Chapter 5

The role of international law in South African health law and policy-making

CONTENTS

5.1 What is the relevance of international law?

This chapter aims to show that international law has both a direct and indirect impact on health law and policy-making in South Africa.

The Constitution of the Republic of South Africa, 1996 (the Constitution) is the starting point for determining the role of international law domestically.

Section 39 of the Constitution states that the courts, and other legal bodies, when interpreting the Bill of Rights:

- *Must* consider international law.
- *May* consider foreign law.

Section 231 of the Constitution says that a treaty binds South Africa after approval by the National Assembly and the National Council of Provinces, unless it is self-executing, or of a technical, administrative or executive nature.

A self-executing treaty has a provision stating that it is self-executing. It becomes law in South Africa when it is signed, unless it is inconsistent with the Constitution or an Act. A non-self-executing treaty that has not been ratified, or even signed, will bind South Africa only if it becomes customary international law.

Section 232 of the Constitution makes customary international law the law in South Africa, unless it is inconsistent with the Constitution or legislation.

Section 233 provides that, when interpreting legislation, courts:

> *"must prefer any reasonable interpretation of the legislation that is consistent with international law over any alternative interpretation that is inconsistent with international law".*

While section 233 gives greater weight to international law, the court will take into account whether the relevant international law is binding on South Africa. Further, where international law is in direct conflict with the Bill of Rights, the courts will not uphold it domestically.

In *S v Makwanyane* 1995 (3) SA 391 (CC), former Chief Justice Chaskalson of the Constitutional Court described the role of international law as follows:

> *"(P)ublic international law would include non-binding as well as biding law. They may both be used under the section as tools of interpretation. International agreements and customary international law accordingly provide a framework*

> *within which [the Bill of Rights] can be evaluated and understood, and for that purpose, decisions of tribunals delaying with comparable instruments, such as the United Nations Committee on Human Rights, the Inter-American Commission on Human Rights, the Inter-American Court of Human Rights, the European Commission on Human Rights, and the European Court of Human Rights, and, in appropriate cases, reports of specialised agencies such as the Internaional Labour Organisation, may provide guidance as to the correct interpretation of particular provisions of [the Bill of Rights]"* (paragraph 35, footnotes omitted).

In the *Grootboom* case, Justice Yacoob of the Constitutional Court said:

> *"The relevant international law can be a guide to interpretation but the weight to be attached to any particular principle or rule of international law will vary. However, where the relevant principle of international law binds South Africa, it may be directly applicable."* (paragraph 26)

There are numerous links between developing and implementing health law and policy domestically, and international law. That international rules are required to deal with health issues is inevitable. Infectious illnesses are not easily confined within national boundaries. As the world became more globalised and international traffic increased, rules governing health became imperative.

The links are a result of an expression of the protection of human rights at an international level, including the right to health. This happens through:

- Treaties and declarations such as the *International Covenant on Economic, Social and Cultural Rights (*ICESCR*)* and the *Declaration of Alma Ata*.
- The work of international organisations that focus on health issues such as the World Health Organisation (WHO) or the Joint United Nations Programme on HIV/AIDS (UNAIDS).

Secondly, the links are also a result of rules that are developed internationally that are meant to protect against the spread of illnesses, such as the International Health Regulations. The WHO adopted an updated version of the International Health Regulations in 2005, which is due to come into effect in 2007. The original regulations have their origins in the mid-19th century during the cholera outbreak that swept across Europe.

The purpose of the International Health Regulations is to prevent and control, and provide a public health response to, the spread of disease with minimal

interference with international traffic and trade. One amendment was to broaden the scope of notifiable events (a public health emergency of international concern) so that it is not limited to only cholera, plague and yellow fever.

Third, agreements that are made at an international level may have a direct impact on the health care of citizens of countries who are party to the agreement. The example that will be discussed in this chapter is the *Agreement on Trade-related Aspects of Intellectual Property Law (*TRIPS Agreement*)*. Chapter 14 also considers the impact of the TRIPS Agreement on access to essential medicines.

A fourth link comes from the nature of issues that may arise in the context of health systems in different countries. For example, South Africa faces a human resources crisis in the health sector owing to a shortage of staff and skills. A major contributing factor is the migration of health care workers from developing countries to better-resourced health systems. This is not only as a result of "push" factors domestically (such as poor salaries and working conditions), but also as a result of "pull" factors (such as attractive salary packages and active marketing by developed countries to draw staff from certain parts of the developing world). For example, 12% of foreign nurses in the United Kingdom are South African.

As a result of the challenges that this presents in health systems globally, and the importance of the health workforce in ensuring the proper delivery of health care services, the World Health Report of 2006 focused on this issue as its main theme.

This chapter will explain:

- What comprises international law.
- The relationship between international law and principles and the right to health care.
- The key international role players within the health context.
- How we may use international law domestically.

This chapter is meant to provide an overall feel of the international human rights system and how it relates to the protection of the right to health care. While the system is imperfect and it is difficult to enforce obligations of states at the international level, there have been significant contributions by international bodies to the protection of human rights generally and the conceptual development of the right to health. This has influenced laws and policies globally.

5.2 What is international law?

International law is a combination of treaties and customs that regulate the conduct of states among themselves.

International law has three main sources:

- Customary international law.
- Treaties and conventions.
- Soft law (guidelines and non-binding judgments).

Customary international law

Customary international law comes from the customs practised over a long period of time by various states. The practice must have state backing or following. These customs are often not written in treaties or legislation, but have become an international standard that governments must follow.

Key Point: Customary international law binding

Customary international law legally binds nations even if it is not formally ratified.

This is not the same as customary law in a domestic setting. Customary law or traditional law in South Africa is the:

> *"customs and usages traditionally observed among the indigenous peoples of South Africa and which form part of the culture of those peoples".*
>
> Section 1, Recognition of Customary Marriages Act, 120 of 1998

Widespread ratification of United Nations (UN) treaties, regional treaties and other instruments means that they may become customary international law.

Treaty law

A treaty (or charter, convention or covenant) is a formal agreement between states that defines and modifies their mutual duties towards their own citizens, or between each other as states.

Treaties may be either bilateral (between two parties) or multilateral (between more than two parties). A treaty system is based on the agreement of states signing and ratifying the treaty.

Key Points: Signature and ratification

- *Signature* – a signature to a treaty by a state is the first step to ratification. This shows the state's intention to ratify and become a state party. A state must not act to defeat the purpose of the treaty after signing.

