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PREVENTING MOTHER-TO-CHILD HIV TRANSMISSION IN SOUTH AFRICA. BACKGROUND, STRATEGIES AND OUTCOMES OF THE TREATMENT ACTION CAMPAIGN CASE AGAINST THE MINISTER OF HEALTH

I INTRODUCTION

In July 2002, the Constitutional Court gave judgment in the Treatment Action Campaign (TAC)'s constitutional challenge to government's policy of limiting the provision of Nevirapine for the purpose of preventing mother to child transmission (PMTCT) of HIV to a limited number of 'pilot sites'. In finding this policy to be unconstitutional, the Court found that:

...the policy of confining nevirapine to research and training sites fails to address the needs of mothers and their newborn children who do not have access to these sites. It fails to distinguish between the evaluation of programmes for reducing mother to child transmission and the need to provide access to health care services required by those who do not have access to the sites.

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The Minister of Health and the nine Health Members of the provincial Executive Committees (MECs) were ordered "without delay" to lift restrictions on the availability of Nevirapine. Thus ended the legal contest... one year and approximately 100,000 infant HIV infections after the start of the case. The Health Ministry tried to put the best slant on the judgment and continued as if it were business as usual: no apology was offered, no admission made that it had been wrong. On the contrary, a statement issued by the Minister on 5 July 2002 went as far as to suggest that the judgment "confirmed" the approach of the cabinet and welcomed the fact that it "has set aside the most restrictive aspects of the Pretoria High Court order."

This paper contextualises the litigation that challenged the South African government's PMTCT policy and documents its causes and effects. It examines the resort to constitutional litigation by civil society organisations, after being frustrated by what Cameron JA described in

1 Minister of Health v Treatment Action Campaign (No 2) 2002 (1) SA 721 (CC).
2 Ibid para 61.
3 On 2 April 2002, the front-page headline of The Sunday Times was "How Many More Babies Must Die?" It added: "Had government implemented the High Court ruling handed down in December last year, and expanded its nevirapine programme to reach only one in every five HIV-positive mothers, it would have saved more than 900 babies from being infected with HIV."

II THE SCIENTIFIC BACKGROUND

One of the earliest and most enduring breakthroughs in the AIDS epidemic was the discovery in 1994 that mono-therapy with the anti-retroviral drug AZT dramatically reduced the risk of mother to child HIV transmission (MTCT). However, it was realised that the drug would be of limited efficacy outside of industrialised countries because of the need to begin administering it relatively early in pregnancy and the infra-structural requirements for its delivery. Consequently, research soon began for shorter and simpler anti-retroviral regimens that would also benefit parents in poorer countries. The most important breakthrough in this regard came in 1996 when a clinical trial in Thailand demonstrated that a short course of AZT given to mother and child (starting at 36 weeks of pregnancy) still brought about significant reductions in MTCT. This has become known as the Thai/Bangkok study. Since then various other regimens have been tested with the aim of further simplifying regimen, testing the durability of the benefit of

5 Presently Secretary, Department of Welfare, Eastern Cape Provincial Government v Minister of Health 2003 (4) SA 1114 (SCA)
6 Ibid p para 5.
reducing intra-partum HIV transmission in breastfeeding populations and limiting drug resistance.10

The practical implementation of this knowledge about how to reduce MTCT is extremely important in developing countries, including South Africa. For pregnant women with HIV there is a 30 per cent risk that the child will be infected with HIV, mostly during the birth and breastfeeding period. In South Africa, by 1998, it was estimated that up to 70 000 children were being born every year with HIV and there were already signs that rising infant mortality was being caused by MTCT.11 Most of these children live short painful lives, with HIV infection carrying a terrible toll for both parents and children. This pain is described by Busiwe Maquobo in one of the personal affidavits that was filed in the TAC case:

My baby was always sick. I had to borrow money from her father’s parents, to take her to hospital. She normally had to go to Red Cross or Contra Hospital and she was once admitted in Tygerburg Hospital. Sometimes my baby would be out of hospital for a week and then she would be sick again. I never had enough time with her.

Doctors always told me that my baby will die and that there was nothing they could do for her. I knew my baby would die, but I didn’t want to hear it, especially not from the doctors all the time. I was told to take her home. I gave birth to an HIV-positive baby who should have been saved. That was my experience, the sad one, and I will live with it until my last day.12

It was with the aim of securing the benefits of these breakthroughs in medical science for parents like Busiwe Maquobo that, as early as 1997, organisations such as the AIDS Law Project (ALP) at the Centre for Applied Legal Studies, the AIDS Consortium and the Prumctal HIV Research Unit at the University of the Witwatersrand began a period of sustained lobbying of the Minister and the Department of Health to develop a policy and programme to prevent MTCT. The objective was to pressure the government to implement the steps to be taken to prevent perinatal transmission of HIV listed in the 1994 National AIDS Plan. These included offering HIV testing at ante-natal clinics on a voluntary basis and conducting research into methods of preventing perinatal transmission such as ‘short course AZT’ and ‘non-nucleoside reverse transcriptase inhibitors’.13 This campaign received renewed impetus in December 1998 when TAC was founded and set as one of its primary objectives a demand that government implement a programme to prevent MTCT.

TAC’s activities around MTCT are too voluminous to describe in detail here. Between 1999 and 2001 there were meetings with the first and second Ministers of Health, demonstrations, the drafting of memoranda, a 50 000 person petition to the President and a campaign that targeted pharmaceutical companies to reduce the prices of essential anti-retroviral medicines14 and particularly GlaxoWellcome’s drug, Zidovudine (AZT).15 Initially, demands for a policy and plan on PMTCT received a relatively sympathetic ear from the government. In 1998, for example, the Gauteng Health Department responded timeously to the results of the Bangkok Thai study16 by announcing the establishment of five pilot sites where programmes to reduce MTCT would be introduced. On 30 April 1999, a meeting between TAC and Dr Nkonza Zuma led to a joint statement that the price of AZT was the major barrier to an MTCT programme and a promise that:

government would earn an affordable price for the implementation of AZT to pregnant mothers and report within six weeks on the price and other issues pertaining to the prevention of mother-to-child transmission.17

At this point it looked as if TAC’s MTCT campaign would be one primarily targeting the manufacturers of anti-retroviral medicines to reduce their prices. However, an unanticipated and unfortunate diversion revealed itself in late 1999.

III THE ADVENT OF AIDS DENIAL IN SOUTH AFRICA AND ITS IMPACT ON PMTCT

Since the mid 1990s there has been a small group of scientists who have developed a thesis that HIV has not been properly isolated as a virus, and that the real cause of AIDS were initially the recreational drugs taken by many gay men in the USA in the late 1970s and early 1980s, and thereafter anti-retroviral medicines. This group (often referred to as ‘AIDS dissidents’) has argued that, rather than helping to restore the immune system, anti-retroviral drugs destroy it by destroying cell

14 The details of this campaign were set out in a ‘Memorandum Calling for Government, Action and Implementation of a Prevention and Treatment Plan’ submitted to the Minister of Health on 11 June 2001 (available at http://www.tac.org.za).
15 Zidovudine or AZT was the first anti-retroviral drug to receive FDA approval as a treatment for HIV/AIDS. Its benefits in reducing MTCT were discovered later.
16 See note 9 above.
17 Joint Statement of the Ministers of Health and TAC (30 April 1999).
replication and causing a range of life-threatening side-effects. Although their arguments vary, the basic conclusion is that AIDS in Africa is caused by poverty and that a range of poverty related illnesses (such as Tuberculosis) are being misdiagnosed as HIV-related in order to create markets for first world drugs, particularly anti-retrovirals.

When TAC launched legal action to demand broader access to Nevirapine in 2001, none of the affidavits filed by government officials made reference to these 'dissonant' views on anti-retroviral medicines, or whether HIV is the cause of AIDS, as reasons to justify the failure to develop or implement a programme. However, a sometimes hidden, sometimes open, relationship that has become apparent between the President and AIDS denialists would seem to be the primary reason for the delays.

From reasons that are not yet fully documented, the fact that such a relationship existed was first signalled in October 1999 in a speech by President Mbeki to the second chamber of South Africa's Parliament, the National Council of Provinces (NCOP). At the end of this speech he unexpectedly questioned the safety of AZT and warned that the 'toxicity of this drug is such that it is, in fact, a danger to health'. Mbeki informed the NCOP that he had instructed the Minister of Health to launch a probe into the safety of AZT and that, until this was complete, it would not be used in South Africa. From this point onwards, progress with implementation of a national programme to prevent mother to child HIV transmission was derailed.

