

WHY STATE POLICIES THAT UNDERMINE HIV LAY COUNSELLORS CONSTITUTE RETROGRESSIVE MEASURES THAT VIOLATE THE RIGHT OF ACCESS TO HEALTH CARE FOR PREGNANT WOMEN AND INFANTS

STU WOOLMAN^{*}
COURTENAY SPRAGUE^{**}
VIVIAN BLACK^{***}

ABSTRACT

The authors make two distinct, but related, arguments. First, their empirical studies – conducted in three antenatal clinics in inner-city Johannesburg – demonstrate a strong correlation between (1) the government’s failure to provide adequate remuneration to and secure employment of lay counsellors for the provision of HIV counseling and treatment; and (2) the failure of many women and children to receive timely medical interventions. The data show that late payment of HIV lay counsellors has a devastating impact on HIV testing in these three clinics. The evidence also demonstrates that such timely HIV prevention and treatment is required for the survival of pregnant women and their neonates. Lay counsellors – through no fault of their own – are often unable to make these timely interventions. Second, the authors contend that the government’s conscious deployment of inadequately remunerated and institutionally marginalized lay counsellors instead of health care professionals (who had previously undertaken counselling and testing) constitutes a *retrogressive measure* in terms of s 27 of the Constitution. In short, despite the government’s commitment to an expanded, more efficacious ART rollout, it is currently delivering *less* health care – not more – and *less access to adequate health care* – not more or better – to this cohort of patients with HIV. Such retrogressive measures offend the Court’s own understanding of the delivery of this constitutionally-mandated public good to pregnant women with HIV and their infants. The failure of the government to provide adequate and timely remuneration and secure employment to lay counsellors rises to the level required for finding an unjustifiable limitation of s 27’s right of access to health care services. As the authors show, the violation flows from the improperly remunerated, insufficiently trained and generally marginalized manner in which lay counsellors are (mis)managed by a public health system that has chosen to supplant well-trained professionals with well-intentioned non-professionals in the delivery of essential components of now constitutionally-mandated ART and PMTCT programmes.

* Professor, School of Law, University of Pretoria; Senior Research Fellow, SAIFAC.

** Associate Professor, Wits Business School; University of the Witwatersrand.

*** Doctor and Senior Clinical Manager, Maternal Health & HIV, Reproductive Health and HIV Research Unit (RHRU), Department of Obstetrics and Gynaecology, University of the Witwatersrand.

I INTRODUCTION

Dante knew who he was looking for during his descent into *The Inferno*: Beatrice. Moreover, he had the benefit of a guide: Virgil. While it may have been one hell of a trip, it was a trip undertaken with some understanding of what lay ahead. The same cannot be said for many of the pregnant women who seek HIV testing, counselling and antiretroviral treatment (ART) for their own health, and antiretroviral (ARV) prophylaxis to prevent HIV transmission to their infants (prevention of mother to child transmission, PMTCT), as part of our government's national HIV/AIDS programme.

On paper, our government appears to possess a comprehensive and coordinated plan to provide ARVs to pregnant woman and children with HIV.¹ The ART programme is intended to keep mothers healthy, while the PMTCT programme is meant to prevent HIV transmission to their infants. And yet, as we aim to show in just one small way, it is a plan that lacks the requisite commitment of resources to make good its promises. The failure to provide adequate remuneration and secure employment to the lay HIV counsellors who work at the coalface of prevention and treatment may be one of the primary reasons that national PMTCT coverage is only 33 per cent.²

Over the past decade, South Africa has witnessed a radical shift in the causes of death for women. Medical Research Council (MRC) findings demonstrate that this shift correlates with an 'extremely rapid change in the cause of death profile resulting from the HIV/AIDS epidemic'.³ (Other epidemiologists concur and, unequivocally document the direct impact of HIV/AIDS on child and adult mortality.⁴) Research conducted by the MRC concludes that: 'HIV/AIDS is the leading cause of premature mortality in 2000 in all provinces, but ranges from 14% of the total in the Western Cape to 51% of the total in KwaZulu-Natal'.⁵ Despite problems with data collection, and variations in findings among six data sources, maternal deaths in South Africa are likewise on an upward trajectory. Of particular import: primary causes of maternal deaths have shifted from hypertension and

- 1 See National Department of Health *HIV & AIDS and STI Strategic Plan for South Africa (2007–2011)* (2007); National Department of Health *Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa* (2003).
- 2 WHO/UNAIDS *Epidemiological Fact Sheet on HIV/AIDS: Core Data on Epidemiology and Response South Africa* (July 2008 Update). UNAIDS/WHO Working Group on Global HIV/AIDS & STIs (2008). It is important to note that only 12 per cent of pregnant women currently enrolled in PMTCT programmes ultimately secure access to antiretrovirals. WHO *Towards Universal Access Scaling Up Priority HIV/AIDS Interventions in the Health Sector: Progress Report* (2008) 94.
- 3 D Bradshaw & N Nannan 'Mortality and Morbidity among Women and Children' in P Ijumba & A Padarath (eds) *South African Health Review 2006* (2006) 127.
- 4 D Jamison, R Feachem, M Makgoba, E Bos, F Baingana, K Hofman & K Rogo (eds) *Disease and Mortality in Sub-Saharan Africa* 2 ed (2006).
- 5 D Bradshaw, N Nannan, R Laubscher, P Groenewald, J Joubert, B Nojilana & R Norman *South African National Burden of Disease Study 2000: Estimates of Provincial Mortality* (2000).

haemorrhage to non-pregnancy related infections resulting from diseases attributed to HIV.⁶

Significant gains in child and maternal health were achieved between 1975 and 1995. However, we are currently witnessing a dramatic reversal in health outcomes for pregnant women and children. Recent increases in child mortality are due, in large part, to HIV and other common, infectious diseases. While children's deaths are underreported,⁷ reliable sources strongly suggest that 50 per cent of current child deaths in South Africa are preventable.⁸

Grim as that picture is, it must be framed by an even broader failure of the public health system to transform a fatal disease into a chronic illness: 1.7 million South Africans require immediate access to ART.⁹ Only some 460,000 South Africans living with HIV who require ART have access to such treatment. Moreover, current efforts to treat our HIV-infected population cannot accommodate the more than 600,000 individuals who will require immediate access to antiretrovirals each year, every year, for at least the next ten years.¹⁰ For pregnant women and children, the situation is

- 6 See National Department of Health *Saving Mothers Report on Confidential Enquiries into Maternal Deaths in South Africa* (1999); R Pattinson 'Maternal Health' *South African Health Review 2006* (2006); National Department of Health *Saving Mothers' Lives: Reviewing Maternal Deaths to Make Motherhood Safer – 2003–2005* (2007) Chapter 7. See also WHO, UNICEF, World Bank & UNFPA *Maternal Mortality in 2005* (2007). Department of Health *Report on Confidential Enquiries into Maternal Deaths in South Africa* (2006); Department of Health (Bob Pattinson (ed)) *Saving Mothers Report on Confidential Enquiries into Maternal Deaths in South Africa* (1999); Department of Health *Report on Confidential Enquiries into Maternal Deaths in South Africa* (2001); D Jamison et al (note 4 above); R Dorrington, D Bradshaw, L Johnson, D Budlender & TJ Daniel *The Demographic Impact of HIV/AIDS in South Africa: National Indicators for 2004* (2004); D Bradshaw, R Laubscher, R Dorrington, D Bourne & I Timaeus 'Unabated Rise in Number of Adult Deaths in South Africa' (2004) 94 *SA Medical J* 278–9; P Groenewald, D Bradshaw, R Dorrington & D Bourne 'Identifying Deaths from AIDS in South Africa: An Update' (2005) 19 *AIDS* 744.
- 7 A central database to collect information on child deaths in South Africa is absent and sorely needed.
- 8 See South Africa Every Death Counts Writing Group 'Every Death Counts: Use of Mortality Audit Data for Decision Making to Save the Lives of Mothers, Babies, and Children in South Africa' (2008) 371 *Lancet* 1294; K Abrahams *Facts about Child Deaths in South Africa 2006* (2007); M Shung-King, RE Mhlanga & H de Pinho 'The Context of Maternal and Child Health' (2007) *South African Health Review 2006* 107. At present, the Department of Health oversees formal national structures to review child deaths through the National Council for the Confidential Enquiry into Maternal Deaths. A broad range of data on child deaths is currently available. These statistics are drawn from different data sources: the Medical Research Council, the Department of Health; Statistics South Africa; the World Health Organisation and others. Criteria for defining and collecting the data vary amongst these agencies. However, even with such inconsistency, it is clear that child mortality and morbidity rates are rising in South Africa.
- 9 See WHO/UNAIDS *Epidemiological Fact Sheet on HIV/AIDS: Core Data on Epidemiology and Response South Africa* (2008 Update).
- 10 See P Barker & F Venter 'Setting District-Based Annual Targets for HAART and PMTCT – A First Step in Planning Effective Intervention for the HIV/AIDS Epidemic' (2007) 97 *SA Medical J* 916.

particularly bleak.¹¹ In 2007, five years after the government *finally* initiated PMTCT programmes, WHO estimated that PMTCT coverage for pregnant women stood at a woeful 33 per cent.¹² HIV transmission rates from mother to child are also unacceptably high: recent estimates suggest that they stand in excess of 20 per cent.¹³