- *Ratification* – the process by which a government formally approves the signing of an agreement. The state considers itself a party to the treaty after it has been ratified and is then bound under international law.

For example, South Africa has signed but not ratified the ICESCR.

For treaty law to become part of domestic law, there are two systems:

- *Monism* – there is no need for domestic legislation for international law to take direct effect.
- *Dualism* – the international law provisions can be enforced only when formally incorporated into domestic law.

As we see from section 231 of the Constitution, South Africa uses a combination of the two systems. International agreements of a technical, administrative or executive nature that do not require ratification, will bind the Republic. Other international agreements have to be enacted into law by national legislation (except for self-executing provisions that have been approved by Parliament and are consistent with South African law).

Soft law

Soft law refers to all sources of non-binding international law that can provide guidance on the interpretation of international treaties.

Examples: Sources of soft law

- Guidelines produced by international organisations such as the WHO that can be helpful to courts that do not have expertise in a particular field.
- Respected experts in their field, who can provide guidance in interpreting particular rights.
- Declarations, as non-binding international instruments, that can be made by any international organisation or body of experts.

5.3 The right to health and international law

The 1945 United Nations (UN) Charter set out these commitments relating to health:

"All members pledge themselves to take joint and separate action" (article 56),

and for states to promote:

"solutions of international …health… related problems" and *"higher standards of living…"* and *"conditions of economic and social progress and development"* (article 55).

The UN Charter is silent on the actual rights, including the right to health. While the International Health Regulations predate the UN Charter, they did not conceive of health as being related to human rights.

The right to health was first expressed as a right in the *Universal Declaration of Human Rights (*UDHR*)* in 1948. Article 25 provides for the right in a very broad sense that includes food, clothing, housing, medical care and necessary social services. In this articulation of the right we see how interconnected various rights and aspects of our life are. In communities that live in poverty, access to medicines alone, in the absence of sanitation, water or food will not necessarily improve the health status of people who live there.

Article 25 of the UDHR

"1. Everyone has the right to a standard of living adequate for the health and wellbeing of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.
2. Motherhood and childhood are entitled to special care and assistance. All children, whether born on or out of wedlock, shall enjoy the same social protection."

The preamble to the Constitution of the WHO also came into force in 1948:

> *"The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."*

Before examining health in international human rights documents, we focus on some key definitions.

Key health definitions

Health:

- The WHO Constitution defines health as not just "the absence of disease or infirmity ", but also as a state of "complete, physical mental and social well-being".
- The WHO definition is wider and more progressive than the definition of health care services, as expressed in the South African Constitution and interpreted by South African courts.

The right to health:

- It is generally accepted by those who advocate for the right to health that complete health is unattainable and that the State alone cannot secure health. For example,

some congenital infirmities may not be curable through medical intervention, even while they may be treated and controlled.

- However, this is often a shorthand means of referring to the right to health care.

The right of access to health care:

- The right of access to health care is the attempt to provide health care to people who cannot afford it, but is usually limited by costs.
- The Government must use its resources to ensure that everyone is able to access health care, whether state-provided or not.

The right of access to medicines:

- The right of access to medicines refers to ensuring that medicines are available and affordable, as well as providing medicines to people who cannot afford them – once again, this may be limited by costs.
- The right of access to medicines is one aspect of the right of access to health care.

Universal Declaration of Human Rights

As stated earlier, the UDHR, adopted by the UN General Assembly in 1948, provides for a right to health. The universal application of the rights that are contained in the UDHR is captured in the preamble, which states that the declaration is:

"a common standard of achievement for all peoples and all nations".

A further provision that is relevant to the right to health care is Article 27. It provides that:

"Everyone has the right… to share in scientific advancement and its benefits."

Innovation in medicines and technology is important in protecting and promoting the right to health care. However, the cost of innovation and the patent regime has often been an obstacle to accessing new medicines and technology, and therefore an obstacle to the enjoyment of the right contained in Article 27. Chapter 14 discusses this issue in detail.

The UDHR was not binding when in was adopted, but is now generally regarded as customary international law that is universally binding. The content of the UDHR was elaborated on in two separate covenants:

- The *International Covenant on Civil and Political Rights* (ICCPR).
- The ICESCR.

The Covenants were adopted in 1966 by the UN and became legally binding on state parties when they came into force in 1977. Together, the UDHR, the ICCPR and the ICESCR are known as the "International Bill of Rights".

Recognition of different kinds of rights

Civil and political rights include such rights as the right to vote, the right to equality, freedom of expression, and so on. Socio-economic rights include such rights as the right to health care, the right to housing, the right to social security and so on. Civil and political rights have traditionally been given greater recognition than economic, social and cultural rights.

There are two common objections to treating these sets of rights as equals. One objection says that the legal recognition of socio-economic rights will result in courts interfering in the domain of the executive and the legislature (Parliament). In other words, it is not the job of the courts to tell the government what to do in relation to providing basic services, especially where these can have a significant effect on the budget. The second objection is that the protection of socio-economic rights requires greater resources than civil and political rights.

However, there are counter-arguments than one can raise to these objections. For example, substantial resources are required to set up a policing and judicial system that is necessary to protect the right to personal security. When the courts make judgments giving effect to such rights, there is a budgetary implication. The right to vote may also have a socio-economic dimension – for how can one exercise the right if one is too sick to do so, or too poor to afford transport to the polling station.

A feature of the development of international human rights instruments has been the gradual closing of the gap between these sets of rights. The difference has been slowly eroded and the interdependency between both sets of rights is now a strong theme in international law. The South African Constitutional Court has recognised the inextricable link between these "sets" of rights.

The right to health in international human rights treaties

These are the most important treaties affecting the right to health in South Africa – we show their status as signed, ratified, or both signed and ratified:

Treaty	Signed	Ratified	Clause/Article
International Covenant on Economic, Social and Cultural Rights (ICESCR)	✓ 1994	X	Article 12: right to health
International Covenant on Civil and Political Rights (ICCPR)	✓ 1994	✓ 1998	Article 6: right to life Article 9: right to security of the person
Convention on the Rights of the Child (CRC)	✓ 1993	✓ 1995	Article 24: right of a child to the highest attainable standard of health
Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)	✓ 1993	✓ 1995	Article 12 (2): equal access to health care services, including those related to family planning
African Charter on Human and Peoples' Rights	✓ 1996	✓ 1996	Article 16: right to enjoy the best attainable state of health
Convention on the Elimination of All Forms of Racial Discrimination (CERD)	✓ 1994	✓ 1998	Article 5(e)(iv): guarantees equality in the enjoyment of the right to public health, medical care, social security and social services

ICESCR

We focus on the ICESCR because its articulation of the right to health is often referred to by courts and commentators. It also expressly provides for some steps that state parties are required to take to give effect to the right. The treaty has been an important vehicle for the conceptual development of the right to health, and for its implementation by state parties. Some national bills of

rights also draw on the interpretation of socio-economic rights clauses in the ICESCR. The South African Bill of Rights (Chapter Two of the Constitution) is an example of this.