Two weeks later, on 16 November 1999, the Minister of Health announced to the National Assembly that, although she was aware of the positive results of AZT, there are other scientists who say that not enough is yet known about the effects of the toxic profile of the drug, that the risks might well outweigh the benefits, and that the drug should not be used. As a result, she had instructed the Medicines Control Council (MCC) to review the use of AZT.

Experiences such as the Thalidomide crisis mean that there is now universal acceptance of the need for governments and regulatory authorities constantly to monitor the safety and efficacy of all registered medicines, including anti-retrovirals. However, the AIDS crisis in South Africa has been compounded by the readiness of senior politicians to cite Thalidomide as cause for caution regarding the use of anti-retrovirals, but then to ignore the advice of the scientists they have called upon to review safety profiles. So, in early 2000 when the MCC issued the report of its careful, internationally supported review of AZT, which was concluded again that benefits of its use outweighed the risks, the report was at first rejected and sent back to the MCC for further work, and later ignored. Indeed, in spite of the views of the MCC, the World Health Organisation (WHO) and a multitude of other scientists, political opposition to the use of AZT continued in January 2000 for example, President Mbeki responded personally to the author of an article in Business Day advising that he 'contact the Perth scientists and Dr Ramnik directly' and stating that '[t]he question we must all answer, including the scientists, is whether we should continue to harm the health of the women in our country, to avoid "causing public confusion"'.

Thalidomide was initially developed in the 1950s as a sedative. It was programmed to prevent women to refuse morning sickness and other pregnancy related, and was registered for this purpose in a number of countries, including Germany, Canada and Britain. However, in 1961 a link was established between Thalidomide and serious birth defects (eventually affecting nearly 13 000 babies) and it was rapidly withdrawn from use. The Thalidomide experience led to greater caution in the regulation of medicines but also to awareness of the scientific corroboration of registered medicines. See L. Harre 'Drug Watch: used for ongoing rethinking of registered medicines.' See L. Harre 'Drug Watch: used for ongoing rethinking of registered medicines.' See L. Harre 'Drug Watch: used for ongoing rethinking of registered medicines.' See L. Harre 'Drug Watch: used for ongoing rethinking of registered medicines.' See L. Harre 'Drug Watch: used for ongoing rethinking of registered medicines.' See L. Harre 'Drug Watch: used for ongoing rethinking of registered medicines.' See L. Harre 'Drug Watch: used for ongoing rethinking of registered medicines.' See L. Harre 'Drug Watch: used for ongoing rethinking of registered medicines.' See L. Harre 'Drug Watch: used for ongoing rethinking of registered medicines.' See L. Harre 'Drug Watch: used for ongoing rethinking of registered medicines.' See L. Harre 'Drug Watch: used for ongoing rethinking of registered medicines.' See L. Harre 'Drug Watch: used for ongoing rethinking of registered medicines.' See L. Harre 'Drug Watch: used for ongoing rethinking of registered medicines.' See L. Harre 'Drug Watch: used for ongoing rethinking of registered medicines.' See L. Harre 'Drug Watch: used for ongoing rethinking of registered medicines.' See L. Harre 'Drug Watch: used for ongoing rethinking of registered medicines.' See L. Harre 'Drug Watch: used for ongoing rethinking of registered medicines.' See L. Harre 'Drug Watch: used for ongoing rethinking of registered medicines.' See L. Harre 'Drug Watch: used for ongoing rethinking of registered medicines.' See L. Harre 'Drug Watch: used for ongoing rethinking of registered medicines.' See L. Harre 'Drug Watch: used for ongoing rethinking of registered medicines.' See L. Harre 'Drug Watch: used for ongoing rethinking of registered medicines.' See L. Harre 'Drug Watch: used for ongoing rethinking of registered medicines.' See L. Harre 'Drug Watch: used for ongoing rethinking of registered medicines.' See L. Harre 'Drug Watch: used for ongoing rethinking of registered medicines.' See L. Harre 'Drug Watch: used for ongoing rethinking of registered medicines.' See L. Harre 'Drug Watch: used for ongoing rethinking of registered medicines.' See L. Harre 'Drug Watch: used for ongoing rethinking of registered medicines.' See L. Harre 'Drug Watch: used for ongoing rethinking of registered medicines.' See L. Harre 'Drug Watch: used for ongoing rethinking of registered medicines.' See L. Harre 'Drug Watch: used for ongoing rethinking of registered medicines.' See L. Harre 'Drug Watch: used for ongoing rethinking of registered medicines.' See L. Harre 'Drug Watch: used for ongoing rethinking of registered medicines.' See L. Harre 'Drug Watch: used for ongoing rethinking of registered medicines.' See L. Harre 'Drug Watch: used for ongoing rethinking of registered medicines.' See L. Harre 'Drug Watch: used for ongoing rethinking of registered medicines.' See L. Harre 'Drug Watch: used for ongoing rethinking of registered medicines.' See L. Harre 'Drug Watch: used for ongoing rethinking of registered medicines.' See L. Harre 'Drug Watch: used for ongoing rethinking of registered medicines.' See L. Harre 'Drug Watch: used for ongoing rethinking of registered medicines.' See L. Harre 'Drug Watch: used for ongoing rethinking of registered medicines.' See L. Harre 'Drug Watch: used for ongoing rethinking of registered medicines.' See L. Harre 'Drug Watch: used for ongoing rethinking of registered medicines.' See L. Harre 'Drug Watch: used for ongoing rethinking of registered medicines.' See L. Harre 'Drug Watch: used for ongoing rethinking of registered medicines.' See L. Harre 'Drug Watch: used for ongoing rethinking of registered medicines.' See L. Harre 'Drug Watch: used for ongoing rethinking of registered medicines.' See L. Harre 'Drug Watch: used for ongoing rethinking of registered medicines.' See L. Harre 'Drug Watch: used for ongoing rethinking of registered medicines.'
Unfortunately, Mbeki’s endorsement of denialist views gained currency in the ANC and the government, and increasingly determined constitutional duties progressively to realize access to health care services, specifically for women and children with HIV. Thus on 5 April 2000 the Minister of Health, Dr Tshabalala-Msimang, made a speech to Parliament that had all the hallmarks of ‘disinterest’. Raising reasonable concerns about a number of deaths of adults on therapeutic drug trials that appeared to be associated with daily Nevirapine use as part of a combination of anti-retroviral drugs, she confused these deaths with use of the same medicine for preventing intra-partum HIV transmission — despite the knowledge that it requires only one dose to mother and child and the fact that there were no reported adverse events following its use in MTCT.

Tshabalala-Msimang remained steadfast in opposition to AZT. At the end of 2000, at a meeting in New York to launch the International Partnership Against HIV/Aids in Africa (IPA), she told the author that the government would “never use AZT” in the prevention of MTCT.

Three years later this position prevailed. The intricacies and ongoing evidence of what emerged as President Mbeki’s sympathies with the AIDS-denialist cause have been partially reported elsewhere. They were admitted to by the late Peter Mokaba and put on public display in a document that was given wide circulation in the ANC titled Castro Hitongwane, Caravan, Cats, Green, Foot and Mouth and Statistics: HIV/AIDS and the Struggle for the Humanization of the African. This anonymous document, which Mokaba admitted was penned by a collective in the ANC, has lengthy chapters on AZT, Nevirapine and MTCT. Its main argument is that an unholy combination of scientists, AIDS activists and pharmaceutical companies are engaged in a campaign of ‘scare-mongering’ that is condemning millions of our own people to ill-health, disability and death — [l] to sustain a massive

27 Statement by the Minister of Health on ‘Nevirapine Drug’ in Debate of the National Assembly Resolved (5 April 2000) 2002-26.
28 C. McGraw “Thabo Mbeki’s Catastrophe” (2001) Propser 47-7. D Farrel ‘Behind the scenes Mbeki and the doctors are divided, there exists a paper trail of speeches and pronouncements the main themes of which are inculcation in a letter to World Leaders’ Presidential Advisory Panel on AIDS (5 May 2000) http://www.cranymouth.net/uploads/hivhealth.htm; Opening Speech to the ReproTech.htm and various articles, including a live television interview with South African journalist Dames Patnsh (ETV) ‘On the Record’ (4 April 2001), when Mbeki told viewers that you do not take an HIV test on the ground that it would be a “publicity stunt”, adding when confronting a particular paradigm. It doesn’t help in addressing the health needs. (Accessed from http://www.cranymouth.net/uploads/hivhealth.htm.)

