marcus (n 3 above) 119.

¹²³ Marcus (n 4 above) 74.

government to make the medicine available in all hospitals within the country without any delay. We cannot know what would have happened had they chosen to address a more broad issue, such as the underlying determinants to health but it has been argued that the narrow focus in this case was both one of the reasons why it succeeded and at the same time this narrow focus has resulted in a narrow conception of what the right to health actually means.¹²⁴

In brief, the decision to embark on litigation and the choice of strategy is made of many factors which need to be reflected on deeply before taking the case to the court. A good litigant must consider the prospects of success and must also consider the impact that the court's judgment may have on the life of vulnerable people, especially, the impact of losing a case.

Conclusion

Litigation on the right to health is a powerful tool to push for the highest attainable standard of health. Many cases on the right to healthcare have been brought to courts in South Africa and in Colombia by PLHIV and some of them have been successful, some have not.

This mini-dissertation is divided into four chapters. After the introductory chapter which sets out the rationale behind this study, the next chapter provided an overview of the right to health under the international and regional human rights instruments and its link with HIV. In this chapter I looked at the obligations of states with respect to the right to health and then specifically as it pertains to PLHIV. In the next chapter, I looked at litigation on the right to health before international, regional and domestic tribunals. Thereafter I looked specifically at a few selected cases that were brought in Colombia and South Africa. After describing them, I provided a brief analysis of each. In the fourth chapter I looked more closely at the obstacles to health rights litigation and factors that contributed to its success. In the final chapter I drew out certain recommendations as a result of the research undertaken in this study.

This study has led me to conclude that cases on the right to healthcare, which is one of the components of the right to health, demonstrate that in South Africa and in Colombia states have been forced by the court to enforce that right when there was an infringement. This study shows also that case related to the right to healthcare are successful because they are linked directly to the right to life and therefore capture the attention of public opinion and the attention of the court thus making it easier to litigate. The right to food, to adequate housing, to water and sanitation which are the underlying determinants of health could also follow the same pathway made by the right to healthcare to improve the state of health of PLHIV.

HIV/AIDS helped to show that justiciability of socio-economic rights is possible. HIV/AIDS shows once more that one component of the right to health, the right to healthcare, is justiciable before the

¹²⁴ A E Yamin et al; 'The role of the courts in defining health policy: The case of Colombia Constitutional Court' 4.

court but only needs an innovative and creative approach. Finally, I conclude that greater strides need to be taken on the other aspects of the right to health with a similar determination to ensure that greater impact is felt in the lives of poor and vulnerable people who live with HIV.

Recommendations

After reflecting upon the cases in Colombia and South Africa on the right to health and after reflecting on the strategies that were used, the judgments that were handed down and the situation of vulnerable people after the case, I now propose a few recommendations to national governments, lawyers involved in right to health litigation and non-governmental organisations (including community based organisations) as follows:

National governments:

- 1) I recommend that national governments who have not already ratified the ICESCR take steps to do so as soon as possible in the interests of their people. Further, that states who are already party to the ICESCR should ensure that they should incorporate and domesticate its provisions in their national laws;
- 2) States who have not already domesticated the provisions should hastily ratify the Optional Protocol to the ICESCR which allows for individual complaints;
- 3) National governments need to ensure that provisions on the right to health, as defined in General Comment 14, are incorporated in their constitution. More specifically their constitutions should include the right to health, water, sanitation, housing, education and a clean and healthy environment;
- 4) States need to consider developing procedures to allow for greater access to courts for ordinary people. More particularly they should look at how ordinary people, including the poor and vulnerable, are able to address constitutional issues. Some courts have chosen to accept letters from people.¹²⁵ In Colombia, the *tutela* action was the chosen route and as was seen above it resulted in substantially greater access to the courts. It is therefore recommended that other national governments should consider incorporating this system;
- 5) As was seen earlier in the discussion regarding the South African context, an expanded *locus standi* provision which allows organizations to stand on behalf of marginalized interests groups enabled the TAC to bring a case on the prevention of mother to child transmission of HIV. Clearly, this type of provision was extremely helpful and necessary. It is consequently recommended that national governments review their law regulating legal standing and expand the provisions where appropriate;
- 6) It has been stated that understanding and knowing what one's rights is important as only then will people realise that their rights have been violated and try to obtain help. Consequently as