For many readers, such developments may not appear shocking. But they should unnerve. An estimated 90 to 95 per cent of infants with HIV will acquire the virus through their mother.¹⁴ Paediatric HIV has been ‘virtually eliminated’ in most industrialised and some developing countries (for example, Botswana).¹⁵ The availability of testing and treatment services in those countries has reduced transmission rates to less than two per cent, while

- 11 At the same time that increases in mortality and reductions in life expectancy have become visible in South Africa, it is well-documented that highly active antiretroviral therapy (HAART) improves the health and survival of those living with HIV/AIDS who are indicated for treatment. See JR Marins, P Jamal, L Chen, Y Sanny et al ‘Dramatic Improvement in Survival among Adult Brazilian AIDS Patients’ (2003) 17 *AIDS* 1675; R Walensky, AD Paltiel, E Losina, L Mercincavage, B Shackman, P Sax, M Weinstein & K Freedberg ‘The Survival Benefits of AIDS Treatment in the United States’ (2006) 194 *Journal of Infectious Diseases* 11; WHO *Antiretroviral Drugs for Treating Pregnant Women and Preventing HIV Infection in Infants in Resource-Limited Settings Towards Universal Access: Recommendations for a Public Health Approach* (2006). In terms of years of life gained, a recent study quantified the cumulative survival benefits of AIDS patients in the United States on ART and concluded that *three million years of life* have been saved for HIV-infected patients receiving treatment from 1989 to 2003. See Walensky et al. Although PMTCT programmes were implemented nationally in 2002 in South Africa, transmission rates are unacceptably high. Pregnant women were the first population group in South Africa to receive state-funded antiretroviral treatment due to their vulnerable health status and the opportunity to reduce the risk of HIV transmission from the mother to the child. However, fundamental problems in delivering timely HIV services for pregnant women persist. Department of Health *Circular Minute on Prevention of Mother-To-Child Transmission of HIV* (16 April 2002). A Ramkissoon, A Coutsooudis, H Coovadia, P Mthembu et al ‘Options for HIV-Positive Women’ *South African Health Review* 2006 (2007) 315; M Besser, F Paruk & N Dinat *Changing Obstetric Practices in the Context of HIV: An Evaluation of Service Provision in the National PMTCT Learning Sites* (2002). HIV prevalence in pregnant women was 30.2 per cent in 2005. Department of Health *HIV & AIDS and STI Strategic Plan for South Africa (2007–2011)* (note 1 above). The data thus indicates that *one in three* pregnant women in South Africa is HIV positive. All pregnant women with HIV qualify for PMTCT in order to prevent, to the full extent currently possible, their infants from contracting HIV. Many of these women qualify for antiretrovirals for their own health. Their qualification for ART depends upon their CD4 count. That count functions as a measure of a person’s current state of immunity and his or her viral load.
- 12 WHO/UNAIDS *Epidemiological Fact Sheet on HIV/AIDS: Core Data on Epidemiology and Response South Africa* (2008 Update).
- 13 G Ashford, V Black, D Nyasulu, & P Pieters ‘The Good, the Bad, and the PCR Negative’ Unpublished report by the Perinatal HIV Research Unit, University of the Witwatersrand (2007).
- 14 Mother-to-child transmission takes place during pregnancy, labour, delivery and breast feeding. Unsafe practices such as contaminated needles, unsafe blood and blood products account for a small percentage of cases. An unknown proportion of children become infected with HIV through rape. See H Coovadia ‘Mother-to-Child Transmission of HIV-1’ in S Abdool Karim & Q Abdool Karim (eds) *HIV/AIDS in South Africa* (2005) 183. See also UNAIDS *Mother to Child Transmission of HIV: UNAIDS Technical Update* (1998).
- 15 On the success of PMTCT in Botswana, see J Donnelly ‘Saving the Babies: A Victory for Africa’ *The Boston Globe* (27 August 2007). See also WHO *Taking Stock: HIV in Children* (2006); WHO, UNICEF *The State of the World’s Children* 2002 (2002).

dramatically increasing the survival rates of HIV-infected infants.¹⁶ Unlike other intractable issues, this problem has readily available solutions: many of the infections that lead to subsequent illness and death are both preventable and treatable. The absence of such obvious solutions warrants an explanation. This article serves as a critique of the current government's programme that 'employs' lay counsellors to do its HIV work and proffers a legal remedy for what we contend is a violation of a fundamental right.¹⁷

To this end, we first briefly set out the Constitutional Court's criteria for finding infringe a government programme to realise a socio-economic right. We look, in particular, at the standards the Court employs with regard to 'access to the right to health care' in terms of s 27's right of access to health. (Those standards are, as we shall see, informed by s 28's protection of children's rights and s 9's right not to be subject to unfair discrimination on the grounds of sex, gender, pregnancy, disability, illness and age.) We suggest – in something of a break with the case law and the academic commentary – that the government should not be solely held to the rather amorphous dictates of the 'reasonableness' standard. We believe that the institutionalised use of poorly remunerated, marginalised 'lay counsellors' to discharge the responsibilities of healthcare professionals (doctors and nurses who had previously undertaken counselling and testing) constitutes a '*retrogressive measure*'. In short, despite the government's commitment to an expanded, more efficacious rollout, it is currently delivering less health care – not more – and less adequate health care – not better – to this particular cohort of patients with HIV. Such retrogressive measures violate international covenants to which South Africa is bound. At the same time, these measures would also seem to offend the Court's own understanding of the delivery of this constitutionally-mandated public good to pregnant women with HIV and their infants.

16 A significant recent South African study of antiretroviral therapy and mortality in infants demonstrated that early HIV diagnosis and early antiretroviral therapy reduced early infant mortality by 76 per cent and HIV progression by 75 per cent. See A Volari, M Cotton, D Gibb, A Babiker, J Steyn, P Jean-Philippe & J McIntyre (CHER Study Team) 'Early Antiretroviral Therapy and Mortality among HIV-Infected Infants' (2008) 359 *New England Journal of Medicine* 2233.

17 Approximately 5.7 million South Africans are living with HIV/AIDS. While HAART became freely available through the public health system in April 2004, four years on, the South African government's treatment programme is meeting a mere 28 per cent of the total demand. See WHO/UNAIDS, Working Group on Global HIV/AIDS & STIs *Epidemiological Fact Sheet on HIV/AIDS: Core data on Epidemiology and Response South Africa* (2008 Update). Joint Civil Society Monitoring Forum/Health Information, Evaluation and Research Cluster, Department of Health (South Africa) *National Comprehensive HIV and AIDS Plan Statistics: Cumulative Number of Children on Comprehensive HIV and AIDS Treatment* (November 2007). Challenges in access to quality health care for those who are HIV-infected remain the norm: an estimated 460,000 people living with the human immunodeficiency virus who require antiretroviral therapy have access to such treatment in public clinics and hospitals. However, more than 600,000 individuals will require immediate access to antiretrovirals each year for at least the coming decade. See P Barker & F Venter 'Setting District-based Annual targets for HAART and PMTCT – A First Step in Planning Effective Intervention for the HIV/AIDS epidemic' (2007) 97 *SA Medical J* 916. One statistic that animates this paper is that after five years of country-wide implementation, coverage of the programme for PMTCT stands at just 33 per cent. WHO/UNAIDS *Epidemiological Fact Sheet on HIV/AIDS: Core data on Epidemiology and Response South Africa* (2008 Update).

The quantitative study we conducted in three antenatal clinics in inner-city Johannesburg confirms the above conclusions. Our study – as well as on-site interviews with various stakeholders (patients and key informants) – demonstrates that a strong correlation exists between the government's failure to provide adequate remuneration and secure employment to lay counsellors and the failure of many women and children to receive timely medical interventions. The data show that late payment of lay HIV counsellors had a devastating impact on HIV testing in these three clinics. Moreover, the study also confirms that no other variable exists that would explain the striking diminution of testing and counselling that followed months of non-payment of lay counsellors.

Lay counsellors must advise women on highly complex elements of the ART and PMTCT programmes within a context of stigma and other socio-cultural impediments.¹⁸ Timely HIV prevention and treatment is required for the health and survival of pregnant women and their neonates.¹⁹ Lay counsellors – through no fault of their own – are often unable to make these timely interventions. The failure of the government to provide adequate and timely remuneration and secure employment to lay counsellors rises to the level required for finding an unjustifiable limitation of s 27's right of access to health care services. Again: the use of lay counsellors itself is not a *per se* violation. Rather, the violation flows from the improperly remunerated, insufficiently trained and generally marginalised manner in which lay counsellors are (mis) managed by a public health system that has chosen to supplant well-trained professionals with well-intentioned non-professionals in the delivery of essential parts of now constitutionally-mandated ART and PMTCT programmes.