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political-commercial campaign to promote anti-retroviral drugs. Poverty is artificially attributed to HIV/AIDS as the real challenge to the health of African people, ignoring the actual link between vulnerability to HIV infection and poverty, and the consequences of HIV infection on household income.

IV THE GOVERNMENT’S CHOICE OF NEVIRAPINE

In July 1999 the first results of a trial known as HIVNET 012, testing the efficacy of a single dose of Nevirapine in reducing MTCT, were released by the National Institutes for Health (NIH). The results showed similar efficacy to AZT but were achieved with a much less complex regimen. In the face of Presidential opposition to AZT the Minister of Health and others latched onto Nevirapine as an alternative – and quickly arranged a study-tour to Uganda, which included the objective of hearing more of the trial of this drug.

In answer to the growing pressure from TAC, Nevirapine was now offered as the government’s probable medicine of choice and TAC was persuaded to still it demands pending the outcome of a local trial known as the South African Intra-partum Nevirapine Trial (SAINT). TAC accepted the bona fides of the Minister and for a period of nine months pressure on government policy on MTCT was reduced and TAC engaged in a number of other successful campaigns that aimed to bring down the price of essential anti-HIV medicines and targeted patent abuse and drug pricing.

This was not well received by clinicians working on MTCT who felt that TAC had ‘let the government off the hook’ over MTCT. As the preliminary results of SAINT supported the use of Nevirapine and started to leak out in mid-2000, a new catalogue of excuses emerged from the Minister. It seemed as if the clinicians’ concerns were correct.

Fear of further delays and political interference in public health policy appeared to be confirmed at the International AIDS Conference held in Durban in July 2000. The conference opened in controversy as President Mbeki spoke eloquently about poverty, but refused to name HIV as a specific challenge for Africa. At the same time the government declined an offer from Boehringer Ingelheim, the manufacturer of Nevirapine, for a ‘free’ supply of the drug for 5 years and reacted coolly to the

30 Ibid
31 For an in-depth analysis of the links between TB, HIV and poverty see J Parsons Infectious and Inequalities, The Modern Plague (2001)
33 See Pending Affidavit (note 12 above) para 254-51.
34 Dr G Gray, internal communication with author (July 2000).
preliminary announcement of the SAIMRT results. It took the intervention of former President Mandela to quell the storm. In his closing speech at the Conference, he called for widespread interventions to prevent MTCT.

In response to these developments, TAC publicly reinstated its threat of litigation. This threat of legal action in July 2000 raises important issues about the timing and objectives of litigation. By this time TAC's campaigns had already made government policy on MTCT a matter of national concern and had achieved wide support. At the International AIDS Conference, TAC seriously considered bringing an urgent High Court application for access to Nevirapine on behalf of several women in the late stages of pregnancy. However, despite scientific consensus on its safety and efficacy, the medicine was not yet registered in South Africa for the prevention of MTCT. AZT was registered, but it was felt that the greater cost of this medicine, together with a more complicated drug regimen (AZT must be taken daily from 36 weeks of pregnancy) made successful litigation more difficult. TAC's legal counsel cautioned against commencing litigation before Nevirapine was registered.

When medicines are registered by the MCC, the registration is for specific indications that are described in the mandatory package insert that accompanies all medicines. "Off-label" use of a medicine refers to its use for indications that have not been formally approved. This happens frequently, particularly in the use of medicines to treat children. But although TAC could point to precedents for "off-label" use of medicines, and even instances where government policy endorsed this, a court would have stuck to the strict letter of the law. For a court formally to condone "off-label" use of medicines was inviting compromise in the system of medicine registration. There was no option for TAC but to continue the campaign, but delay the litigation. Pressure was now turned to the MCC to speed up registration of the drug and for government to clarify its programme.

On 12 and 13 August 2000 the Department of Health convened a meeting with South African scientists to assess the new knowledge gleaned from the Durban conference. After this meeting, MinMEC (a committee of the Minister of Health and the nine Provincial MECs for Health) decided that the current policy of not using AZT would continue and that the use of Nevirapine, once registered, would first be tested for two years at two "pilot sites" in every province. The reason for this was to determine whether or not the exercise would be feasible, taking into account all the operational issues. Should the pilot sites be successful, the next step would be phased implementation, should this not be possible the exercise would be terminated. 35

35 Many medicines are used "off-label" for children because there have not been full clinical studies. But their efficacy and safety is assessed based on evidence from adult use.
37 Health MinMEC Minutes (18 August 2000).

What exactly MinMEC decided in August 2000 later became a major subject of dispute in the legal proceedings. Although the government's affidavits were peppered with repeated references to the MinMEC minutes, the actual document was never officially disclosed to the Court. Repeated requests by TAC's attorney were stonewalled and then refused. On 12 November 2001 TAC brought an application to compel the government to produce the minutes. Shortly afterwards, the MinMEC minutes were given in confidence to TAC chairperson Zachie Achmat and, on 20 November, TAC filed a supplementary affidavit that annexed the document. However, this was opposed by the government in an affidavit which was served minutes before the start of the main proceedings on 26 November. In this affidavit the Director General of the Health Department, Dr Ntshalintshali, claimed that "for the sake of good governance the minutes were confidential and protected against disclosure." He also claimed that they were "irrelevant" and that disclosure of such confidential documents "could reasonably be expected to frustrate the success of that policy." Dr Ntshalintshali's affidavit refused to admit the authenticity of the minutes, claiming that he had not had time to study them. A strange situation then arose when adv. Moersen, senior counsel for the government, claimed in the first hour of the first day of the court hearing, that the Director General (who was seated behind him) had not had time to authenticate the document. The state then attempted to argue that the case could not proceed until the question of the admissibility of the MinMEC minutes had been determined. At this point, in order to prevent the issue of the MinMEC minutes becoming cause for a delay in the main proceedings, TAC withdrew its application to compel - and the case proceeded.

However, the reasons for government's desire to keep this critical decision out of the court's eye seem clear. The minutes showed that in August 2000 Dr Nono Simelela, the Chief Director for HIV/AIDS and STDs, had recommended a revision to the existing policy and had spoken unambiguously of a range of benefits that would flow from expanding the programme. 38 She proposed that a specially formed task team or the

38 See correspondence between G Baloulud and the State Attorney (October 2001) in Republic of South Africa v. Ntshalintshali et al. 2001 (22) SA 434 (C) (23 November 2001) (Respondents Further Affidavit TAC v. Minister of Health). In this letter the request was finally denied on the grounds that access to documents, such as the MinMEC Minutes, is subject to limitations, such as privileges and that disclosures 'could reasonably be expected to frustrate the success of that policy'.
40 See page 35.5.
41 See page 35.5.
42 Note 37 above. "The benefits of a preventive mother to child transmission programme will be wider than those for positive women and their children..." Several studies have demonstrated the powerful prevention benefits of knowing about a negative HIV status.

35 Many medicines are used "off-label" for children because there have not been full clinical studies. But their efficacy and safety is assessed based on evidence from adult use.
37 Health MinMEC Minutes (18 August 2000).
Research Monitoring and Evaluation Task Team of the SA National AIDS Council (SANAC) be charged with developing a specific plan for implementation. In addition, she had made the Minister and MECs aware of the ethical problems arising from denying access to a life-saving medication to women who already knew their HIV status and arrived at health facilities seeking means to reduce the risk of HIV transmission to their children. A discussion document she had prepared for the MinMEC read:

"The provision of a package of intervention for the prevention of MTCT requires strengthening health services to offer VCT in order to identify HIV positive women. However, some consideration should be given to the case of pregnant women who already know that they are HIV infected. Ethically, it is important to provide NVP to these women while strengthening existing health services (my emphasis)."

This recommendation was ignored by MinMEC. The adverse consequences of this for doctors were profound. Dr Haroon Salsooji, a paediatrician working at a hospital in Johannesburg, complained that doctors who place the health of our patients first, we would act against our constitutional duty to freedom of conscience and against our ethical duty of clinical independence, if we were to deny women the right to use anti-retroviral therapy to prevent mother to child transmission of HIV. The current policy . . . denies women this right and undermines the doctor-patient relationship."