Article 2 of the ICESCR says:

> *"Each state party … undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realisation of the rights recognised in the present Covenant."*

Article 12 of the ICESCR provides that:

> *"The state parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."*

The ICESCR sets out the steps to be taken by states to realise the right fully, including those necessary for:

- The reduction of the stillbirth-rate and infant mortality.
- The healthy development of the child.
- The improvement of all aspects of environmental and industrial hygiene.
- The prevention, treatment and control of epidemic, endemic, occupational and other diseases.
- The creation of conditions to ensure that everyone has medical services and medical attention for sickness.

The ICESCR right to health emphasises equal access to health care and minimum guarantees of health care for sickness.

The ICESCR qualified the UDHR's right to "a standard of living adequate to health" as the right to the "highest attainable" standard of health. This opens up the question: what is the *highest attainable* national and international standard of health, especially where there is such a big difference in the wealth of nations?

We will see below how the rights in the ICESCR are interpreted by the Committee on Economic, Social and Cultural Rights.

5.4 International organisations and the development of international law

International organisations co-operate in an attempt to set standards or rules in international law. International organisations monitor the implementation of treaty obligations and develop international law by issuing guidance or interpretation of obligations through declarations, resolutions and statements.

International treaties can be administered by:

- A UN body, such as the Committee on Economic, Social and Cultural Rights (the CESCR).
- The International Court of Justice that interprets and uses treaties in resolving disputes between states.
- A body independent of the UN system, such as the World Trade Organisation (WTO) that deals with trade rules between nations, and implements WTO agreements, such as the TRIPS Agreement.
- A regional level body such as the African Union (AU).

Within the UN, there are four key bodies that are involved in the protection of the right to health. These are the WHO, the CESCR, the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the Office of the High Commissioner for Human Rights (OHCHR).

In this part, we will look at the role of these bodies in the health context. We will also briefly highlight the role of the WTO, which does not work directly on health issues, but which has an impact on the ability of states to protect adequately the right to health domestically. But before doing so, we briefly consider the UN's broader role.

The UN was established after and because of the atrocities of the Second World War to create a stronger international order for peace and security. One of the primary objectives of the UN is to prevent human rights violations from occurring within particular countries, or between two or more countries.

The founding document of the UN is the UN Charter. The Charter sets out the rights and obligations of member states and established the structure of the UN. 50 countries signed it in 1945. There are now 191 countries that are members of the UN.

One of the greatest contributions of the UN to human rights law is the development of the International Bill of Rights. The UDHR laid the foundation for the adoption of 80 covenants and declarations on aspects of human rights.

In September 2000, the UN adopted the Millennium Development Goals in the *UN Millennium Declaration* of the General Assembly:

> *"We recognise that, in addition to our separate responsibilities to our individual societies, we have a collective responsibility to uphold the principles of human dignity, equality and equity at the global level. As leaders we have a duty therefore to all the world's people, especially the most vulnerable and, in particular, the children of the world, to whom the future belongs."*
>
> Source: paragraph 2: the UN Millennium Declaration

Of these development goals, three are directly related to health:

- To reduce the maternal mortality by three-quarters of the 2000 rate by 2015.
- To reduce the child mortality rate by two-thirds of the 2000 rate by 2015.
- To halt and begin reversing the spread of HIV, malaria and other major diseases by 2015.

The first goal is to eradicate extreme poverty and hunger. While not directly health-related, progress towards this goal will have an obvious and significant impact on the health status of people.

Key Point: Impact of key diseases

Just five diseases — pneumonia, diarrhoea, malaria, measles and AIDS — account for half of all deaths in children under the age of five.

Source: Millennium Development Goals Report, 2005

The Office of the High Commissioner for Human Rights

The UN system has many specialised agencies and offices. The Office of the High Commissioner for Human Rights (OHCHR) is the main body under the UN system mandated to promote and protect all human rights for all.

The OHCHR has many related bodies, committees and experts to develop international law. These bodies monitor the ICESCR, the ICCPR, the CRC, the CEDAW and CERD.

Examples: Relevant monitoring bodies

- The Committee on Economic Social and Cultural Rights (CESCR)
- The Human Rights Council (which replaced the Human Rights Committee in April 2006)
- The Committee on the Rights of the Child

- The Committee on the Elimination of Discrimination against Women
- The Committee on the Elimination of Racial Discrimination.

Each state has to provide a report approximately every five years on the measures taken to implement a treaty and appear before one of the committees to answer questions. The committee then issues recommendations and concluding observations. Concluding observations can severely embarrass a government internationally, even if they are non-binding.

Activists and NGOs are a vital part of any reporting mechanism. Reporting bodies rely heavily on alternative or "shadow" reports from NGOs to get a balanced view of the legislative measures, policy decisions and practical steps taken by the state to meet its obligations.

Reports sent early in the reporting cycle can influence the UN's special rapporteur in drafting the "list of issues" the country must address in its report. This list of issues influences the report produced by the country, as well as any concluding observations and recommendations.

OHCHR RESOLUTIONS

OHCHR adopted two resolutions (2001/33 and 2002/32) declaring that "access to medication … is one fundamental element" for realising the right to health.

These resolutions further call upon states to:

- "Pursue policies which would promote the availability and affordability of medicines and medical technologies".
- "Ensure that the application of international agreements is supportive of public health policies promoting broad access to safe, effective and affordable pharmaceuticals and technologies."

Key Point: Role for NGOs

Committees do not always follow up on their own recommendations, so NGOs should follow up on concluding observations and recommendations.

For guidance on using shadow reports effectively, see Danie Brand and Christof Heyns (eds.) *Socio-economic Rights in South Africa: A Resource Book*, at page 96.

South Africa must ratify the ICESCR before the reporting obligations take effect, even if other obligations are already binding under customary international law.