II CONSTITUTIONAL INFIRMITY STANDARDS FOR THE RIGHT TO ACCESS TO HEALTH CARE SERVICES

(a) Extant constitutional standards of the right to access to healthcare services

(i) Reasonableness

The text of the Constitution of the Republic of South Africa, 1996, s 27, with respect to the right to health care, reads as follows:

18 Such advice often concerns feeding options (breast versus formula) and HIV disclosure to a partner, for instance.

19 Women have a short window of opportunity during their pregnancy to be tested, to initiate treatment for themselves, and to prevent HIV transmission to the child. Following HIV testing and counselling, follow-up tests are required. Patients undergo viral load and CD4 tests. The tests indicate whether they should begin antiretroviral therapy. The tests also determine whether they should receive ARV prophylaxis if they do not qualify for ART. If they don't qualify for ART, pregnant women initiate AZT treatment from 28 weeks of gestation. They also receive a single dose of nevirapine, which they take home with instructions to take the pill at the onset of delivery. Women are given feeding options. They are told about the advantages of formula feeding in reducing the risk of transmission. Lay counsellors perform the majority of these educational and oversight responsibilities. They are thus an integral part of the successful implementation of this complex programme.

(1) Everyone has the right to have access to – (a) health care services ... (2) The State must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.²⁰

However, to understand properly the constitutional requirements that the State must discharge with respect to the right to access to health care, one must tease out the desiderata for compliance from the major cases handed down by the Constitutional Court thus far.²¹ While substantial disagreement exists on what the criteria ought to be,²² commentators have reached a general consensus regarding how the Court's elucidation of s 27 criteria are best understood:

- 20 Section 27 is formulated differently from the right to health at an international level. The South African Constitution splits that right in two. The right to an 'environment that is not harmful to health' has been placed in the environmental right: s 24(a). The rights of access to health care and emergency medical treatment are found in s 27(1) & (3). See D Bilchitz 'Health' in S Woolman et al (eds) *Constitutional Law of South Africa* 2 ed (2006) Chapter 56A.
- 21 See *Soobramoney v Minister of Health, Kwazulu-Natal* 1998 (1) SA 765 (CC); *Government of the RSA v Grootboom* 2001 (1) SA 46 (CC); *Minister of Health v Treatment Action Campaign* (2) 2002 (5) SA 721 (CC); *Khosa v Minister of Social Development* 2004 (6) SA 505 (CC); *Occupiers of 51 Olivia Road, Berea Township and 197 Main Street, Johannesburg v The City of Johannesburg* 2008 (3) SA 208 (CC).
- 22 Positions on the normatively desirable content of socio-economic rights fall across a broad spectrum: and many positions on the most desirable content would require substantially more of the Court than its current commitment to reasonableness review requires. Some commentators take a strong view of the necessity of a minimum core. See for example D Bilchitz *Poverty and Fundamental Rights: The Justification and Enforcement of Socio-Economic rights* (2007); Bilchitz in Woolman et al (note 20 above) Chapters 33, 56A; D Bilchitz 'Towards a Reasonable Approach to the Minimum Core: Laying the Foundations for Future Socio-Economic Rights Jurisprudence' (2003) 19 *SAJHR* 1; D Bilchitz 'Giving Socio-Economic Rights Teeth: The Minimum Core and Its Importance' (2002) 119 *SALJ* 484; C Steinberg 'Can Reasonableness Protect the Poor? A Review of South Africa's Socio-economic Rights Jurisprudence' (2006) 123 *SALJ* 264. Other commentators offer a rather robust view of reconstruction of reasonableness review undergirded by a commitment to dignity and to participation. See, for example, S Liebenberg *Adjudicating Socio-Economic Rights under a Transformative Constitution* (2008); S Liebenberg 'Towards a Transformative Adjudication of Socio-Economic Rights' (2007) 21 *Speculum Juris* 41; S Liebenberg 'The Value of Human Dignity in Interpreting Socio-Economic Rights' (2005) 21 *SAJHR* 1; S Liebenberg 'The Interpretation of Socio-Economic Rights' in Woolman et al (note 20 above) Chapter 33; R Dixon 'Creating Dialogue about Socio-Economic Rights: Strong-Form Versus Weak-Form Judicial Review Revisited' (2007) 5 *Int J of Constitutional Law* 391; M Pieterse 'Resuscitating Socio-Economic Rights: Constitutional Entitlements to Health Care Services' (2006) 22 *SAJHR* 473; M Pieterse 'The Potential of Socio-Economic Rights Litigation for The Achievement of Social Justice: Considering The Example of Access to Care in South African Prisons' (2006) 50 *J of African Law* 118. See also M Pieterse 'Coming to Terms with the Judicial Enforcement of Socio-Economic Rights' (2004) 20 *SAJHR* 383; D Brand 'The "Politics of Need Interpretation" and the Adjudication of Socio-Economic Rights Claims in South Africa' in AJ van der Walt (ed) *Theories of Social & Economic Justice* (2005) 17; M Heywood 'Shaping, Making and Breaking the Law in the Campaign for a National HIV/AIDS Treatment Plan' in P Jones & K Stokke (eds) *Democratising Development: The Politics of Socioeconomic Rights in South Africa* (2005) 181; D Moellendorf 'Reasoning About Resources: Soobramoney and the Future of Socio-Economic Rights Claims' (1998) 14 *SAJHR* 327. For a somewhat more tepid views of 'reasonableness' review that border on rationality review – see, for example, CR Sunstein 'Social and Economic Rights? Lessons from South Africa' (2001) 11 *Constitutional Forum* 123; DM Davis 'Adjudicating the Socio-Economic Rights in the South African Constitution: Towards "Deference Lite"?' (2006) 22 *SAJHR* 301. The number of participants in this South African debate far outstrips the interlocutors in any other area of fundamental rights jurisprudence. We are aware that in identifying various participants, and their positions, that we may well be leaving others out. They have been read even if they are not expressly acknowledged in these pages.

- The right to healthcare services does not, generally speaking, embrace an entitlement to the immediate award of a remedy in the event of a breach;²³
- The right simply requires the State to progressively realise the access to health care services for individual members of the polity and to do so within ‘available resources’;²⁴
- Whether the State has discharged its duty to progressively realise the right will be evaluated by the courts in terms of the ‘reasonableness’ of the plan;²⁵
- To be found reasonable, a comprehensive and coordinated programme to realise the right to access to health care services:
 - (1) must ensure that ‘the appropriate financial and human resources are available’;
 - (2) ‘must be capable of facilitating the realisation of the right’;
 - (3) must be reasonable ‘both in their conception and their implementation’;
 - (4) must attend to ‘crises’;
 - (5) must not exclude ‘a significant segment’ of the affected population;
 - (6) must ‘respond to the urgent needs of those in desperate situations’;²⁶
- The State, when contriving programmes or policies to realise socio-economic rights such as the right to health, ought to consult with the persons or communities most immediately affected.²⁷

For reasons that shall become obvious as we proceed, we believe that the State’s current policies governing lay counsellors will be more profitably challenged as a retrogressive measure, rather than as an instance of ‘unreasonable implementation’ that falls short of the Court’s desiderata for reasonableness.

23 *Soobramoney*, *Grootboom*, and *TAC* (note 21 above). But see *Khosa* (note 21 above) (violation of permanent resident’s rights to social security and equality could only be remedied by distribution of benefits); *Van Biljon v Minister of Correctional Services* 1997 (4) SA 441 (C) (Four prisoners determined to be HIV positive sought orders declaring that, under s 35(2)(e), they had the ‘the right ... to ... the provision, at State expense, of adequate ... medical treatment’. All four had CD4 counts of less than 400/ml. All four therefore satisfied generally accepted criteria for antiretroviral treatment at the time. Two of the prisoners had already been prescribed appropriate antiretrovirals by medical practitioners. The other two prisoners had not had any antiretroviral treatment prescribed by the State. The High Court held that the two prisoners who had been prescribed a combination of AZT and ddI by medical practitioners were entitled to provision of that cocktail at State expense, but that the two prisoners who had not as yet been prescribed either ARV mono-therapy or dual therapy were not entitled to provision of any treatment at State expense. Although not decided under s 27 of the Constitution, but under the health care provision for prisoners under s 35(2) of the Constitution, *Van Biljon* stands for the proposition that socio-economic rights do not entitle individuals to specific remedies unless the State has already committed itself to the provision of specific benefits. Thus, in *Van Biljon*, only the two applicants who had been provided with ARVs were entitled to the requested relief because only the first two applicants could form a legitimate expectation that the State would provide them with such treatment.)

24 See *Soobramoney* (note 21 above).

25 See *Khosa* (note 21 above) para 43 (‘In determining reasonableness, context is all-important. There is no closed list of factors involved in the reasonableness enquiry and the relevance of various factors will be determined on a case by case basis depending on the particular facts and circumstances in question.’)

26 See *Grootboom* (note 21 above) paras 39–46, 52, 53, 63–9, 74, 83.

27 See *Occupiers of 51 Olivia Road, Berea Township* (note 21 above). See also *City of Johannesburg v Rand Properties (Pty) Ltd* (2007) 6 SA 417 (SCA).

While the following section elucidates and clarifies the grounds for that choice, we can, in sum, put our proposition as follows. ‘Reasonableness’ permits the State – and the courts – a substantial degree of latitude in determining whether a programme violates a particular socio-economic right. The use of a retrogressive measures criteria, by contrast, affords the state virtually no ‘wiggle’ room if it can quantitatively and qualitatively demonstrate a reversal in the access to a right. We believe that we can demonstrate, quantitatively and qualitatively, a reversal in the health care afforded pregnant women and infants with HIV.