The policy's effect on mothers is described in two affidavits obtained by TAC. In one case a pregnant woman with HIV, Sarah Hlatele, described how she had obtained a Nevirapine tablet from Chris Hani Baragwanath Hospital, sixty kilometres away from her home in Soweto. Unfortunately, she went into premature labour and left the tablet at home. Soweto hospital, where she gave birth to K, her son, had neither Nevirapine tablets nor syrup. In another case, 'DEN', a young woman from Wolcom, had to receive a Nevirapine tablet and syrup by courier, sent to her by staff at the AP, after a nurse at Virginia hospital told her that she could not get Nevirapine because she was not a resident of Virginia and I could not be a part of the project. I asked her how I could get into the project. She said she didn't know."

After the August MinMEC meeting, local clinicians tried to make the best of a bad decision by investing energy and time in setting up the pilot sites which were due to start in March 2001. Once again however, there were allegations of political interference. In April the start of the pilot sites was delayed because Nevirapine was still not registered for prevention of intra-partum transmission. This led to one newspaper publishing allegations by members of the MCC that the delays were deliberate 'knowing to government antagonism towards a life-saving anti-retroviral drug' by some members of the MCC. Actions were also said to have been taken that the protocol for the pilot sites would have to be submitted to Cabinet for approval.

The role of the MCC at this point requires further scrutiny. In the context of an epidemic where children were being infected daily, the delays and obfuscations surrounding the registration of Nevirapine were inexcusable. TAC learnt indirectly via a letter to the Human Rights Commission that Nevirapine had received registration for 'prevention of intra-partum transmission' on 18 April 2001. But minutes of MCC meetings requested by TAC, together with documents included by the government in its Answering Affidavit, later revealed that the registration had first been recommended on 24 November 2000 when it was considered that the drug was safe and effective. After this, inexplicably, there was a delay of a further six months as the wording of the package insert was finalised between the MCC and the manufacturer - something that ought to have taken a few days."

It is worth noting that these facts were only established through the legal process and after repeated requests by TAC's attorney for access to the relevant files, requests that were initially declined. Once the files were obtained they showed that some of the public justifications for the delay by the MCC were misleading as the most important determinations regarding safety and efficacy had been made in 2000. They also suggested that those provinces that had delayed the start of pilot sites because Nevirapine had not yet been registered were, in reality, being delayed by a technicality that was probably politically motivated. According to one report, the Western Cape, which had commenced using

49 O Marais & R Majola, Supplementary Submission on Behalf of TAC, Dr Salsooji and the Children's Rights Centre (16 May 2002).
50 In their answering affidavit the government included two affidavits from members of the MCC which revealed confidential information about the registration process. TAC complained that the government was allowing selective access and demanded similar access to the files. See Answering Affidavit TAC v Minister of Health TPO 2118/2001 (hereafter 'Answering Affidavit') (23 October 2001), Bodenker v State Attorney; 26 October, Baitt Attorney to Affidavit (23 October 2001), Bodenker to State Attorney; 2 November, Bodenker to Module 2001- Bodenker: 2 November, Nsabalala to Module 2001- Bodenker; 2 November, Nsabalala to Bodenker: 2 November, Nsabalala to Module 2001-
51 In the final stages of the legal case the actual date of registration of Nevirapine briefly became an issue. On 13 May 2001 the Constitutional Court unanomously rejected supplementary arguments from the parties concerning the date of registration. TAC's lawyers argued that the de facto start of registration had been November 2000. In the end Court decided that this matter was too crucial to their findings.
Nevirapine in January 2001, had been threatened with legal action by the national health department. During this period relations between activists and the government worsened. They reached their nadir in June 2001 at a meeting between the Minister of Health, TAC, COSATU and paediatricians who had founded a campaign known as ‘Save Our Babies’. At the beginning of the meeting TAC members were subjected to personal insults by the Minister, who then went on to berate the meeting over a range of issues, including the donation of the anti-fungal drug Diffucan. After the Minister of Health left, the meeting was held by senior health officials, including the Director General, Dr Ayanda Ntsaluba, and Chief Director HIV/AIDS and STIs, Dr Nono Sintela, attempted to salvage the situation. In the discussion that followed, however, when they were questioned by Dr Haroom Saloojee and Dr Ashraf Coovadia, the two founders of Save Our Babies, about how doctors should respond to women who know their HIV positive status and were requesting Nevirapine, they said that they had no answer to this ethical dilemma.

V LAUNCHING LEGAL ACTION

In April 2002 the formal registration of Nevirapine for the prevention of intra-partum transmission removed the last obstacle to legal action. TAC decided that both morally and politically it had no other options than to launch a case against the government. TAC was able to elicit the support of some of the most experienced constitutional lawyers in the country, whose commitment and professionalism were central to the success of the case.

On 17 July 2001, TAC’s first letter of demand to the Minister of Health and the nine Provincial MECS for Health for had been sent by its attorney. This carefully crafted letter set out the facts of the epidemic and the potential to save lives through an MTCT programme and asked that the Minister and MECS:

(a) provide us with legally valid reasons why you will not make NVP available to patients in the public health sector, except at the designated pilot sites, or alternatively undertake forthwith to make NVP available in the public health sector.

53 Mail and Guardian (15 June 2001).
54 TAC Press Statement “Meeting With Minister of Health Reveals Serious Division” (12 June 2001) (available at http://www.tac.org.za); author’s personal notes of meeting.
56 TAC’s legal team consisted of Geoff Budlender, an attorney and director of the Legal Resources Centre (LRC) Constitutional Litigation Unit, Adv Benjamin Moghul and Adv Gilbert Marcus SC.

The provision of health services is a functional area of concurrent national and provincial legislative competence. Thus South Africa’s nine provincial governments are given shared responsibility for health policy and provision. The State Liability Act 20 of 1957 permits MECS to be cited as representatives of the provincial government in legal proceedings. The decision to cite the nine MECS for Health in the case and to request responses from each of them to the questions in this first letter proved to have significant legal and political implications in the short and long term.

TAC was informed that the Minister had instructed the provinces not to reply individually and that her letter should be the only response from the Government. All the MECS complied with this. The Minister’s letter, when it came, was couched in language of ostensible concern and commitment to addressing the HIV epidemic. But in essence it contained a list of barriers to the roll-out of a plan and to immediate access to Nevirapine for those who needed it. These were issues around Nevirapine-induced viral resistance, breastfeeding and the sustainability of the programme. However, none of the substantive questions posed in Budlender’s letter were addressed and the Minister’s letter concluded:

We do not underrate the ethical dilemmas that confront health professionals in the public sector. However, at the same time we were bound to balance their desire to provide the best treatment that they can for their patients with the government’s obligations to root out public policies in the practical realities of the daily life experience of all of our citizens, equally.

This letter was the first admission by the Minister that she knew the policy was intruding on the ethical duties of doctors to act in the best interests of their patients. However, it is justified on the grounds of the duty on government to ensure equality in access to health care services. This is a misuse of the principle of equality. Whilst the notion of government rationing of health care services on the basis of cost has been accepted by the Constitutional Court, the ‘best treatment’ being demanded here was neither expensive nor complicated. In fact, the Ministry of Health’s own research had found that an MTCT programme using Nevirapine would cost only R1.99 per capita and that the result of this would be ‘the lives of almost 14 000 babies would be saved’...
over 250,000 years of life saved with them'. In the TAC judgment the Constitutional Court commented on the Minister's letter saying that it 'did not deny the restriction imposed by government on the availability of nevirapine; nor was any plan or programme to extend its availability mentioned. The undertakings requested were neither given or refused outright. The meaning of the Minister's letter is, however, quite unmistakable'.

The Western Cape complied with the Minister's instruction not to reply individually. Nonetheless, the MEC for Health simultaneously wrote to TAC's attorney explaining that he had 'written to the National Minister of Health in order to provide details of the MTCT programme in the Western Cape Province with a view that this information be included in the Minister's reply to you'. The MEC attached this report to his letter. Significantly, the Minister's letter had made no reference to this response from the Western Cape, or to the fact that at least one province had a different approach to preventing MTCT. TAC subsequently annexed the Western Cape's reply to the Minister to its Founding Affidavit. This set up a juxtaposition between the position adopted by eight provinces, each of whom claimed that they could do nothing outside of the pilot sites, and the Western Cape which explained that:

'We would have liked to reach 100% coverage as soon as possible but estimate that at least 90% of HIV positive women will be reached by July 2003. This we believe, is comparable to the outcome of MTCT programmes in Thailand, Brazil and Botswana - the only developing countries that have embarked on MTCT programmes aimed at reaching the total population.'