¹²⁵ India and South Africa countries do have an authority who receive letters from people.

part of its obligation to fulfil, national governments must ensure that their education system, from primary school to higher education, includes knowledge and some basic skills regarding human rights in general and the right to health in particular;

- 7) From the beginning of this mini-dissertation, I have discussed the various dimensions of the right to health and that it includes the underlying determinants of health, namely food, water, sanitation, housing, education and a clean and healthy environment. The departments of health of each government should ensure that they understand the full meaning of the right to health *and* its underlying determinants. Appropriate training programmes should be undertaken to achieve this goal and national strategic plans on health should include interventions on all aspects of the right to health and its underlying determinants;
- 8) The relevant department within government should ensure that access to justice, including access to international and regional human rights mechanisms, is addressed in their programme of action. More specifically, they should ensure that they have a structured and efficient system to provide free legal aid to people who cannot afford a private lawyer.

Lawyers involved in right to health litigation

- 1) Throughout this mini-dissertation I have talked about the importance of international and regional human rights norms and standards regarding the right to health. Lawyers involved in litigation on the right to health should ensure that they have a deep and thorough understanding of the right to health under international and regional human rights law. Further that they are able to apply these norms and standards in their litigation strategy. And finally, if called upon to do so that they are able to use the mechanisms created under international and regional human rights law;
- 2) In this study I have looked at cases on the right to health in South Africa and Colombia. Each country has provided a rich body of jurisprudence and interesting strategic approaches that could help litigation elsewhere. I have not discussed litigation in countries like India and Brazil but suggest that it is also very important that lawyers involved in health rights litigation ensure that they study strategies used in other countries, what was successful and what strategies presented problems as they develop their litigation strategy;
- 3) The relationship between the lawyer and the non-governmental organisation was also seen to be an important dimension, particularly in the *TAC case*. This resulted in a victory of the community of people living with HIV and not just a victory in court. It is therefore important for lawyers involved in right to health litigation to ensure that those that are directly involved in the case and the outcome of the case should understand their rights, the strategy and should play a central role at all stages in the case, including after the judgement has been handed down;

- 4) Lawyers who specialise in human rights litigation and particularly right to health litigation should establish and participate in forums where they discuss their strategies and share ideas on how to learn from mistakes and improve their interventions; and
- 5) Lawyers at universities should establish legal aid clinics where possible and those in private practice should assist these legal aid clinics in litigating on health rights particularly, but also more generally on other issues as well.

Non- Governmental Organizations (NGOs)¹²⁶:

- 1) As was seen in both Colombia and South Africa, active, engaged and committed non-governmental organizations were extremely important to the success of the litigation strategy. It is therefore important that non-governmental in all countries that deal with health related issues ensure that their members and beneficiaries understand the human rights dimension of health issues where possible. They should play an active role in increasing awareness, mobilising and organising people around right to health issues including its underlying determinants;
- 2) Non-governmental organisations that are involved in public interest and human rights litigation generally, and particularly on the right to health should ensure that they build a strong network of committed people to help those who need their services but cannot afford a private lawyer. This network will also help ensure that knowledge and materials are shared and lessons are learned from each other's mistakes;
- 3) The role of non-governmental organisations in right to health litigation does not end at the point where they refer clients to a lawyer or public interest non-governmental organisation. They should actively participate in each stage of the case as stated above and ensure that once a favourable decision has been handed down that they continue to follow up on the implementation of the decision that has been made by the court. By doing this they will apply pressure on a government that does not have the will or does not want to implement judgments which improve the lives of its population and therefore the right to health. In addition, this type of role sometimes results in implementation taking place faster as the government knows that the non-governmental organisation is watching them;
- 4) Non-governmental organisations that operate in countries that are state parties to the ICESCR should ensure that they participate in the development of shadow reports to state party's periodic report to the Committee of ESCR and the ACHPR and particularly raise issues on the implementation of the norms and standards regarding the right to health; and
- 5) Where possible and necessary organisations should engage in media-advocacy strategies to popularise the cases that were fought in court.

Word count: 15 725

¹²⁶ CBO's recommendations are included in the NGO's recommendations.

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