(ii) *Retrogressive measures*

‘Retrogressive measures’ often appears to be a concept in search of a definition. In their recent treatise on the subject of socio-economic rights, David Weissbrodt and Connie de la Vega have only ‘this’ to say about retrogressive measures: ‘Retrogressive measures are prohibited’.²⁸ That, in a nutshell, constitutes much of the learning on the subject. The United Nations Committee on Economic, Social and Cultural Rights (CESCR) writes, rather opaquely, that: ‘[A]ny deliberately retrogressive measures in that regard would require the most careful consideration and would need to be fully justified by reference to the totality of the rights provided for in the Covenant and in the context of the full use of the maximum available resources’.²⁹ Our own Constitutional Court has quoted this throwaway line in *Grootboom*, but given it no discernable content.³⁰ The term has never applied in any constitutional challenge to State policy grounded in a socio-economic right.

Of course, that does not mean that no learning and no guidance exists on the subject. In his analysis of right to education under the Maastricht Guidelines, Frans Coomans writes:

According to paragraph 14(e) of the Maastricht Guidelines, the adoption of any deliberately retrogressive measure that reduces the extent to which the right is guaranteed amounts to a violation of the right. [In terms of paragraph 14(f)], a violation of the right also occurs from the calculated obstruction of, or halt to, the progressive realization of the right, unless the State is acting within a limitation provided by the right, or does so due to a lack of available resources or force majeure. These paragraphs embody the idea that reversing existing levels of realization, or obstructing further realization without sufficient justification, amounts to a violation.³¹

28 D Weissbrodt & C de la Vega *Int Human Rights Law* (2007) 139.

29 CESCR General Comment 3 (1990) para 9.

30 See *Grootboom* (note 21 above) para 45

31 F Coomans ‘In Search of the Core Content of the Right to Education’ in A Chapman & Sage Russell (eds) *Core Obligations: Building a Framework for Economic, Social and Cultural Rights* (2002) 217, 239. See further F Coomans ‘The Maastricht Guidelines on Violations of Economic Social and Cultural Rights’ (1998) 20 *Human Rights Quarterly* 691. As Sandra Liebenberg notes, ‘[t]he Maastricht Guidelines are non-binding, but influential, interpretations of the obligations imposed by the ICESCR adopted by a group of experts in international law’. S Liebenberg ‘The Interpretation of Socio-Economic Rights’ in S Woolman et al *Constitutional Law of South Africa* (note 20 above) Chapter 33. Matthew Craven largely endorses the same position as Coomans. See M Craven *The International Covenant on Economic, Social and Cultural Rights: A Perspective on its Development* (1995) 132 (‘[W]here the retrogressive measures were the result of deliberate policy, the Committee

Coomans advances our understanding of retrogressive measures by identifying three discrete criteria: (a) ‘deliberate reduction’, (b) ‘calculated obstruction’, and (c) ‘a halt to realisation of the right’. Sandy Liebenberg offers the following example of a putative ‘deliberate reduction’ that halts the realisation of the right to social security: ‘an amendment to the regulations under the Social Assistance Act, 1992, raising the eligible age limit for the child support grant from 7 years to 10 years ... would have the effect of reducing the number of impoverished children entitled to the child support grant.’³²

As Bilchitz has been quick to note, however, given the shifting landscape of medical treatment for life-threatening diseases, the identification of a retrogressive measure – as opposed to a policy choice to follow a different regimen – can be quite challenging.³³ However, in light of his constructive engagement with our text, and given the state of the law on s 27 after the Constitutional Court’s decision in *Treatment Action Campaign*, we would like to offer the following argument:³⁴

1. ARVs are essential medicines – as defined by the World Health Organization (and a definition used by the South African government) for the treatment of HIV/AIDS.³⁵
2. The State has a clear constitutional obligation – as recognised by the Constitutional Court in *Treatment Action Campaign* – to provide efficacious and safe ARV treatment to pregnant women and ARV prophylaxis to their newborn babies.
3. Effective counselling is necessary for the efficacious use of ARVs.³⁶
4. A large cohort of lay counsellors – unlike trained healthcare professionals – quite often fail to provide the counselling necessary for the efficacious use of ARVs. (We discuss the factors that underpin this systemic failure below.)
5. The State’s recent choice to supplant qualified healthcare professionals with poorly paid and insufficiently trained lay counsellors constitutes a retrogressive measure with respect to the provision of life-saving treatment and adequate healthcare services provision. Whereas the State had previously committed competent professional staff to the provision of

would do better to consider [them] a prima facie violation of the Covenant’. Scott & Macklem place a slightly different gloss on the term, but one that largely accords with Coomans: ‘[retrogressive measures] ... create a kind of ratchet effect in that lowering the fulfilment level of a right is presumptively prohibited once that level has been achieved. Existing levels of provision can thereby be used as a baseline, adding further precision to the judicial task. See C Scott & P Macklem ‘Constitutional Ropes of Sand or Justiciable Guarantees? Social Rights in a New South African Constitution’ (1992) 141 *U Penn LR* 1, 26.

32 S Liebenberg in S Woolman (note 20 above) Chapter 33, 43–44.

33 See D Bilchitz *Poverty and Fundamental Rights* (2007) 217.

34 E-mail correspondence between Stu Woolman and David Bilchitz (10 January 2008).

35 The WHO publishes a Model List of Essential Medicines. The latest version was prepared by the WHO Expert Committee in March 2007. Essential medicines are selected with due regard to disease prevalence, evidence on efficacy and safety, and comparative cost-effectiveness. For more information, see <http://www.who.int/selection_medicines/en/>.

36 Such counselling embraces the management of issues of adherence, disclosure, infant feeding, nutrition and a range of considerations concerning an individual’s health.

counselling and testing pregnant women with HIV/AIDS, the State now seems satisfied to allow unqualified, unregulated personnel – poorly-paid non-governmental organisation (NGO) employees – to provide the information, care and support required by HIV-positive pregnant women.

6. The State's decision to shift the burden of professional care of women and children with a potentially life-threatening illness to lay counsellors cannot be understood as anything but a retrogressive measure that, in its current guise, denies such women and children the level of care to which they were previously entitled, ie, service provision by qualified nurses and doctors.
7. Even if the use of lay counsellors cannot be shown to be a calculated obstruction – which some might contend is a reasonable assessment in an AIDS denialist culture and of an AIDS denialist regime – then (under current conditions) it still qualifies as a 'deliberate reduction'³⁷ in essential healthcare services and 'a halt to the realisation' of the right to access to health care for pregnant women (and children) with HIV/AIDS.³⁸

37 We argue that this policy choice constitutes a reduction – even if State-provided HIV services have generally increased – because the reduction occupies a critical role in the delivery of HIV services and that the reduction can be linked to an increase in the percentage of negative outcomes. Some might contend that the international law literature on retrogressive measures implies a violation only where there is a measure of 'deliberateness' on the part of the State or where the measure unequivocally leads to a *reduction (in toto)* in access to adequate healthcare. If so, then a potential credible counter-argument might be that the current policies do not amount to a deliberate retrogressive measure because more people have access to testing and counselling than would have been the case if the current contingent of nurses and doctors had continued to manage the process. First, we note elsewhere that lay counsellors have been employed as ad hoc, stop-gap measures for some time. Second, the diminution of the use of trained healthcare professionals for the tests, treatment and counselling of pregnant women and infants leads, ineluctably, to a diminution in both the quality-dimensions of access to adequate healthcare and to the quantity-dimensions of adequate healthcare under the present framework (when the latter is viewed from the perspective of the collapse of many lay counsellor programmes for want of adequate pay, training and marginalisation).

38 This form of analysis has appeared in the South African literature on at least one previous occasion. See D Brand 'Food' in Woolman et al *Constitutional Law of South Africa* (note 20 above) Chapters 56C, 56C–29 to 56C–30. Danie Brand writes:

Recent efforts by the National Department of Agriculture (NDA) and the National Department of Land Affairs (DLA) to effect redistribution of agricultural land are good examples of such retrogressive measures. Before 2001, the NDA redistributed agricultural land to farm workers and emerging farmers from previously disadvantaged groups with the explicit purpose of 'improvin[g] their livelihoods and quality of life'. Land was redistributed through a system of State subsidy. Qualifying households would receive a Settlement/Land Acquisition Grant (SLAG) of R16 000 with which to buy land. The Grant for the Acquisition of Municipal Commonage enabled municipalities to make communal land available to the urban and rural poor for grazing and cultivation. These land redistribution efforts enabled people to produce food for their own food needs and to create the additional income needed to purchase extra food and other basic commodities. Problems in the redistribution process and an emphasis on promoting equitable access for emergent black farmers in commercial agriculture¹ led to a reconsideration of the programme in 2000. A new programme – Land Redistribution for Agricultural Development (LRAD) – was launched in 2001. In LRAD, the focus has expressly shifted from improving livelihoods and quality of life to enabling access to the commercial agriculture sector for 'those aspiring to become full-time, medium to large-scale commercial farmers'. This change in focus is reflected in LRAD's structure. To qualify for a SLAG subsidy, a recipient household had to fall