This early disjunction between the provinces was to be the undoing of the government's legal case. By offering an example of what could be done, it created a moral pressure on other provinces to extend their programmes beyond the artificial boundaries of the pilot sites. Hereafter a divergence developed, sometimes openly, sometimes covertly, between those provinces who saw it as part of their constitutional duty to expand prevention programmes, and those who apparently did not.

Some of the most stark examples of the impracticality of the MinMEC policy were found in Gauteng, where large teaching hospitals with capacity to provide the programme were initially excluded as pilot sites. To illustrate this, TAC's Founding Affidavit included an affidavit signed by two senior members of the SA Pediatric Association (SAPA), both doctors working in large public hospitals, who described some of the

unsquares that were being taken by doctors to circumvent a policy that prevented them from acting in the best interests of their patients. Both were working at hospitals that were not pilot sites but which did have capacity to provide the full service. A letter from the CEO of Johannesburg Hospital was also attached stating that he was 'keen to see the implementation of a cost effective and affordable prevention programme ... in the immediate future' but that the hospital had not then been appointed a pilot site. Under the pressure of the litigation, the hospital became a pilot site on 1 October 2001. However, to illustrate the irrationality of the original decision, Professor Cooper explained how, although the hospital was now an officially designated site, 'it has not been given any additional staff resources' - the only difference being that it had been given an additional patient occupational therapist. The legal pressure to implement the programme in a number of provinces, as if to contradict TAC's claims of irrationality and unreasonableness, once the 'two pilot sites per province rule' had been breached, it became unenforceable, encouraging health officials at provincial level to move ahead. By December 2001, Gauteng had 12 pilot sites covering many of the major hospitals in the province.

In KwaZulu Natal the pressure of the litigation brought about a split between the MEC for Health, Dr Zweli Mkhize, and the Premier of KwaZulu Natal, Lionel Mtshali, over the roll out of the programme. Initially the province had responded in the manner instructed by the Minister, explaining under oath that 'no public health facilities outside the present pilot programme ... have the capacity to immediately implement a comprehensive MTCT programme'. This seemed highly improbable in a province with 61 hospitals and 390 clinics. Indeed, some hospitals admitted to having the requisite capacity. TAC attached to its Replying Affidavit an affidavit from a doctor Andrew Grant, the Acting Medical Superintendent of Bethesda Hospital in Umzumbe, a rural area in Northern KwaZulu Natal. Grant explained that:

"... my colleagues and I are convinced that our current setting framework is already in place, and that we are in a position to safely and effectively implement a programme ... for this reason, Doctor at this hospital have bought Nevirapin with their own money and are already administering it to pregnant women who are confirmed to have HIV and who give informed consent. It is an easy..."

62 Minister of Health's Treatment Action Campaign (note 1 above) para 11.
64 Letter from Western Cape Province MEC for Health to Minister of Health (27 July 2001).
drug to administer and we have seen no side effects on this region (except extreme 
greatness)." Faced with the evidence of these doctors, the pressure increased on those who resisted the extension of the pilot programme to other hospitals. The division created in KwaZulu Natal became obvious early in 2002 when the Premier issued a press statement that "commended the courageous decision of doctors who have committed themselves to supply anti- 
retroviral drugs to pregnant mothers at Empangeni, Bethesda and other 
hospitals in these parts of KwaZulu Natal which are ravaged by the 
scourge of HIV and Aids."70 Days later, during the opening of the provincial 
lawmakers, the Premier announced plans to expand greatly the 
scope of the programme.71

By contrast, provinces such as Mpumalanga stuck rigidly to the 
MimMEC position, with MECs obstructing access to life-saving services, 
closing down NGOs, causing avoidable HIV infections and fostering a 
conflict between health professionals and politicians.72 In Mpumalanga 
for example, in April 2002 TAC resorted to providing Nevirapine directly 
to Philadelphia Hospital, one of the biggest hospitals in the Province, 
after requests and petitions from the doctors to the provincial 
government were repeatedly ignored.73

VI 'MOST IF NOT ALL OF THE DISPUTATION IS BEYOND THE POINT'

(a) The case is filed
TAC, together with Save Our Babies (SOB), a loose coalition of 
paediatricians,74 and the Children’s Rights Centre (CRC) in Durban,75 
filed a constitutional claim against the government on 21 August 2001. 
The parties sought a declaration that the current policy was unconstitu-
tional and asked further that:

[the government] be ordered to make Nevirapine available to pregnant women with HIV 
who give birth in the public health sector, and to their babies, where in the judgment of the 
attending medical practitioner or health professional this is medically indicated.

69 Affidavit of Dr Andrew James Grant in Repling Affidavit (note 12 above) Annexure X 2005-
71 State of the Province Address by the Premier of KwaZulu Natal (25 February 2002) 
(Annexure A to Application by the Premier to explain the MEC for Health at 5th Roundtable 
in the proceedings before the Pretoria High Court).
72 See independent monitoring affidavit in MEC for Health, Mpowumalanga v Chancellor 
Moipatitse Rate Intervention Project (Gscp) TIP (1972)000. These detail the campaign of harassment 
of the GRP providing antiretroviral medicines to rape survivors.
73 Petition to MEC Mzantsi by medical students, medical practitioners, doctors in community 
service, intern doctors, dentists, dentists in community service, pharmacists and pharmacists in 
community service at Philadelphia Hospital, Mpumalanga (25 April 2002).
74 Amended to the SOB affidavit were the names of over 150 doctors who declared their support 
for the litigation and gave consent for their names to be disclosed in the Court.
75 Dr H Slaaouine in Founding Affidavit (note 12 above) 322-35, Ms C J Vastb in Founding 
Affidavit (note 12 above) 358-66.
76 3200 D BCLR 377 (2002).
77 Youth Respondent in Answering Affidavit (note 9 above) 650-752A.
pregnant women to include Nevirapine or any 'other appropriate medicine'.

e) The government opposes

The state opposed the TAC case on grounds that the relief was not available, that the efficacy and safety of Nevirapine was not fully proven and that its widespread use risked a public health catastrophe. It is significant that the architects of the MTCT 'policy', particularly the Minister of Health, did not personally deposite to the replies that sought to justify their policy. This task was left to the Director General of Health, the Chief Director of HIV/AIDS and a number of lesser officials from the national and provincial health departments. This point was not lost on the judges of the Constitutional Court who noted that 'although the two main issues relate to government policy, as distinct from mere administration, neither the Minister nor any of the MECs was a deponent'.

The government admitted that Nevirapine has been registered by the Medicines Control Council for use in reducing risk of HIV transmission. Included in its reply was an 'information to patient and informed consent' sheet that stated that Nevirapine 'has been found to be safe and effective' and that 'side effects have not been commonly reported for one dose'. But despite this, on numerous occasions the court papers cast doubt on the safety of the medicine for individual women (often mixing-up documented adverse effects in adults using Nevirapine as part of 'combination therapy' with its single-dose use for MTCT). Repeatedly claims were made that the use of Nevirapine would pose a threat through the possible development of resistance and other variants of HIV that could be 'catastrophic for public health'.30 Doctors prescribing Nevirapine outside of the pilot sites were described as 'acting irresponsibly and risking a serious public health crisis'.31 These allegations were not made by experts in virology or pharmacology but by officials of the Department of Health. The allegations were also made despite conclusive scientific evidence to the contrary. The intention appears to have been to confuse the court and to try to persuade it that the matter was of such great scientific complexity that it was inappropriate for a court to rule on it (an early hinting of the separation of powers argument).

The government's reply pointed out that breastfeeding carries the risk of HIV transmission even for a child who has avoided infection as a result of Nevirapine use. Essentially, it argued that this future risk justified denying the intervention to women and children at the point when its

benefits are undisputed – because it made the intervention less cost-effective.32 It argued that until breastfeeding habits in South Africa changed or until formula feed and clean water could reach all poor people who would need it, access to the medicine should be limited. Effectively its policy was to deny parents the opportunity to make choices, or keep control over their own lives, through access to a medically proven intervention.

The government also argued that the most effective use of Nevirapine was as part of a programme that included voluntary counseling and testing, counselling about breastfeeding practices and access to formula milk. The provision of such a programme, it claimed, was impossible because, beyond the identified pilot sites, there was no capacity to provide this service. Affidavits from heads of health in the provinces, sometimes apparently drawn from a common template,33 drew a picture of the readiness of the health service that is contradicted by fact and by the government's own documentation. For example, the Head of Health in the Eastern Cape, which had set up pilot projects in East London and Jeffrey, stated that there was no capacity to do this in other parts of the province, including major urban areas such as Port Elizabeth, Grahamstown and Bisho.