Special rapporteurs

Special rapporteurs, experts in their particular field, report to the OHCHR on particular issues. The Special Rapporteur on the Right to Health was established in 2002 (OHCHR resolution 2002/31). This Special Rapporteur has a three-year mandate to report on laws and policies supporting and hindering the realisation of the right to health. The Special Rapporteur has emphasised the need to pay special attention to vulnerable groups regarding the right to health.

The CESCR

Of the committees that work under the OHCHR, the CESCR deals more directly with the right to health. The CESCR monitors the implementation of the ICESCR. While state parties are required to report regularly to the CESCR, the CESCR is not able to hear individual complaints. A working group has therefore been established to consider the adoption of an Optional Protocol that would provide for individual complaints to the CESCR. The CESCR also issues documents (General Comments) that are aimed at providing interpretative guidance on the provisions of the ICESCR. General Comments 3 and 14 are particularly important for the right to health.

GENERAL COMMENT 3

To clarify state parties' obligations under Article 2(1) of the ICESCR, the CESCR adopted General Comment 3 in 1990. The CESCR was concerned that socio-economic rights would not be observed as strictly as civil and political rights. Many see the latter as having immediate effect, but the former not. In order to clarify the meaning of socio-economic rights, the CESCR gave greater definition to Article 2(1).

Importantly, the CESCR stated that the term "progressive realisation" should not be interpreted in a way that strips the rights of meaningful content. There are indeed immediate steps that are required of governments. According to the General Comment, these "steps should be deliberate, concrete and targeted as clearly as possible towards meeting the obligations recognized in the Covenant". Further, governments should move expeditiously towards that goal.

The means that states may use to give effect to the rights may include, but are not limited to, legislative, administrative, financial, educational and social measures.

A significant development in the interpretation of Article 2 by the CESCR is the notion of a "minimum core obligation". Basically this means that

while states cannot fulfil the rights immediately, they are required to fulfil the minimum essential level of each socio-economic right. For example, in a country where a large number of people are deprived of essential primary health care (such as immunisations for children), the state is in breach of its minimum core obligation in respect of the right to health.

The fulfilment of the rights is qualified by the resources available to the state. The CESCR stated that while resources may be limited, the state must show that it has made every effort to use resources that are at its disposal. In the international context, available resources would include such resources that may be available through international co-operation and assistance.

In South Africa, the Constitutional Court in the *Grootboom* case considered General Comment 3, but rejected the idea of a "minimum core obligation". The Court was of the view that this concept is too difficult to define. However, as we saw in Chapter 1, the Court did require the government to address the plight of people in desperate need as a priority.

GENERAL COMMENT 14

The CESCR adopted General Comment 14 in July 2000. This is the most detailed expression and interpretation of the content of the "right to the highest attainable standard of health" in Article 12 of the ICESCR. The CESCR says that the right to health is the enjoyment of a variety of facilities, goods, services and conditions that allow the realisation of the right.

General Comment 14 highlights three types of obligations of the right to health:

- *Respect* – the state must not interfere directly or indirectly with the enjoyment of the right to health, such as by denying or limiting equal access.
- *Protect* – the state must take measures to prevent other parties from interfering with the right, including the duty to adopt legislation to ensure equal access to essential health facilities, goods and services.
- *Fulfil* – the state must adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realisation of the right.

KEY POINTS: GENERAL COMMENT 14

The health care system of a state party must have institutional features to realise the right to health, including:

- **Availability** – sufficient facilities, goods, services and programmes, including services affecting the underlying determinants of health such as safe and potable drinking water. This includes trained medical and professional staff and essential drugs, as defined by the WHO Action Programme on Essential Drugs (currently the 13th Model List of Essential Medicines).
- **Accessibility** – access to health care facilities and services without discrimination, including physical accessibility, affordability and access to information.
- **Acceptability** – services and facilities must respect medical ethics and confidentiality. They must be culturally appropriate and improve health status.
- **Quality** – services must also be scientifically and medically appropriate, and of good quality.

The CESCR relied heavily on the *Declaration of Alma Alta* when it set out the minimum core obligations imposed on states to do the following:

- Ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalised groups.
- Ensure access to the minimum essential food that is nutritionally adequate and safe, to ensure freedom from hunger to everyone.
- Ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water.
- Provide essential drugs, as defined from time to time under the WHO Action Programme on Essential Drugs.
- Ensure equitable distribution of all health facilities, goods and services.
- Include in the plan of action methods, such as right to health indicators and benchmarks, and to focus particularly on all vulnerable groups.
- Provide appropriate treatment of prevalent disease, illnesses, injuries and disabilities.

The *Declaration of Alma Alta* is discussed in further detail below.

LIMBURG PRINCIPLES

The *Limburg Principles on the Implementation of the ICESCR* (1977) provide a non-binding authoritative guide to the interpretation of the ICESCR.

The Principles explain that:

- Progressive realisation of the right to health requires states to move as expeditiously as possible towards the full realisation of economic, social and cultural rights, and to take steps immediately to provide for core minimum entitlements.

- The phrase "the maximum of its available resources" means states must ensure minimum subsistence rights for everyone, regardless of the level of economic development in a country.
- "State parties shall provide for effective remedies, including, where appropriate, judicial remedies." This is especially important, as there is no individual complaint system in force yet under the ICESCR.

OPTIONAL PROTOCOL FOR THE ICESCR

Individual complaint procedures under other international treaties, such as the ICCPR and CEDAW (under optional protocols) and CERD (under article 14) develop case law and bring real meaning to the treaty rights. The case law can be used by:

- states to interpret or amend legislation, or implement policies;
- NGOs to press states to make changes in law or policy.

The CESCR has responsibility for promoting, implementing and enforcing the ICESCR. The major drawback of the ICESCR is the inability of individuals to bring complaints. In response, the international community has accepted the need for an optional protocol to help enforce economic, social and cultural rights.

The Working Group established by the OHCHR to consider an optional protocol for the ICESCR had its mandate extended by a further two years on 19 April 2004 by OHCHR resolution 2004/29.

Key Points: South Africa's obligations

- South Africa has signed the Optional Protocol to the ICCPR accepting individual complaints and CERD, where the mechanism for accepting individual complaints is in the main text.
- South Africa has not signed the Optional Protocol to CEDAW.

World Health Organisation

The UN has established several agencies to promote economic and social development worldwide. The WHO is a specialised agency for health in the UN system. It has a legislative capacity to develop international law by producing international health regulations, declarations and guidelines. It also conducts research and issues publications on various health topics.