III STATISTICAL AND QUALITATIVE ANALYSIS OF THE HIV/AIDS LAY COUNSELLORS PROGRAMME

(a) Problems with the lay counsellors' programme

(i) Task-shifting

After seven years of country-wide implementation of PMTCT programmes, maternal and infant mortality linked to HIV remains unjustifiably high. In order to address these limitations, the South African government released a five-year national coordinated plan in 2007: *The HIV & AIDS and STI Strategic Plan for South Africa, 2007–2011* (NSP). The plan has received praise from many quarters for its robust approach to reversing the epidemic.³⁹ The goals of the NSP are ambitious by any measure. They encompass: (a) reducing new HIV infections by 50 per cent; (b) reducing the impact of HIV/AIDS on individuals, families, communities and society by expanding access to appropriate treatment, care and support to 80 per cent of all HIV-positive people (and their families); and (c) scaling up coverage and improving the quality of the PMTCT programmes to reduce mother-to-child transmission (MTCT) to less than five per cent. The target date for reaching these goals is 2011.⁴⁰

Of greatest import for our argument is one critical component of the National Strategic Plan (NSP) – ‘task-shifting’. The NSP defines ‘task-shifting’ as follows: ‘[Task-Shifting] involves the delegation of activities to *less* qualified cadres and includes, for example ... lay counsellors (rather than nurses) ‘pricking’ patients for rapid HIV tests’.⁴¹

under a maximum monthly income of R1 500. To qualify for a grant under LRAD, a recipient has to make a minimum own contribution to the acquisition of land of R5 000. As Edward Lahiff has pointed out, this requirement clearly excludes the poorest of the poor from the benefit of the programme and dramatically reduces the extent to which LRAD can make a contribution to the fulfilment of the right to food. A change in redistribution policy that withdraws its benefits from such a large cohort of individuals is a *prima facie* infringement of the right to food.

Ibid citing E Lahiff ‘Land Reform in South Africa: Is It Meeting the Challenge?’ (2001) 1 *PLAAS Policy Brief* 2, 4 (other footnotes omitted).

39 C Kapp ‘South Africa Unveils New 5-year HIV/AIDS Plan’ (2007) 369 *Lancet* 1589.

40 See note 1 above, <<http://www.info.gov.za/otherdocs/2007/aidsplan2007>>.

41 NSP (note 1 above) 147–8 (our emphasis). The magnitude of this task and the gross dereliction of duty associated with burden shifting cannot be underestimated. The duties of lay counsellors are complex and weighty: they must absorb the shock and the anxiety that patients express when first learning of their HIV status, and provide patients with advice and support. This first job requirement demands a great deal of sensitivity and skill, on the part of the counsellors, in communicating options. It also requires delicate negotiations around complex questions regarding disclosure to the patient’s partner. Such disclosure is complicated by the stigmatisation associated with HIV, gender inequality, and other social and cultural norms that place significant constraints on women’s choices and subsequent behaviour. See B Klugman ‘Sexual Rights in Southern Africa: A Beijing Discourse or a Strategic Necessity?’ (2000) 4 *Health and Human Rights* 144; L Ackermann & G de Klerk ‘Social Factors that make South African Women Vulnerable to HIV Infection’ (2002) 23 *Health Care for Women Int* 163; K Dunkle, R Jewkes, H Brown, G Gray et al ‘Gender-Based Violence, Relationship Power, and Risk of HIV Infection in Women attending Antenatal Clinics in South Africa’ (2004) 363 *Lancet* 141; C Sprague ‘Women’s Health, HIV/AIDS and the Workplace in South Africa’ (2008) 7 (3) *AJAR* 341. Such an important role warrants qualified personnel, as well as adequate remuneration. However, it must also be noted that despite debates around the use of lay counsellors in such a complicated setting as PMTCT programmes, their work, generally, is of documented value to the general population. See

In many clinics in South Africa, lay HIV counsellors have become the cornerstone of HIV voluntary counselling and testing (VCT) services.⁴² They form a critical entry point for HIV prevention and treatment services. The primary responsibilities of lay counsellors within the PMTCT programme are: providing pre- and post-HIV test counselling; assessing and preparing patients for treatment readiness; adherence counselling for PMTCT regimens and for antiretroviral therapy; provision of counselling for pregnant women regarding infant feeding choices; and, the identification of women who qualify for antiretroviral treatment but who have been missed previously in the hospital or clinic system.

Whether lay counsellors should have been employed in their current capacity is no longer a live issue. That horse has already bolted from the barn. In many provinces, as per national policy, lay counsellors have become the stewards of HIV service delivery in South Africa.⁴³

While the counsellors work in public hospitals and clinics, they are employed by intermediary NGOs that provide a low monthly stipend: they are not volunteers. Nor are the counsellors qualified medical personnel or public

A Rowe, D de Savigny, CF Lanata, CG Victoria 'How Can We Achieve and Maintain High-Quality Performance of Health Workers in Low-Resource Settings?' (2005) 366 *Lancet* 1026; A Shetty, C Marangwanda, L Stranix-Chibanda, W Chandisarewa, E Chirapa, A Mahomva et al 'The Feasibility of Preventing Mother-To-Child Transmission of HIV Using Peer Counsellors in Zimbabwe' (2008) 5 *AIDS Research and Therapy* 17. V Narasimhan, H Brown, A Pablos-Mendez et al 'Responding to the Global Human Resource Crisis' (2004) 363 *Lancet* 1469. Recent research also shows that when the number, mix and competence of health workers (including lay counsellors) and their distribution is appropriately matched to local needs, and health workers are provided with adequate levels of training, supervision and support, then the health system is more likely to be accessible, responsive, efficient and caring. S Anand & T Baernighausen 'Human Resources and Health Outcomes: Joint Learning Initiative on Human Resources for Health and Development' (2003) 7 *JLI Working Paper* 2; LH Aiken, P Clarke & D Sloane 'Hospital staffing, Organization, and Quality of Care: Cross-National Findings' (2002) 14 *Int J for Quality in Health Care* 5.

- 42 The use of lay counsellors in the South African health care system is not new. In 1994, the African National Congress (ANC) released a document titled 'A National Health Plan for South Africa'. A section of the Plan titled 'Staffing the Public Health Sector' reads as follows:

Community Health Workers can play a unique role in promoting health and in expanding and improving health services provided they have effective support structures and referral systems and they receive ongoing training. They can also be catalysts for community development, mobilising people around health issues. Local programmes will be encouraged provided they are integrated into the local health services, but no national programme will be launched at this stage.

Community health workers (CHWs) were also not a creation of the ANC government. CHWs had been 'deployed' by the apartheid government in the 1980s to supplement the public health care system. They were actually employed – or compensated – by international aid organisations. Because CHWs relied upon such international funding their functions and their locations were rather ad hoc. Their use was determined less by a coordinated assessment of public need, and more by the funding imperatives of particular donors. See I Friedman 'Community Health Workers and Community Caregivers: Towards a Unified Model of Practice' in P Ijumba & A Padarath (eds) *SA Health Review 2005* (2005), <<http://www.hst.org.za/uploads/files/sahr05>>. Under the new ANC government, CHW programmes were permitted to deteriorate as the government focused on strengthening the public health care system and not on what it tended to view as charitable, decentralised adjuncts. See I Friedman, M Ramalepe, F Matjuis, L Bhengu, B Lloyd, A Mafuleka, L Ndaba & Busi Boloyi *Moving Toward Best Practice: Documenting and Learning from Existing Community Health Care Worker Programs* (2007). The government's disregard for CHWs and, in our case, lay counsellors, has meant that CHWs and lay counsellors often can no longer discharge adequately the support functions for which they were ostensibly hired.

- 43 Department of Health 'Policy and Guidelines for the Implementation of the PMTCT Programme' <<http://www.doh.gov.za/docs/policy/pmtct-f.html>>.

employees. These simple facts cast something of a pall over our government's decision to approve a policy that makes lay HIV counsellors the bulwarks of HIV service delivery in many public health settings in South Africa.

(ii) *Delayed payment*

We investigated whether late payment of HIV lay counsellors had an impact on VCT service delivery in three antenatal clinics in inner-city Johannesburg. The lay HIV counsellors working in these clinics have direct employment contracts with NGOs. They are not volunteers. They expect to be paid like any other employed professionals and they rely on monthly payments to fund basic costs of living, including transport to work.