Despite a report in the 2001 Intergovernmental Fiscal Review (attached as an annexure in the government's replying affidavit) showing under-spending of the health budget of R473 million in 2000/01, it was claimed by all but three of the Provincial Heads of Health that budget limitations constrained their ability to do what was necessary.34 Several of the Provincial Health Departments provided estimates of what full provincial roll-out of the programme would cost, totaling approximately R250 million – less than half of what the government failed to spend from its current budget. Much emphasis was placed on the lack of trained counselors and the difficulties this presented. Here, too, the real situation was widely misrepresented. For example, the Free State Health Department claimed that there were 'no NGOs which the department could work through in order to manage lay counselors and in order to support a programme of infant feeding choices'.35

In his affidavit Ntsaluba, the Director General, admitted that 'the argument that MTCT [anti-retroviral] programmes are cost-effective may

78 Mentor of Health's Treatment Action Campaign (note 1 above) para 7.
79 Dr N Smuts 'Information to Patient' in Answering Affidavit (note 10 above) 1997.
80 Dr A Nauseba in Answering Affidavit (ibid 438; 685, 765, 818).
81 Ibid 438.
82 Ibid 679.
83 Affidavit that were filed in the Government's replying affidavit in the Application for Leave to Executor to dismiss the action filed in the Constitutional Court. For example, in the affidavits of Queen Thompson (KwaZulu Natal), Rosa Charm (Mpumalanga), Michael Hendricks (Northern Cape) and Mamedle Mienie (Northern Province) the same error of 'public funding' occurs at the same point in each affidavit.
84 See Affidavits of Mkhize (ibid 1533); Liftekkhiya (ibid 1571); Green Thompson (ibid 1605).
85 First Respondent Answering Affidavit (note 20 above) 1565-74.
well be sustained." However, he argued that this would not make it affordable. Again, deceptive arguments were deployed such as a claim that TAC had not given consideration to the individual cost borne by parents who must have money to use public transport to reach public health clinics, purchase formula feed and sterile bottles. This ignored the affidavit of Thembisa Mhlongo, supplied by TAC, which detailed the financial and personal costs, particularly to women, of looking after young children as they sicken as a result of HIV infection and eventually AIDS. Indeed, on 11 September 2001, Sibongile Mazeka, the child referred to in this affidavit, died at the age of 3 of AIDS. A picture of her small coffin was later used by TAC in a poster to mobilise support for the case.

Although intimidating in volume, once deconstructed it was clear that the government papers were full of deception and contradiction. Health Department officials sought to undermine established science and scientific institutions. There seemed to be very little of a sense of urgency to come to the assistance of pregnant women with HIV or to resolve the dilemmas expressed by hundreds of doctors in the TAC papers about not being able to treat women properly. Sometimes the lack of compassion is quite startling. For example, in one affidavit by Dr Lindi Makubalo of the Department of Health an effort is made to contain an assertion by one of the TAC experts that the HIV epidemic in SA is "explosive." Makubalo claimed this was an incorrect depiction because the epidemic had peaked and was levelling off. However, several pages later, a report from one of the pilot sites provided by the government showed that 49.5 per cent of women who entered the programme had tested positive for HIV infection. In his affidavit, the Director General accused Sarah Hulele, the mother who gave an affidavit describing her valiant efforts to protect her child, as being "neglectful of her health and the health of her baby." TAC had ten days in which to reply to these papers. Although initially the task seemed to be near impossible, the information that contradicted and exposed the falsifications and misrepresentations was quickly obtained and turned into affidavits. TAC's local and international networking paid dividends here. For example, contact was made with Dr Mark Wainberg, one of the world's leading virologists, based in the United States, who agreed to deposite to an affidavit countering the selective quotation of one of his own articles by Ntshaba around the issue of

86 Ntshaba (note 80 above) 722: 742.
87 Ibid 722.
88 TC Mhlongo in Founding Affidavit (note 12 above) Annexures DD 411-44: "Ms Mhlongo is working in the middle of the night by health caregivers and pays between R30 and R200 in transport costs to get the child to hospital. Ms Mhlongo has lost her previous employment because of constant absenteeism related to Sibongile's AIDS related illnesses and is in danger of losing her current employment."
89 Answering Affidavit (note 9 above) 449-510.
90 Ntshaba (note 80 above) 771 para 1978. See also note 45 above.

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Nevirapine resistance. Similarly, Dr Laura Guay, the principal investigator on the HIVNET012 trial, was contacted and supplied an affidavit countering a number of distortions made with regard to this clinical trial. It was also in this period that TAC compiled an expert affidavit to counter the claims of lack of capacity in the state, which was to prove decisive in turning the judgment in TAC's favour. At short notice Dr Helene Schneider, the Director of the Centre for Health Policy (CHP) at the University of the Witwatersrand, provided an affidavit on the capacity of South Africa's health system to support a programme of MTCT. Drawing largely from the government's own published reports she showed how there was in fact significant latent capacity to support the provision of Nevirapine in eight out of nine of South Africa's provinces and concluded that "[t]he complexity of a PMTCT programme is no greater than tackling malnutrition, tuberculosis and other chronic diseases – aspects that the SA health system has committed itself to dealing with."

VII POLITICS AND MOBILISATION

In essence TAC's challenge was about public health policy. It should have been managed by government as a legitimate challenge, envisaged and encouraged by the Constitution, similar for example to the Southafrica case. But it was not. Throughout this period the President's denialist AIDS policy was under fierce attack. This case, because ultimately it was a manifestation of the President's AIDS policy, was therefore fiercely defended. In a number of instances there were also examples of what appeared to be political interference in the case.

After the case had been set down, two organisations applied to join as amicus curiae. One was the South African Human Rights Commission (SAHRC). The SAHRC has a constitutional mandate to protect human rights, a special interest in socio-economic rights and a direct interest in this case because of its involvement with related investigations, such as that lodged by Dr Costa Gazza. However, shortly before the hearing, it instructed its attorneys to withdraw its application to be amicus curiae.

The reasons for this emerging in newspaper articles where it was alleged that the government's senior counsel had phoned SAHRC chairperson

92 Ibid Annexure V 2015.
94 Note 48 above. Southafrica involved a constitutional challenge to a policy of the KwaZulu Natal Health department limiting access to AZT therapy in the public sector by setting criteria for patients.
95 Gazza, a doctor from the Eastern Cape Province, has lodged a complaint with the SAHRC accusing the Minister of Health of misconduct for failing to implement an MTCT programme. This led to an investigation by the Constitution.
Barney Pityana to complain about the case, and that the President's legal adviser had contacted another member of the Commission. This prompted an internal discussion in the SAHRC, with some commis-
sioners suddenly deciding that the SAHRC had nothing to add to the case. A vote took place among commissioners, which led to a narrow five to four majority in favour of withdrawing. Thus, despite some commis-
sioners wanting to continue, the instructions to the attorneys remained to withdraw. The SAHRC later denied that it had come under political pressure, claiming that "the decision to withdraw was based on the fact that we had nothing new or additional to contribute to the TAC case."96

TAC, however, was prepared for the politics that surrounded the case. This was because TAC believed that the MTCT policy was based upon a political decision taken at the highest level of government. TAC's constitution empowers it to engage in litigation as a means of challenging 'any type of discrimination relating to the treatment of HIV/AIDS in the private and public sector.'97 This allows it to take legal action to enforce any right that is explicitly recognized in the Constitution. The reference to litigation in TAC's constitution occurs in the same paragraph as a reference to 'lobbying, advocacy, and all forms of legitimate mobilization'. For TAC, litigation both emerges from and feeds back into a social context. Resort to litigation is not exclusive of other strategies. Litigation can also help to catalye mobilisation and assist public education on contested issues, as well as to bring about direct relief to individuals or classes of applicants.98 Thus, between August and December 2001, TAC engaged in intensive public mobilisation, attracting enormous support and media interest.