A key annual publication is the *World Health Report*, which assesses and reports on the global health situation of health systems and care. Each issue focuses on a theme. The *World Health Report* for 2006 focuses on human resources for health.

The objective of the WHO is to achieve the highest possible level of health for all people. The WHO has 192 member states that govern the WHO through the World Health Assembly. Their mandate is specific to policy-making and decisions on the operation of the WHO, and is distinct in this respect from the UN General Assembly.

Examples: WHO documents

- The *Declaration of Alma Ata* is a WHO declaration.
- The South African Constitutional Court in the 2002 case of *Minister of Health v Treatment Action Campaign* (the *TAC* case) referred to the WHO guidelines on the use of nevirapine to assess whether the government policy on the prevention of mother-to-child transmission of HIV was reasonable.

Declaration of Alma Ata

In 1978, an International Conference on Primary Health Care was held in Alma Ata in the former Union of Soviet Socialist Republics (USSR). After this conference, the WHO and the United Nations Children's Fund (UNICEF) adopted the *Declaration of Alma Ata* in 1978.

This Declaration:

- stated that the attainment of the highest possible level of health is a "most important worldwide social goal", and was critical for decent life and a precondition for the meaningful enjoyment of most human rights;
- set out minimum core obligations imposed on states by the right to health – these were expanded on by the CESCR in General Comment 14.

This statement was part of the Declaration:

> *"An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts.*
>
> *A genuine policy of independence, peace, détente and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share."*

The vision of the *Declaration of Alma Ata* has still not been achieved. The call for an end to military conflicts and excessive spending on arms and weapons

was to some extent realised by an end to the cold war, but has gone no further than that. Wars and armed conflicts continue to rage across the globe, and the socio-economic situation and health status of those who live in areas that are affected by the conflicts continue to worsen.

Joint United Nations Programme on HIV/AIDS (UNAIDS)

The Joint United Nations Programme on HIV/AIDS (UNAIDS) is the main advocate for global action on the HIV epidemic. It gathers statistics on HIV/AIDS and disseminates this information. These facts and figures are a very useful tool for advocacy.

UNAIDS leads, strengthens and supports an expanded response that aims to:

- prevent transmission of HIV;
- provide care and support for people living with HIV/AIDS;
- reduce the vulnerability of individuals and communities to HIV/AIDS;
- lessen the impact of the epidemic.

UNAIDS Guidelines

The *International Guidelines on HIV/AIDS and Human Rights* (UNAIDS Guidelines) were adopted by the OHCHR and UNAIDS in 1998.

The UNAIDS Guidelines give states clarity on their approach to the epidemic that is meant to foster a consciousness of HIV/AIDS in all branches of government. Guideline 6, for example, provides that:

> *"States should enact legislation to provide for the regulation of HIV-related goods, services and information, so as to ensure widespread availability of qualitative prevention measures, adequate HIV prevention and care information and safe and effective medication at an affordable price."*

The guidelines highlight the need for general anti-discrimination laws to cover HIV/AIDS and vulnerable groups, and for disability laws to be enacted or revised.

Guideline 6 was revised in 2002 to emphasise the following:

- Access to HIV/AIDS-related treatment is fundamental to realising the right to health.
- Preventative, curative and palliative care of HIV/AIDS, and related opportunistic infections and conditions, should be included.
- Access to medication is one element of comprehensive treatment, care, and support.

- International co-operation is vital in realising equitable access to treatment, care and support for all in need.

Declaration of Commitment on HIV/AIDS

In June 2001, 189 member states at the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS adopted the *Declaration of Commitment on HIV/AIDS* without reservation.

The Declaration contains the commitment of leaders of governments and states to take action on HIV/AIDS in a number of areas, including:

- Leadership.
- Prevention.
- Care, support and treatment.
- HIV/AIDS and human rights.

In the preamble, member states recognised the HIV/AIDS epidemic as a global economic, social and development crisis. They agreed on the need to address HIV/AIDS by strengthening respect for human rights and, in particular, the rights of those most vulnerable to infection, including women and children.

Key Points: Making commitments on HIV/AIDS real

- Realisation of human rights and fundamental freedoms for all is essential to reducing vulnerability to HIV.
- Respect for the rights of people living with HIV/AIDS drives an effective response.

The 3 by 5 campaign

There are currently more than six million people living with HIV in the developing world who need access to antiretroviral therapy (ART) to restore health and quality of life. By mid- 2006, only 1.3 million people in the developing world were receiving this lifesaving treatment.

At the UN General Assembly High-Level Meeting on HIV/AIDS on 22 September 2003, the WHO declared the lack of access to HIV treatment "a global health emergency". To address this emergency, the WHO, UNAIDS and other partners developed a detailed strategy to reach three million people with ART by the end of 2005. While not reaching its target, the 3 by 5 campaign was instrumental in putting access to ART on the global agenda. At the 2006 UNGASS, member States adopted a *Political Declaration on HIV/AIDS*, which calls for universal access to HIV/AIDS prevention, treatment and care services. Included in this strategy were guidelines for scaling up ART in resource-limited settings.

World Trade Organisation

The impact of international law on South African health law is not restricted to international health law. International trade law also has an impact on South African health law, through the increasing influence of non-state role players on access to medicine.

International trade can affect public health in a range of ways. It may be necessary to restrict trade or travel in order to contain the spread of infectious diseases. The import and export of food products (for humans or animals) may raise food safety concerns, and the import of certain non-food goods (such as asbestos) will also raise health issues. It is permissible in such circumstances to restrict trade in those goods.

The World Trade Organisation (WTO) is a relatively new body, established in 1995 to regulate world trade. The WTO is primarily a trade organisation, and is not part of the UN system. It has drafted key multilateral treaties affecting trade between countries, which also have an impact on health. These include Agreements on Technical Barriers to Trade, Sanitary and Phytosanitary Measures and the TRIPS Agreement, which has attracted the greatest attention by health activists owing to its potential to undermine access to medicines that are essential for public health.

TRIPS Agreement

If a country wants to benefit by becoming a member of the WTO, it must follow the treaty rules. The powerful lobbies of industrialised governments and multinational corporations heavily influence the WTO.

These powerful lobbies voiced their view that the General Agreement on Tariffs and Trades (GATT) was insufficient to meet the needs of an ever-expanding global world trade. During the Uruguay round of negotiations from 1986 to 1994, they emphasised the need for trade in intellectual property to be included. The Final Act, signed on 15 April 1994, established the WTO and included the TRIPS Agreement.