The number of pregnant women attending antenatal clinics for the first time was recorded by administrative staff. The number of women who had an HIV test was recorded by midwives who conducted rapid HIV tests in the clinics. Using the data, we calculated the number and percentage of HIV testing for each month. The months in which lay counsellors had received their remuneration was recorded (over the same time period). The proportion of women completing HIV testing was compared with the months when lay counsellors were and were not paid (using the Fisher's exact test).⁴⁴ The mean number of women completing HIV tests in the months where women were and were not paid was compared using an unpaired t-test. Data from June 2007 was excluded from the analysis: we did so because a national public workers' strike affected nurse and lay counsellor attendance. Comparisons were also calculated that included and excluded December 2007. December has a different pattern of clinic attendance: many women leave the city and travel to distant homes during the holidays.⁴⁵

(aa) Findings regarding delayed payment

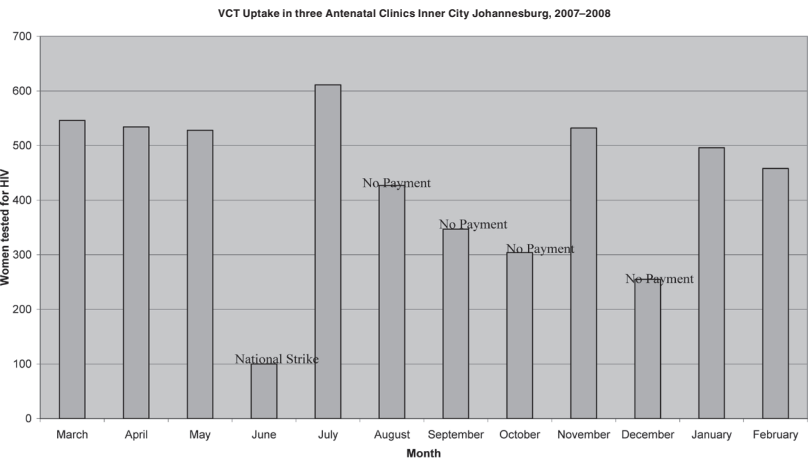
Lay counsellors did not receive remuneration at the end of July, August, September and November 2007. They received remuneration for July through September only at the end of October 2007. They received November 2007 pay at the end of December 2008. Following each of the seven months when remuneration was received (March, April, May, October and December 2007; January and February 2008), of the 4,722 women who attended an antenatal clinic, 78.5 per cent had an HIV test. Following the four months of non-payment, among 2,502 women who attended the clinic, 53.3 per cent had an HIV test. If we exclude December from the analysis, this difference remains significant (with a p value of <0.0001). Following the three months when counsellors were not paid, of 2,069 women who attended antenatal clinics, 52 per cent had an HIV test (Figure 1). Again, only 52 per cent of pregnant

44 The Fisher's Exact Test is a statistical significance test used to determine if there are non-random associations between variables where sample sizes are small. See *Handbook of Biological Statistics*, <<http://udel.edu/~mcdonald/statfishers.html>>.

45 Data was entered into a Microsoft Excel 2003 database and analysed using Graph Pad Calculator (2002–2005 Graph Pad Software Inc).

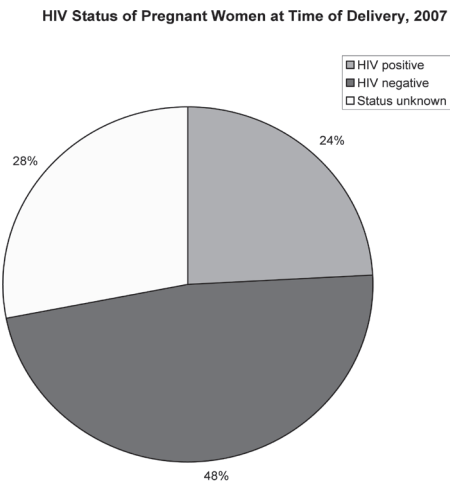
women received HIV tests after non-payment of lay counsellors: a figure that contrasts sharply with 78.5 per cent of women who received HIV tests during months when counsellors were paid timeously.

Figure 1



From the birth register, 10,111 deliveries occurred during this period. Among the women who delivered, 2,436 (24.1 per cent) were HIV sero-positive, 4,839 (47.9 per cent) were HIV negative, and 2,835 (28 per cent) were of unknown HIV status (see Figure 2). The 2,835 women of unknown HIV status missed HIV testing completely. Those who would have tested positive missed life-saving interventions and opportunities to reduce the risk of HIV transmission to the child.

Figure 2



(bb) Implications of findings – delayed payment

The data demonstrate that late payment and non-payment of lay HIV counsellors has a significant impact on HIV testing in these three clinics. HIV testing figures decline precipitously following non-payment of the counsellors. No alternative explanations for the drop in testing uptake exist. That is, we can identify no other specific variables that would affect the rate of HIV testing: such as changes in the total number of counsellors, alterations in counsellors' responsibilities, changes to management policy or delivery or new interventions designed to improve HIV testing but which might have had the opposite effect.

The data suggest that while the total number of staff did not change, absenteeism increased. Absenteeism appears linked to an inability of counsellors to pay for transport. The motivation and the morale of the lay counsellors also appear to have declined and, as a consequence, affected their on-the-job performance. While we did not interview staff regarding their motivation or morale during this period, it was clear that lay counsellors were anxious about non-payment. (They made repeated verbal inquiries about late payment to clinic staff.)

Our findings in these three clinics also indicate that pay may be a marker for, or a primary indicator of, overall health care worker (HCW) performance. Diminished HCW performance would appear to be a significant rate-limiting factor with respect to effective VCT delivery. If lay counsellors are asked to provide these services without reliable pay, then it can hardly come as a surprise that service provision, and outcomes, are negatively affected.

(iii) *The nexus between poor remuneration and tasking shifting of lay workers, the provision of VCT and PMCT and the deleterious consequences for pregnant women and infants with HIV/AIDS*

In our investigation of the three clinics in Johannesburg (and other clinics in South Africa), the new NSP brief for lay counsellors has not been accompanied by the legally commensurate employment conditions that govern their scope of work, the provision of adequate training for PMTCT and ART delivery, health benefits and other employment benefits, career development and trajectory, psychological support, protection against infection and ill-treatment, and other forms of statutory and constitutional protections afforded employees under South African labour law.⁴⁶

The most significant downstream consequence of declining HIV testing is the negative impact it has on the health of HIV-infected pregnant women and their infants. HIV testing and staging determine whether pregnant women are

46 See C Cooper 'Labour Relations' in S Woolman et al *Constitutional Law of South Africa* (note 20 above) Chapter 53.

able to initiate antiretrovirals and thus improve their health and survival, and whether they are able to access PMTCT services to reduce the risk that their neonates will contract HIV. The absence of HIV testing during antenatal care is a common finding in empirical studies of missed opportunities for PMTCT.⁴⁷ Of particular concern is the high percentage of women giving birth in public hospitals whose HIV status remains unknown (as shown in Figure 2).⁴⁸

Our research demonstrates that the insecure employment status and lack of proper payment directly correlates with HIV testing uptake. These shortcomings invariably undermine the provision of services central to meaningful HIV/AIDS prevention, treatment, care and support. Our findings suggest that task-shifting (or burden-shifting) of HIV/AIDS counselling and testing from qualified nurses (who receive legally required training and benefits) to lay people (who lack the same wages, benefits, support and protection afforded healthcare workers) without proper financial and other support has an undeniably detrimental effect on health outcomes for pregnant women (and children) with HIV/AIDS.

We have highlighted the situation within three clinics in Johannesburg. However, clinicians and researchers working in different provinces reported, through more informal investigations, that this phenomenon is replicated more broadly (though not in all sites) throughout South Africa. These factors are undoubtedly limiting South Africa's ability to achieve the goals set forth in the NSP. If these practices continue, then they will likely constitute a relatively insuperable barrier with respect to the achievement of a five per cent rate of mother-to-child transmission. Policy does not equal progress. However, creating the enabling conditions for progress is imperative if the NSP goals are to be realised. Given the inadequate number of professional HCWs employed in the public sector and the insufficient number of HCWs dedicated to HIV/AIDS, continued reliance on lay counsellors as the bulwarks of the ARV and PMTCT programmes is inevitable. And any measures that undermine the capacity of lay workers to discharge their responsibilities ought to be viewed as retrogressive, and ought to be remedied – by the State or by our courts – with all deliberate speed.

- 47 See L Nkonki, T Doherty, Z Hill, M Chopra et al 'Missed Opportunities for Participation in Prevention of Mother to Child Transmission Programmes: Simplicity of Nevirapine does not Necessarily Lead to Optimal Uptake: A Qualitative Study' (2007) 4 *AIDS Research and Therapy* 27; D Doherty, D McCoy & S Donohue 'Health System Constraints to Optimal Coverage of the Prevention of Mother to Child HIV Transmission Programme in South Africa: Lessons from the Implementation of the National Pilot Programme' (2005) 5 *African Health Science* 213.
- 48 A Ramkissoon, A Coutsoodis, H Coovadia, P Mthembu et al 'Options for HIV Positive Women' in P Ijumba & A Padarath (eds) *SA Health Review 2006* (2006) 315.

IV ANALYSIS OF THE HIV LAY COUNSELLOR PROGRAMME IN LIGHT OF THE CONSTITUTIONAL STANDARDS OF S 27⁴⁹

(a) Retrogressive measures

(i) Poor remuneration, late payment and marginalisation of lay counsellors

The employment status of lay counsellors in South Africa bears closer scrutiny. Lay counsellors, as we noted above, are employed by intermediary NGOs. The Department of Health makes payments to the NGOs and the NGOs, in turn, administer a monthly stipend at the rate of R1,000. That meagre wage

49 Rights are often used to support one another. While noting that different rights constitute different and distinct guarantees, the Constitutional Court has repeatedly stated that ‘constitutional rights are mutually interrelated and interdependent and form a single constitutional value system’. *S v M (Centre for Child Law as Amicus Curiae)* 2008 (3) SA 232 (CC) at para 26 quoting *De Reuck v Director of Public Prosecutions, Witwatersrand Local Division* 2004 (1) SA 406 (CC), 2003 (2) SACR 445 (CC), 2003 (12) BCLR 1333 (CC) paras 54–5.