However, support within TAC for a strategy of litigation could not be taken for granted. Internally numerous workshops were conducted with TAC volunteers to explain the case. Externally, and amongst some of TAC's main allies, particularly the Congress of South African Trade Unions (COSATU), there was reluctance publicly to endorse taking "our" government to court. Therefore the right of civil society to use litigation to claim and enforce rights had to be argued in meetings and workshops against those who considered it "disloyal" or "unpatriotic". Although COSATU welcomed each judgment in TAC's favour, it never openly supported the litigation. The mobilisation culminated on 25 and 26 November, when rallies and marches took place around South Africa, including an all-night vigil of 600 TAC volunteers outside the court before the hearing commenced. For the two days of the hearings the court was packed by people with

96 "HRC: 'No Nothing New to Add' - Mail and Guardian (3 November 2001).
97 Available at http://www.tac.org.zajur/down/letters/letter.htm

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HIV wearing TAC's trademark 'HIV-positive T-shirt, health professionals and journalists, listening intently to the evolution of the argument.99

The urgency of the case seemed to be understood by Judge Chris Botha, who handed down his judgment to a tense and expectant court on 14 December 2001. On all the key issues Botha found in favour of TAC, commenting that in the government's arguments there was "no unqualified commitment to reach the rest of the population in any given time or at any given rate . . . a programme that is open-ended and that leaves everything to the future cannot be said to be coherent, progressive and purposeful."100 Botha declared that [a] countrywide MTCT programme is an ineluctable obligation of the state.101 Botha's order was bold and original. He instructed the government to allow Nustipin to be prescribed where it was "medically indicated" and where, in the opinion of the doctors acting in consultation with the medical superintendent, there was capacity to do so.102 Botha also ordered the government to develop "an effective comprehensive national programme to prevent or reduce MTCT" and return to the Court with this programme for further scrutiny before 31 March 2002.

Botha's judgment was welcomed in South Africa and worldwide.103 The acclaim, however, was not universal. In South Africa it attracted the ire not only of the government but also of a number of legal academics, one of whom declared it a case of "when judges go too far."104 The accusation arose because Botha had breached the principle of separation of powers between judiciary and the executive by interfering in health policy and ordering the government to supply a specific medicine. Thus, on 18 December 2001 when the Minister of Health announced that she would seek leave to appeal directly to the Constitutional Court, it was claimed that the appeal was "aimed at clarifying a constitutional and

Africa.
100 TAC v Minister of Health 2002 (4) BCLR 356 (T) para 67.
102 Ibid para 102.
103 M Hoywood "Protest High Court Hands Down Premier Setting Judgment" (April/May 2002) 13 AIDS Analytio Africa. The Sunday Times (16 December 2001) carried an editorial headed "Thanks to Our Constitution" stating: "For once, the outcome shows that even strongly dominant political opinion cannot stand in the way of a Constitution that is supreme. Every child born free of HIV as a result of this week's decision will be living proof of the wisdom our society showed in opting for this form of democracy."104 K Hopkins "Shattering the Divide: - When Judges go Too Far" (March 2002) Dr Ruth 21:4.

Hopkins asserts that the judgment was an illustration of when judges forget themselves and created the powers that they are enshrined in, in performing their judicial functions ... Government policy is a political creature and this is why it is governments which make policy, not judges. The remedy for unpopular government policy should rightfully be political, not legal." Ibid 21:4.
jurisdictional matter which, if left vague, could throw executive policy making into disarray and create confusion about the principle of the separation of powers, which is a cornerstone of our democracy.105

In an attempt to soften the decision to appeal, the Minister’s press statement promised that the policy would be reviewed and that the Department of Health would host an ‘inclusive’ national consultation involving all stakeholders ‘to share the lessons of the pilot sites and to chart plans for the future on the basis of broad consensus’.106 These promises were not kept. However, an instruction was sent to speed up an interim evaluation of the existing 18 pilot sites that was being conducted by the Health Systems Trust (HST) on behalf of the Department of Health. This was completed in late January 2002, but became yet another example of the clash between political agendas and the recommendations of scientists and researchers. On 31 January 2002 the evaluation was presented to a meeting of the Health MinMEC. The report provided a comprehensive assessment of each of the pilot sites and made a number of salient recommendations. In its Executive Summary it recommended that

[...]

It also proposed that

[...]

For several weeks, the HST report was kept under wraps as politicians pondered how not to comply with its unpalatable recommendations. The contrary to its recommendations, the Minister announced that it would not be possible to take a decision on expansion of the programme

105 This line of argument was developed further in an article by the Minister of Health in the Sunday Times (30 December 2001). “Government, not courts must decide on HIV/AIDS and other social policy.” As in the fashion with politicians, this article misrepresented the judgment by claiming that it was extremely prescriptive and that “it amounts to a position that policy should be in the hands of the judge”. What the Masseur failed to recognize here and in subsequent legal papers was that the decision was on Ntsepe as the drag of choice of the programme not its detail.


107 Health Systems Trust “Interim Findings on the national PMTCT Pilot Sites, Lessons and Recommendations” (February 2002) it.

108 Ibid v.

until May 2002, after it has been running for one year.109 At the time, tensions ran high in the Department and several persons inside the Department claimed that during the MinMEC meeting Director General Dr Ayanda Ntsuwa had left the room saying that he could no longer ‘defend the indefensible’.110 This was the second occasion on which politicians took decisions directly counter to those recommended by senior officials in the Department. However, whilst the MinMEC members were trying to work out ways in which to save face and defend their policy, two other processes were taking place. On the one hand TAC’s lawyers were preparing a new application to the Pretoria High Court to seek an order to execute part of the Botha judgment, and on the other a political division around the issue was developing that saw the Premiers of Gauteng and KwaZulu Natal publicly announce and defend decisions to expand their PMTCT programmes.

VIII THE POLITICAL AND LEGAL UNRAVELING OF THE GOVERNMENT CASE

When President Mbeki opened Parliament in February 2002 he appeared to signal a shift in government policy by promising that “continuing work will be done to monitor the efficacy of anti-retroviral interventions against mother-to-child transmission in the sites already operational and any new ones that may be decided upon”.111 A few days later this shift seemed to be confirmed in a live television interview when Mbeki explicitly stated that provinces should be able to provide an MTCT programme according to their respective capacities and that “provinces with the resources to extend the programme should not be delayed by provinces that did not have the resources”.112 This new approach was cautiously welcomed by TAC and seems to have been read by a number of senior ANC politicians as condoning the roll out of programme to health facilities where capacity existed or could easily be created. Thus, on 18 February 2002, Mbalaphile Shilowa, the Premier of Gauteng,

109 A press statement issued by the Ministry stated that: “Provincial MECS for Health and representatives of SALGA will take the report generated back to their respective provinces, study it and consult with the aims of formulating a response that is appropriate and in line with the national policies on managing MTCT. They will subsequently report back to MinMEC to consider the appropriate response.” Outcome of the MinMEC Meeting of 31 January – 1 February, available at: http://www.doh.gov.za/mediacen/index.html

110 Throughout this time there was much evidence of a conflict of loyalties manifesting itself in the decision that should arise as a health professional and the desire to government or the ANC (which seems to have perceived itself as the target of this cost). This was often evident among senior officials of the Department of Health who privately claimed to have sympathy with the TAC case, were even encouraged it, and yet allowed themselves to be made depositories to affidavits they could not have believed in. The tragedy is that, despite the fact that they role of doctors in the killing of Steve Biko and others had led to intervention about dual loyalties in SA, during this case a misconstrual understanding of loyalty to the government/ANC came to have hold sway.