Through the TRIPS Agreement, the WTO created a "one size fits all" approach to intellectual property law. This is not fair or feasible since countries are at different levels of development, and have specific domestic needs and duties to their citizens. Some commentators see the inclusion of intellectual property rights as eroding the principle of health as a fundamental human right if intellectual property rights can have a negative impact on this human right.

Patents are a form of intellectual property. They are an incentive mechanism granted to inventors in order to stimulate innovation. They do this through the creation of an "artificial monopoly". This means that the patent holder is able to prevent all others from reproducing the invention or innovation. In this way, the patent holder (eg a pharmaceutical company) can recover the costs of research and development that went into the invention or innovation. But the monopoly also allows them to profit excessively, by keeping prices artificially high.

For more on patents and related concepts, see Chapter 14.

Impact of TRIPS on WTO members

TRIPS is binding on all WTO members, including South Africa. TRIPS aims to strengthen the protection of intellectual property rights worldwide and balance the rights of the inventor and the rights of others to access to the invention.

In attempting to develop a comprehensive patent system, the WTO:

- Mandates all members to establish minimum standards of patent law, and to grant patents for a minimum of 20 years for all new inventions and their process of production, including medicines (Article 33 of TRIPS).
- Establishes a mechanism for enforcement of the provisions.
- Establishes a dispute settlement mechanism.

There are some protections within TRIPS. The agreement:

- Allows members to adopt measures "necessary to protect public health and nutrition" (Article 1).
- Recognises the need for "appropriate measures ... to prevent the abuse of intellectual property rights" (Article 8(2)).
- Allows "limited exceptions to exclusive rights" (Article 30).
- Sets out conditions for use "without authorisation of the patent holder" (Article 31). This is known as compulsory licensing.

Many consumer, development and charity organisations, including the Consumer Project on Technology, Médecins Sans Frontières, Oxfam and the Treatment Action Campaign argue that TRIPS awards global market exclusivity for the manufacture and sale of patented medicines without providing global availability of the products. They say that pharmaceutical patents held by multinational corporations keep the prices for medicines artificially high for those who need the drugs most, but cannot afford them.

Doha Declaration

The Fourth Ministerial Conference of the WTO in Doha in November 2001 produced the *Ministerial Declaration on the TRIPS Agreement and Public Health* (called the Doha Declaration).

The Declaration recognises concerns about the effect TRIPS has on prices, but notes that:

- Each member has the right to grant compulsory licences and the freedom to determine the grounds on which these licences are granted.
- Each member has the right to determine what amounts to a national emergency or other circumstances of extreme urgency – with the understanding that public health crises, including those relating to HIV/AIDS, tuberculosis, malaria and other epidemics, can represent a national emergency or other circumstances of extreme urgency. In emergencies, WTO members are entitled to act more speedily against patent holders.

TRIPS does not and should not prevent members from taking measures to protect public health. In fact, the Doha Declaration reaffirms the right of WTO members to use the options under TRIPS. The Declaration provides remedies to states to prohibit the pushing up of prices by pharmaceutical companies with patents.

The Declaration can be used as a further tool of interpretation of international law under Article 31 of the Vienna Convention on the Law of Treaties 1972. The Declaration partially resolves the conflict of human rights versus intellectual property rights in favour of promoting and protecting human rights.

THE CESCR ON INTELLECTUAL PROPERTY AND HEALTH

In 2001, the CESCR produced a policy statement on *Human Rights and Intellectual Property* (the Statement). This was to be a precursor to a more considered and comprehensive General Comment 15 on Intellectual Property and Human Rights. At the time of writing, the General Comment has not been finalised.

The Statement called on all states party to international agreements to:

- "take due account of" the right to health; and
- ensure that the application of international agreements "is supportive of public health policies which promote broad access to safe, effective, affordable, preventative, curative and palliative pharmaceuticals and medical technologies".

A joint study by the WTO and WHO considered the impact of international trade rules on public health. The study stated:

> *"The endorsement by the international community of the Doha Declaration on the TRIPS Agreement and Public Health is a very visible expression of governments' commitment to ensuring that the rules-based trading system is compatible with public health interests."*
>
> Source: *WTO Agreements and Public Health, a joint study by the WHO and WTO Secretariat*, 2002

Some debate whether there should be direct binding obligations for non-state role players in international law, such as pharmaceutical companies and the WTO. The preamble to the UDHR refers to "every organ of society" and the preamble to the ICESCR says "realising that individuals have duties to other individuals". These statements clearly suggest that there ought to be obligations on non-state actors.

For more information, see *Norms on the Responsibilities of Transnational Corporations and Other Business Enterprises with Regard to Human Rights*, UN, 2003.

PROTECTING THE RIGHT TO HEALTH

In General Comment 14, the CESCR called upon the International Monetary Fund (IMF), the World Bank and regional development banks to pay greater attention to the protection of the right to health in influencing their lending policies, credit agreements and international measures.

The CESCR focused on poor debtor nations of the world and stressed that a human right to health could shape lending policies by:

- aiding efforts to protect infrastructure for the provision of health care;
- ending the disruptive practice of requiring user fees at publicly funded clinics and other health care services.

Direct foreign investment into national infrastructure and introducing new technology can be beneficial, but also can have undesired effects if commercial objectives are allowed to outweigh social objectives of protecting the enjoyment of the right to health.

Source: Gupta and others, IMF, 2002

US Free Trade Agreements

Following the concessions made in the negotiations leading up to the adoption of the *Doha Declaration*, the United States has been encouraging countries and regional bodies to enter into Free Trade Agreements (FTAs).

FTAs are agreements between two (bilateral) or more (usually regional) trading countries to open up domestic markets to trade on equal terms with the country seeking to export.

However, in practice, the agreements merely open up the developing country's market to the developed country on preferential terms. This is because exports by the developed country far outweigh reciprocal exports by the developing country. In the case of pharmaceutical products, for example, FTAs often push up the price of the medicine for those who can least afford it.

These agreements take place outside the purview of the WTO so that the stronger country is able to negotiate for measures that go beyond the WTO agreements. That is, as a result of greater economic power, developed countries are able to insist on measures that are more favourable to them than the developing country that is a party to the agreement. The multilateral WTO agreements are therefore seen as setting only the minimum standards for trade rules.

Countries such as Chile and Morocco have already signed agreements that go beyond the intellectual property rights negotiated in TRIPS.