Of course, this dictum cuts both ways. In many instances, say in equality and dignity challenges, the two rights work in tandem. See *National Coalition for Gay and Lesbian Equality v Minister of Home Affairs* 2000 (2) SA 1 (CC), 2000 (1) BCLR 39 (CC); *Bhe v Magistrate, Khayelitsha, (Commission for Gender Equality as Amicus Curiae)*; *Shibi v Sithole; South African Human Rights Commission v F President of the Republic of South Africa* 2005 (1) SA 580 (CC), 2005 (1) BCLR 1 (CC). Of greater import for our discussion is the finding in *Khosa* that the impairment of the right to equality enjoyed by permanent residents underwrites the *Khosa* Court’s holding that the denial of social security benefits to permanent residents constitutes a violation of their right to access to adequate social security in s 27. *Khosa* (note 21 above); *Mahlaule v Minister of Social Development* 2004 (6) SA 505 (CC) 2004 (6) BCLR 569 (CC). We would contend that discrimination on the basis of HIV status, sex, gender and age reinforce our conclusion that the current lay counsellors programme constitutes a violation of s 27’s right of access to adequate health care. See, for example, *Hoffmann v South African Airways* 2001 (1) SA 1 (CC), 2000 (11) BCLR 1211 (CC).

However, in children’s rights cases, the Court has been loathe to allow the paramouncy provision in s 28 to trump automatically other guarantees in our basic law. See *Sonderup v Tondelli (or LS v AT)* 2001 (1) SA 1171 (CC), 2001 (2) BCLR 152 (CC); *Minister of Welfare and Population Development v Fitzpatrick* 2000 (3) SA 422 (CC), 2000 (7) BCLR 713 (CC); *De Reuck v Director of Public Prosecutions, Witwatersrand Local Division* 2004 (1) SA 406 (CC), 2003 (2) SACR 445 (CC), 2003 (12) BCLR 1333(CC); *Jooste v Botha* 2000 (2) SA 199, 210 (T)(‘The wide formulation [of s 28(2)] is ostensibly so all-embracing that the interests of the child would override all other legitimate interests of parents, siblings and third parties. It would prevent conscription or imprisonment or transfer or dismissal by the employer of the parent where that is not in the child’s interest. That can clearly not have been intended’.) See also A Friedman, A Pantazis & A Skelton ‘Children’s Rights’ in S Woolman et al (eds) *Constitutional Law of South Africa* 2 ed RS1 (2009) Chapter 47.

Perhaps the best-known rebuff to s 28 paramouncy – and the most powerful reinforcement of the proposition that when rights are read and harmonised with one another, it can cut either way – occurred in *Grootboom*. The Constitutional Court in *Grootboom* reversed the High Court’s finding that a children’s right to shelter in s 28 could be employed to shoehorn a more general familial right to housing into s 26. *Grootboom* (note 21 above), 2000 (11) BCLR 1169 (CC) reversing, in part, *Grootboom v Oostenberg Municipality* 2000 (3) BCLR 277 (C).

In the case of ART programmes for pregnant women with HIV/AIDS, no conflict exists between the rights of mothers and children to adequate healthcare, in terms of s 27, or the rights of women and children to equality before the law and non-discrimination, in terms of s 9. Indeed, the right to equality – and non-discrimination – should buttress a claim that s 27 rights to access to adequate healthcare are being inequitably distributed on the grounds of sex, gender, pregnancy and age. See C Albertyn & B Goldblatt ‘Equality’ in S Woolman et al *Constitutional Law of South Africa* (note 20 above) Chapter 35; C Albertyn & B Goldblatt ‘Towards a Substantive Right to Equality’ in S Woolman & M Bishop (eds) *Constitutional Conversations* (2008) 231. For an especially important intervention on the relationship between equality and socio-economic rights, see B Goldblatt & S Liebenberg ‘Achieving Substantive Equality in South Africa: The Relationship between Equality and Socio-Economic Rights (2007) 23 *SAJHR* 335.

– for persons charged with improving the life chances of pregnant women (and their children) with HIV – is startling. First, it is below the living wage in South Africa. Second, it is below the legal minimum wage of R1,663.20 per month for those persons who work full-time. Amazingly, the government would appear to be in breach of its own standards under the Basic Conditions of Employment Act.⁵⁰

It is worth noting that in a range of countries, lay counsellors and other community health workers or cadres are used to expand access to health care and essential medicines to good effect. In particular, they often extend health care to remote rural areas that would not otherwise offer care. So even as we draw attention to the manner in which the performance of community health workers and lay counsellors could be improved, their work is of documented value.⁵¹ At issue is the deployment and the management of these cadres. As currently conceived, the performance of lay counsellors is fundamental to the success of the NSP. Their performance, as currently conceived under the NSP, will undermine that success.

Of particular import for our discussion of lay counsellors is the holding of *Treatment Action Campaign (TAC)*.⁵² *TAC* could be viewed as simply extending a benefit to a class of persons who might have already formed a legitimate expectation of an entitlement to that benefit. However, *TAC* required somewhat more of the State. First, the *TAC* Court had to assess whether the State possessed the available resources necessary to make a comprehensive and coordinated programme of universal nevirapine provision possible. The *TAC* Court found that the State did. Second, the order of the *TAC* Court clearly posits *adequate* testing and counselling capacity as prerequisites for the administering of ARVs and the Court explicitly requires that such capacity be *increased* progressively.

These two holdings have an important bearing on our assessment of the ability of the State to pay for lay counsellors. As evidence from the Western Cape and KwaZulu Natal suggests, proper remuneration of lay counsellors is not merely possible. It can be accomplished. Moreover, it is, as the record shows, essential to the success of any prevention of mother-to-child HIV transmission programme.

(iii) *Are poor remuneration, marginalisation and task-shifting retrogressive measures?*

Recall that Coomans identified ‘deliberate reduction’, ‘calculated obstruction’ and ‘a halt to realisation of the right’ as the primary identifiers of retrogressive

50 Basic Conditions of Employment Act 75 of 1997; Regulations for Wages under the Basic Conditions of Employment Act 75 of 1997 (14 November 2006) Government Gazette No 29385, <<http://www.info.gov.za/gazette/regulation/2006/29385.pdf>>.

51 UNAIDS/WHO *Task Shifting: Rational Redistribution of Tasks Among Health Workforce Teams* (2007); Rowe et al (note 41 above); A Shetty et al (note 41 above); V Narasimhan, H Brown, A Pablos-Mendez et al ‘Responding to the Global Human Resource Crisis’ (2004) 363 *Lancet* 1469.

52 *Minister of Health v Treatment Action Campaign* (2) 2002 (5) SA 721 (CC).

measures. Although we have yet to mention the AIDS denialism of the Mbeki regime, one might be inclined to view the (mis)use of unpaid or poorly paid lay counsellors as a form of ‘calculated obstruction’. Even if one offers a more benign account, it seems fair to say that what began as an interim measure became misguided, and still extant, State policy.

Even on the benign account, however, the conscious use of lay counsellors in place of trained health care professionals does amount to a ‘deliberate reduction’ in the access to health care to which HIV-positive pregnant women are constitutionally entitled. VCT is the gateway for service delivery. When not properly delivered, it is the choke point for PMTCT services for the child and lifesaving antiretroviral therapy for the mother. The failure to deliver meaningful HIV services has an unarguable impact on maternal and child morbidity and mortality.⁵³ Given our experience and ongoing review of this situation, it is impossible not to conclude that the use of counsellors in place of health care professionals constitutes a ‘halt to the progressive realisation of the right to access to healthcare services’.

Premise 1: Effective VCT from lay counsellors is a pre-requisite to access HIV services, including HIV testing, ART for women and PMTCT for children.

Premise 2: A large cohort of pregnant women do not receive HIV testing or effective counselling from lay counsellors and, therefore miss ART and PMTCT.

Premise 3: Failure to initiate ART in a timely fashion leads to poorer health outcomes in women.

Premise 4: Failure to initiate PMTCT in pregnant women leads to poorer health outcomes in children.

Conclusion: These failures results in early morbidity and mortality for many children and women with HIV.

That syllogism constitutes, with the data set out above, the basis for our conclusion that the general use of lay counsellors in place of health care professionals constitutes both a retrogressive measure, and, by necessity, a ‘halt to the progressive realisation of the right to health care’.

Given the mere ‘fact’ of a NSP, with set roles envisaged for healthcare professionals and lay counsellors with respect to the provision of VCT, it might appear, at first blush, difficult to convince any court that the government had engaged in a calculated obstruction of VCT for pregnant women with HIV/AIDS. However, the text of the NSP itself reflects a ‘deliberate reduction’ in the quality of care that pregnant women receive. Lay counsellors are (generally) improperly paid and inadequately trained and supported. Without these provisions the lay counsellors cannot – as our evidence shows – provide the level of care required for patients with HIV/AIDS. Again, as the data demonstrate, the late payment of lay counsellors undermines VCT delivery and has

53 M Chopra, T Doherty, D Jackson & A Ashworth. ‘Preventing HIV Transmission to Children: Quality of Counselling of Mothers in South Africa’ (2005) 94 *Acta Paediatrica* 357. See Every Death Counts Working Group (note 8 above); A Volari et al (note 16 above).

a deleterious effect on the health outcomes of pregnant women with HIV and their neonates. Thus as the data in Part III of this paper suggests, the use of lay counsellors fails the seven-part test laid out at the end of the section on retrogressive measures in Part II.

What should happen after one fails this novel test? Well, that too is uncharted legal terrain. One of the authors has argued strenuously that the failure of the State to pass muster under 26(2) or 27(2)'s test for reasonableness leaves, as a logical matter, no argument from reasonableness to be made under s 36 of the Constitution.⁵⁴ The Constitutional Court in *Khosa* forthrightly acknowledged this problem: but chose to split no meaningful analytical hairs. (And so it continues to find itself – in socio-economic rights cases – writing one-paragraph general limitation analyses that rehearse, in brief, the finding made in terms of the internal limitations analysis required by the socio-economic right in question.) Would a finding of a retrogressive measure be different? It might – were any court to adopt it. We've concentrated on Coomans' three forms of retrogression: calculated obstruction, deliberate reduction and halting the realisation of a right. Were a court to adopt such a retrogressive measure test, it might make sense to employ two-stage analysis. Having found that the State violated s 27's right to access to healthcare, it might then be possible for the State to argue that, given countervailing constitutional interests or some other concern of import, the retrogressive measure is reasonable and justifiable in terms of s 36. (That, however, is quite unlikely. Without committing itself to its logical impossibility, the Court in *Khosa* did intimate that a failure to demonstrate reasonableness in terms of the right was unlikely to leave much space for an alternative finding under the limitations clause.⁵⁵)

But let us be clear. The authors are not particularly concerned with how many angels can stand on the head of a pin. What we would like any court to do is provide an adequate remedy for the current retrogressive measures found in the State's use of lay counsellors for HIV service delivery.

(i) Reasonableness

Reasonableness review certainly constitutes more familiar terrain for jurists, practitioners and academics alike. Which questions, of the myriad queries one can ask under s 27(2) review, would be likely to interest a court faced with a challenge to the reasonableness of the State's use of lay counsellors for HIV service provision? We would suggest that the following questions would seize the court:

1. Is the State's use of lay counsellors to administer these HIV/AIDS programmes in public health settings a 'reasonable' plan for the realisation of the right?
2. Reasonableness, in turn, raises the following set of issues:

54 S Woolman & H Botha 'Limitations' in S Woolman et al *Constitutional Law of South Africa* (note 20 above) Chapter 34.

55 Ibid.

- a. Has the State ensured that the ‘the appropriate financial and human resources are available’?
 - b. Can the State ensure that the use of lay counsellors for HIV service delivery is ‘capable of facilitating the realisation of the right’?
 - c. Is the use of lay counsellors for the national HIV/AIDS programme reasonable ‘both in [its] conception and [its] implementation’?
 - d. Does the use of lay counsellors for VCT, ART and PMTCT ‘respond to the urgent needs of those in desperate situations’?⁵⁶
3. Did the State, when contriving to employ lay counsellors for HIV/AIDS, consult with the persons or communities most immediately affected?⁵⁷

Given our analysis under retrogressive measures, and the higher threshold retrogressive measures require, we believe the answers to the above questions are relatively straightforward.

Is the State’s use of lay counsellors to administer the HIV/AIDS programmes in public health settings a ‘reasonable’ plan for the realisation of the right? As we suggest in Part V, when we discuss remedies, the proper use of lay counsellors could turn out to be ‘reasonable’. However, any plan to use lay counsellors would have to be better coordinated, provide for better training and oversight, ensure staff retention through adequate remuneration and not shift inappropriate responsibilities from health care professionals to lay staff.

Has the State ensured that the ‘the appropriate financial and human resources are available’? The misuse of CHWs under both the apartheid State and the ANC government makes it patently clear that the State has never really taken seriously the financial requirements of other cadres of health care workers. It has either relied on sporadic and spotty international aid for CHWs and lay counsellors or it has actively promoted their exclusion from the health care system. Good lay counsellors often leave for better paid work and, quite often, are encouraged by their clinic colleagues to find secure employment.

Can the State ensure that the lay counsellor VCT programme is ‘capable of facilitating the realisation of the right’? The answer again: not as the programme is currently conceived by the national government. The lack of adequate remuneration, the delayed payment of inadequate remuneration and the absence of adequate training for lay counsellors constitute a choke point for effective VCT, ART and PMCT programmes. VCT programmes in the Western Cape and KwaZulu Natal offer a useful template for the conception of a programme capable of facilitating the right to adequate treatment (where lay counsellors are appropriately paid).

Is the use of lay counsellors for the national HIV/AIDS programme reasonable ‘both in [its] conception and [its] implementation’? Rather than risk repeating our findings and conclusions a third and a fourth time, the answer is no.

56 See *Grootboom* (note 21 above) paras 39–46, 52, 53, 63–9, 74, 83.

57 See *Occupiers of 51 Olivia Road, Berea Township* (note 21 above). See also *City of Johannesburg v Rand Properties* (note 27 above).

Does the use of lay counsellors 'respond to the urgent needs of those in desperate situations'?⁵⁸ The answer is: sometimes. Pockets of excellent lay counsellor performance exist in this country. However, if the question is whether lay counsellor programmes across the country generally respond to the majority of women and children in urgent, desperate need, then the answer again must be 'no'.

Did the State, when contriving to employ lay counsellors for HIV/AIDS consult with the persons or communities most immediately affected?⁵⁹ Although the NSP looks good on paper, no record or document – in our possession or our reach – suggests that lay counsellors themselves were briefed or had their opinions about the effectiveness of existing programmes solicited by the State.

V CONCLUSION

Since 2001, a range of policies have been mooted with regard to the official management of community health workers, home health care and community-based care in South Africa.⁶⁰ However, the frameworks formulated to govern community health care workers have never been finalised. Lay health care workers are also generally not recognised by formally employed health workers. This lack of recognition by the State and fellow workers marginalises lay counsellors and undermines their confidence and performance. Lack of formal employment with low and resultant late payment undermines HIV service delivery. An accessible, caring and high quality health care system – the principal aim of the Department of Health – is not possible without the strategic and effective deployment of appropriately trained, skilled and remunerated health workers operating in tandem with one another.

Recognised public health care workers, it must also be said, face institutional hurdles that compromise their work, their health, and the overall functionality of the public health-care system.⁶¹ The straitened circumstances of healthcare personnel, and lay counsellors in particular, must be addressed without further delay if South Africa ever expects to improve our currently miserable mortality and life expectancy rates.

58 See Grootboom (note 21 above) paras 39–46, 52, 53, 63–9, 74, 83.

59 See *Occupiers of 51 Olivia Road, Berea Township* (note 21 above). See also *City of Johannesburg v Rand Properties* (note 27 above).

60 On community health care workers, see Government of South Africa *Tuberculosis Strategic Plan for South Africa 2007–2011* (2007); Government of South Africa *Human Resources Framework* (2005).

61 Government health workers face high staff turnover rates. The reasons for such turnover include limited career and development opportunities, over-work, sickness and death. The concatenation of problems seriously undermines government-led efforts to combat the crisis in human resources. See A Padarath, A Ntuli & L Berthiaume 'Human Resources' in P Ijumba & A Padarath (eds) *South African Health Review 2003/2004* (2004) 299. Gilson and McIntyre observe that an increase in staff salaries in 1995 failed to retain public sector health workers because the higher salaries were not maintained over the next several years and failed, at the very minimum, to keep pace with inflation. L Gilson & D McIntyre 'Post-apartheid Challenges: Household Access and Use of Care' (2007) 37 *Int J of Health Services* 673.

Human resource planning, leadership and management within the public health system have, historically, been weak. One consequence is inadequate implementation of those programmes that have been approved by the State. Another unfortunate hallmark of the public health system is a general failure to undertake consultation with all relevant stakeholders when taking important policy decisions.

To remedy the immediate rather dire situation of lay counsellors, we suggest that the government should officially recognise their status and put the requisite policies, regulations and laws in place:

- Lay counsellors should be formally employed with statutorily-compliant remuneration (namely, a living wage and employment benefits).
- Lay counsellors should receive appropriate debriefing, training and mentoring to ensure that the service they provide is of an appropriate standard, and to allow them to discharge their duties with confidence.
- Clearly-defined job descriptions and roles should be designed: they should allow lay counsellors to be better integrated into the health team and provide improved care to their patients.
- The effective implementation of this programme will not only require policy and regulatory changes, it will also demand the cooperation and the collaboration of all stakeholders in health – investments in health facilities and personnel – and a focus on improving the effectiveness and efficiency of health services in response to the needs of patients who access healthcare.

Failure to articulate such a plan, to promulgate the requisite legal regime to achieve its goals and to undertake the appropriate steps to ensure the cooperation and the coordination of all affected parties, should constitute a breach of s 27's right to access to health care. As we have been at pains to make clear, the poor pay, delayed remuneration and maltreatment of lay counsellors constitutes more than a form of social degradation, and more than a denial of their right to fair conditions of employment. The unacceptable consequence of these retrogressive measures with respect to the use of lay counsellors is the unacceptably high morbidity and mortality rates for women and children with HIV in this country.⁶²

62 As one anonymous referee has noted, the overarching deficiency in the State's human resources strategy constitutes a relatively clear violation of the progressive realisation criterion in s 27.