Médecins Sans Frontières (MSF) says that these kinds of FTAs:

"could put an end to competition from generic medicine producers and to countries ability to make use of the existing safeguards against patent abuse".

(MSF briefing note, 2004)

Implications for the Southern African Customs Union

The Southern African Customs Union (SACU) is made up of South Africa, Botswana, Lesotho, Namibia and Swaziland. SACU's main aim is to maintain the free interchange of goods between member countries.

Until recently, the US was in negotiations with SACU regarding an FTA. Its attitude to the negotiations was set out in its 2004 document entitled *Comprehensive Report on US Trade and Investment Policy Toward Sub-Saharan Africa and Implementation of the African Growth and Opportunity Act:*

"Through an FTA with SACU, US businesses will gain preferential access to their largest export market in sub-Saharan Africa. Other exporters such as the European Union already receive preferential access to the South African market."

Fortunately, the negotiations reached deadlock. For now, SACU countries still benefit from preferential trading rules in the US African Growth and Opportunity ACT (AGOA), excluding any agreement on TRIPS+ intellectual property standards.

5.5 The right to health in the African regional system

While the UN operates at an international level, there are also regional institutions that aim to promote human rights. These institutions produce regional treaties and declarations.

Examples: Regional Human Rights Institutions

- The European Commission on Human Rights and the European Court of Human Rights are responsible for applying the *European Convention on Human Rights*.
- The Inter-American Commission on Human Rights and the Inter-American Court of Human Rights apply the *American Convention on Human Rights*.

The reports, recommendations and decisions that come from these bodies are very persuasive, and have been referred to by domestic courts in interpreting various human rights provisions.

In this chapter, we will focus on the African system.

African Union (AU)

The AU is Africa's principal organisation for the promotion of socio-economic integration of the continent. The AU grew out of the Organisation for African Unity (OAU). The OAU was a regional body with multiple objectives, including ridding Africa of the legacy of colonisation and apartheid, as well as fostering social and economic co-operation amongst African states. In 1999, the Heads of States of the OAU issued the Sirte Declaration that called for the creation of the AU.

Some of the AU's aims are to:

- Accelerate the political and socio-economic integration of the continent.
- Encourage international co-operation, taking into account the UN Charter and the UDHR.
- Promote and protect human rights in accordance with the African Charter and other relevant human rights instruments.
- Work with relevant international partners in doing away with preventable diseases and in promoting good health on the continent.

African Commission on Human and Peoples' Rights

The African Commission on Human and Peoples' Rights is the monitoring body for the *African Charter on Human and Peoples' Rights*.

The African Commission:

- receives reports from state parties, interstate reports and individual complaints where there are serious abuses;
- has the power to investigate abuses;
- must bring these abuses to the attention of the Assembly of Heads of State and Government of the AU.

After being informed of abuses, the Assembly may then request the Commission to make an in-depth study, and to present a report with conclusions and recommendations.

Regional agreements

The African Charter

The primary regional instrument for South Africa relevant to economic, social and cultural rights is the *African Charter on Human and Peoples' Rights* (African Charter). South Africa became a party to the African Charter in 1996.

The African Charter includes the "right to enjoy the best attainable state of physical and mental health" in Article 16.

The Article goes on to provide: "State Parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick".

We see that the wording differs from the ICESCR. There is no mention of progressive realisation and available resources. This suggests that the obligations of the State Parties to fulfil the right (and not just the minimum essential level of the right) are immediate.

However, this was not the interpretation given to Article 16 by the African Commission in the case of *Purohit and Moore v The Gambia* [Communication 241/2001]. Among other rights, this case also concerned the right to health for mental health patients. The Commission noted the dissimilarity between the wording of the right to health in the Charter and the ICESCR, but interpreted the Charter in line with the ICESCR. It read into Article 16 the qualifiers of available resources and progressive realisation.

The *Abuja Declaration*

The *Abuja Declaration* of 2001 was drawn up by the Heads of State and Government of the OAU (now AU).

The Declaration considered the HIV/AIDS pandemic:

"As a state of emergency in the continent. To this end, all tariff and economic barriers to access to funding of AIDS-related activities should be lifted."

The states committed themselves to:

- Take all necessary measures to ensure that the needed resources are made available.
- Mobilise all the human, material and financial resources required to provide care, support and quality treatment.
- Enact and use appropriate legislation and international trade regulations to ensure the availability of drugs at affordable prices.

African Court on Human and Peoples' Rights

In June 1998, the *Protocol to the African Charter on Human and Peoples' Rights on the Establishment of the African Court on Human and Peoples' Rights* (the Protocol) was adopted by the Organisation of African Unity (OAU), the predecessor of the AU.

Civil society and NGOs played an important role in the drafting and adoption of this Protocol. More than five years after the adoption of the Protocol, 15 ratifications were achieved, and the Protocol took effect on 15 January 2004. South Africa ratified the Protocol in 2002.

At the time of writing, the African Court on Human and Peoples' Rights (ACHPR) was in the process of being set up, despite a decision that was taken at an AU summit meeting in 2004 to merge the ACHPR with the African Court of Justice that has yet to be established. The merger raises complexities that threatened to delay the establishment of the ACHPR, but the AU decided that setting up the court is a priority and should not be delayed.

While human rights activists welcome the move to create the ACHPR, there are some concerns regarding the proposed manner of operation. For example, there are no clear rules as to how the ACHPR and the African Commission are to work in relation to each other, especially regarding the procedure for referring cases from the African Commission to the ACHPR.

Another important concern is that the Protocol restricts access to the ACHPR by individuals and NGOs. State parties are required to sign a declaration that states that they recognise the competence of the ACHPR to receive complaints from NGOs. If a state has not done this, the ACHPR will not be able hear complaints against that state that are brought by NGOs. Further, only NGOs that have an observer status with the African Commission may file cases before the ACHPR.

New Partnership for Africa's Development (NEPAD)

NEPAD was adopted at the 37th session of the Assembly of Heads of State and Government in July 2001 in Lusaka, Zambia.

NEPAD is an integrated development plan to address key social, economic and political priorities. It is meant to develop values and monitor their implementation within the AU to:

- promote accelerated growth and sustainable development;
- eradicate widespread and severe poverty;
- halt the marginalisation of Africa in the globalisation process.

Policy reform in the human development sector is a priority and focuses on health together with other areas. Some of the health objectives of NEPAD are to:

- strengthen programmes for containing communicable diseases;
- achieve secure health systems that meet needs and support disease control effectively;
- successfully reduce the burden of disease on the poorest people in Africa.

NEPAD's action plans include strengthening Africa's participation in processes

aimed at procuring affordable drugs, and exploring the use of alternative delivery systems for essential drugs and supplies.

For more detail on steps towards more affordable drugs, see Chapter 14.

African Peer Review Mechanism

In July 2002, the African Peer Review Mechanism (APRM) was established at the 6th summit of the Heads of State and Government Implementation Committee of NEPAD. The APRM is a self-monitoring mechanism designed to track the progress and performance of member states in their quest for democracy, human rights and good governance.

The ARPM's main aim is to foster the adoption of appropriate laws policies, standards and practices that lead to political stability and economic growth and integration. The APRM does this through:

- Sharing experiences.
- Reinforcing successful and best practices.
- Reviewing the performance of particular countries – one of the four focus areas for review is socio-economic development.

The APRM depends on member states voluntarily agreeing to be reviewed. South Africa was one of the first countries to agree, and this process began in late 2005. The peers or fellow heads of state receive reports prepared by experts and make recommendations. However, they have no mandate to punish member states that do not follow these recommendations.

However, there is pressure on participating states to achieve positive reports from the Review Team as the APRM influences donor organisations and countries on which countries should be favoured as funding recipients. This is a strong incentive for states to conform with NEPAD's values.

Key Point: Opportunity for NGOs

There are possibilities for NGOs to take part in the APRM at Stage 2 of a review when the Review Team visits the state before preparing a peer review report. The mechanism requires consultation with key stakeholders within a country, including civil society organisations.

Southern African Development Community

The Southern African Development Community (SADC), previously the Southern African Development Coordination Conference, was formed in April 1980, by 9 southern African countries: Angola, Botswana, Lesotho, Malawi, Mozambique, Swaziland, Tanzania, Zambia and Zimbabwe. It has now expanded to a membership of 14 countries, including South Africa.

One of SADC's aims is:

"to achieve development and economic growth, alleviate poverty, enhance the standard and quality of life of the peoples of Southern Africa and support the socially disadvantaged through regional integration".

In 1997 SADC adopted the *SADC HIV/AIDS and Employment Code*. This Code has been used by NGOs to try to persuade governments to adopt legislation that is similar to the Code.

The S*ADC Protocol on Health* aims to improve the health of the population through close co-operation in the region, recognising that this is:

"essential for the effective control of communicable diseases, non-communicable disease and for addressing common health concerns".

The Protocol aims to:

- Promote activities that have the potential to improve health, such as the development of health personnel and facilities.
- Encourage co-operation with international partners.
- Help develop common strategies to address the needs of vulnerable groups.

In August 2000, SADC approved the *Principles to Guide Negotiations with Pharmaceutical Companies on provision of Drugs for Treatment of HIV/AIDS and related conditions in SADC Countries*. SADC is making efforts to implement its *HIV and AIDS Strategic Programme and Plan of Action 2003-2007*.

5.6 How can we use international law?

Law-making

International law, in all its forms, can be a useful tool in assisting individuals, NGOs and other interested parties to make submissions on draft legislation. This is especially true for bills having a direct impact on the protection of human rights, such as South Africa's National Heath Act.

National laws are mainly governed by the Constitution. It is not the government's duty to draft legislation in accordance with non-binding international law. However, norms and standards that are developed internationally can be used to support submissions to parliamentary committees on draft laws that affect the right to health care.

Example: Lobbying on pregnancy legislation

The introduction of the Choice of Termination of Pregnancy Act followed intense lobbying by NGOs working in the area of gender equality and women's health.

For more detail, see *Socio-economic Rights in South Africa: A Resource Book*, page 244.

Litigation

The use of international law in litigation is crucially important in a young democracy with very few domestic cases as precedents to guide the courts. Section 27 of the Constitution, which includes the right to health care, was informed by the interpretation of the ICESCR at the international level.

Cases may refer to the prevailing international opinion on the interpretation of the international agreement. In the *TAC* case, the Constitutional Court referred to the approval by the WHO of the use of nevirapine to prevent mother-to-child transmission of HIV.

There may also be cases where the international obligations of South Africa (eg under the TRIPS Agreement) may be the subject of litigation. For example, the Doha Declaration and other authoritative interpretations of the TRIPS Agreement are directly relevant to the application of the TRIPS Agreement in South Africa.

Complaints and communications to regional or international bodies

Individuals and interested parties can use the international human rights systems as a way of establishing and developing rights. Below are some examples of how one may engage the international mechanisms.

Where South Africa is a signatory to an international treaty or a regional body that permits individual complaints, the individual must have exhausted domestic remedies (unless the remedy is ineffective, or the remedy will take an unreasonable length of time). In other words, you must try to take up your case through South African courts first before using complaint procedures under international law.

Examples: Mechanisms for protecting rights

- CERD permits individual complaints under the main convention – South Africa is a signatory.
- CEDAW permits individual complaints under the Optional Protocol, although South Africa has not yet signed this.
- Individuals and NGOs may lodge petitions with the African Commission on Human and Peoples' Rights and examine "communications" from individuals of other states.

Advocacy aimed at influencing law and policy-making

Advocacy within the UN system to establish elements of the right to health, including access to medicines, is a lengthy process. Advocacy can refer to international documents and should be directed to special rapporteurs and treaty monitoring committees.

It is now possible to raise all health-related rights violations, including issues of access to medication, with the Special Rapporteur on Health, who will have input into any international instruments that may be developed on the issue.

5.7 Conclusion

We have seen that international law has been integral to the development of human rights, and the right to health in particular. Given that the South African Constitution compels courts to have regard to international law in applying the Bill of Rights, it will remain an important aspect of the interpretation of rights domestically.

Using the international or regional system to advance rights on the other hand is more complex and time-consuming. One needs to have exhausted domestic routes, and have the capacity to engage the international mechanisms. Where there are strong institutions within countries that support the protection of human rights – such as an independent judiciary, national human rights commissions and public protectors – the need to use the international institutions to protect rights is weaker. However, the international and regional bodies are especially valuable for those countries without strong independent domestic institutions.

It is therefore important that these bodies are accessible to individuals and organizations interested in the protection of rights. That the Protocol that established the African Court of Human and Peoples' Rights is not easily accessible, is worrying. It will be important for civil society across the region to advocate strongly for a revision of the Protocol to address this (and other) issues.