111 State of the Nation Address to the Joint Sitting of the Two Houses of Parliament (8 February 2002). See http://www.sabc.org.za/series/history/mbeki

112 Newsletter SABC 3 (18 February 2002).
announced a bold roll-out of the programme. He promised that ‘[d]uring the next financial year, we will ensure that all public hospitals and our large community health centers provide Nevirapine’. He also named 9 further hospitals that would commence the programme ‘within the next 100 days’.112

However, once again falling foul of public opinion and her own Department, which had initially claimed the Gauteng roll-out was ‘within the parameters set by the Health MinMEC’, the Minister of Health publicly rebuked Shilowa. Earning herself the name of ‘Dr No’ from The Star, one of the biggest newspapers in the country, the Minister made a statement to the press disassociating herself from Gauteng’s pronouncement and claiming that it was in breach of the resolution taken by MinMEC on 30 January 2002. In behind the scenes meetings over the following days the impression was conveyed that an understanding had been reached between the Minister and Shilowa.113 Although Shilowa gave the appearance of backing down, his programme continued. By October 2002 he was in a position to announce that Nevirapine was available at 70 per cent of all health facilities in the province.114 During this period politics and law developed an interesting dialectic. The pressure of the ongoing legal action forced the government back into court, and the different stages of the appeal and application for an execution order spurred further advocacy and social mobilisation – which in turn placed new pressures on government. At its National Executive Committee in January 2002 and in discussion with its legal team, TAC had decided to embark on an offensive in response to the appeal and to return to the Pretoria High Court to seek an order of execution on the part of the judgment that instructed that Nevirapine be made available where capacity existed. The justification for this was that it could save up to ten lives a day during the period in which the legal process around the appeal took place – approximately six months. In the words of Sipho Mkhiti, the deponent in TAC’s new affidavit: ‘every day in which the implementation of paragraphs one and two of the order is delayed, results in unnecessary infection and death of ten children’.115 Outside and inside the court TAC argued that this approach was validated by developments in the political arena, such as Mbeki’s ‘State of the Nation’ address and the extension of the programme in Gauteng and KwaZulu Natal. The legal test for deciding whether an order should be executed pending the final decision on appeal is whether it would cause ‘irreparable harm’ to the party to the proceedings. TAC argued that the harm to government of providing a medicine and encouraging doctors to do their job would be minimal, compared to the irreversible harm that would be suffered by women whose children were refused a life-saving intervention.116 Again, the Ministry opposed the application, now claiming that it would cause irreversible harm to ‘patients other than HIV-positive pregnant women’ by diverting resources away from ‘the services they so direly need’ and that the orders could ‘have the real potential of crippling an already overburdened public health care system’.117

On 1 March 2002 new demonstrations took place at the Pretoria High Court hearing of the government’s application for leave to appeal to the Constitutional Court and TAC’s application for an execution order (which were heard together). Ten days later, on 11 March 2002, another judgement was handed down in favour of TAC. In this judgement Botha J drew attention to the fact that TAC’s argument that up to ten lives a day could be saved by execution of Orders 1 and 2 ‘is not denied’ by the government. Then, deliberating on the consequences of his decision to order execution, he wrote:

If order 2 is implemented, and the appeal succeeds, the result will be that health facilities will have suffered some inconvenience here and there and that resources, especially human resources, will have been strained. In many cases that will be an inconvenience that ethically motivated health workers will gladly assume. At the same time there will be a gain in lives saved which cannot be considered a loss even if the Constitutional Court should find that parallel access to Nevirapine should not have been granted at all. If the order is suspended and the appeal went to full, it is manifest that it will result in loss of lives that could have been saved. It would be odious to calculate the number of lives one could consider affordable in order to save the respondents the sort of inconvenience they foresee. I find myself unable to formulate a motivation for selecting preventable deaths for the sake of sparing the respondents prejudice that cannot amount to more than organisational inconvenience.’118

Inexplicably, the government decided to seek leave to appeal against this judgment directly to the Constitutional Court. In response, TAC’s legal team quickly filed a counter application arguing that government’s main purpose for further legal action was solely to ‘stultify the execution order’.119 New legal issues arose as to whether interlocutory orders could be appealed. TAC argued ‘no’, government argued ‘yes’. The matter was heard on 22 March and judgment was handed down three days later.

115 M Shilowa Speech at the Opening of Gauteng AIDS Summit (2 October 2002).
117 Application’s Heads of Argument in Application for Leave to Execute.
118 Application, Nattrass, Anning affidavit in the Application for Leave to Execute para 13.5.
Once more Botha J set out the core of the case. In the days immediately before the hearing, government had taken advantage of the decision by Boehringer Ingelheim to withdraw its application to the Food and Drug Administration (FDA) for the registration of Nevirapine for prevention of intra-partum HIV transmission. 122 Inside (and outside) of court government cast this as a safety issue, justifying their caution in making the medicine more widely available. However, Botha J saw it for what it was: a red-herring that was put back into the sea. In a few sentences he explained that if the registration of Nevirapine was withdrawn it would be for all uses of the drug, including at the government pilot sites. On the issue of whether by granting the execution order he had exercised his discretion properly, he had this to say: 123

In essence I had to balance the loss of lives against prejudice that could never amount to more than inconvenience. I find it unlikely that another court will conclude that the decision that I made was wrong. It was argued that the assumption of the loss of ten lives a day was speculative. It was no more speculative than the facts of chaos and disruption exposed by the deponents of the respondents. 124

During this time it seemed as if sensible legal advice to the government was the last thing driving its case. It was as if a nerve had been touched and the pain was driving an irrational response that took everything to the extreme, regardless of public perceptions, lives lost or the cost of ongoing legal action. Thus, on 26 March, one day after the Pretoria High Court had dismissed the attempt to appeal the execution order, the government launched a further and final application for leave to appeal - this time directly to the Constitutional Court. 125 The application was heard on 3 April 2002. In the court of public opinion, the announcement of this was lambasted by political cartoonists and newspaper leaders. It was also a failure of legal strategy. This was because although the legal issues that the Constitutional Court had to decide were narrow, and different from those it would consider in the main appeal, those could not be approached without consideration of the actual issues, including the rationality of the MTCF policy. The result was that the government itself created a situation that allowed the issues to be aired in the highest court in the land a month before the dates set for the full appeal.

During the hearing, the Constitutional Court judges frequently appeared to be at a loss as to why government was so fiercely opposed to the execution order. In answer to a question from Chief Justice Chaskalson about how infants would suffer from being provided by a potentially life-saving drug, the government’s advocate, Moorene SC, referred to ‘drug resistance’. When asked by Madala J whether government had documented any adverse events resulting from the use of Nevirapine in the past 11 months, Moorene answered ‘no’. Yet, when O’Regan J later asked precisely what harm would be caused by the execution of the order, his answer was that there was ‘potential for great, great harm’. The judges seemed frustrated by the answers and at one point, for example, Sachs J appealed that ‘in the interests of the nation government come up with an approach that would meet the issues raised by TAC’ before the hearing of the appeal. He asked whether in government’s approach, ‘the good was not being made a victim of the best’. Not surprisingly, on 4 April the Constitutional Court refused government leave to appeal against the order of execution. 126 The next day, the headline of The Star was ‘YES, you will, Dr No’.

IX When Politicians Go Too Far

The role of the Minister of Health throughout this period had arguably brought both the government and the country into disrepute. Repeatedly her public utterances concerning the case seemed in direct conflict with the rights entrenched in South Africa’s Constitution and the corresponding duties imposed on the government. She seemed prepared to misuse medical information to confuse public opinion and the courts. For example, in March 2002, Boehringer Ingelheim, the manufacturer of Nevirapine, withdrew its application for registration of the drug for preventing intra-partum transmission with the Food and Drug Authority (FDA) in the USA. However, it was clearly stated that this was because the clinical trials in Uganda had not been conducted to meet the standard expected for FDA approval, and that a preliminary re-evaluation of the trials had noted a number of technical irregularities.

122 See below at text accompanying note 127.
124 TAC v Minister of Health (d/b/a) Notice of Application for Leave to Appeal (26 March 2002), the applicants are ordered to give effect to paragraphs 2 of the order of the High Court granted on 14 December 2001. In the affidavit of Abdullahack Adam (para 13), TAC argued that government was choosing legal process by its ongoing efforts to appeal. It is clear from the course of conduct which the Appellants have adopted, that they seek to prevent the Respondents exercising their statutory and common law right to seek execution of the order of 14 December. They do this by seeking leave to appeal against any order which is made with that effect. Because appeal proceedings in the ordinary courts await the order against similar effect'. Government’sRejoinder Affidavit was filed on 1 April, 24 hours before the hearing. Because it raised new matters, implying again that Nevirapine was unsafe, TAC filed a further Rejoinder Affidavit on 2 April that attached the uncontroverted statements of UNAIDS, the CDC and the WHO for the duration of the Court. A month later a further affidavit from Mustafa stated ‘unbelievably that I did not deliberately convey this information from the above Honorable Court’ (para 4.2).
125 Personal notes taken during the hearing (3 April 2002).
126 The Constitutional Court: reserved judgment and handed down its decision on this matter together with its main judgment on 5 July 2002. When Chief Justice Chaskalson announced that leave to appeal against the order of execution was refused, he issued a temporary note that the decisions should not be read as in any way determining the issues that would be heard in the main Appeal. Despite this, TAC’s lawyers, and every other observer, could see that the Court was far from thinking that this was a case where judges had ‘gone too far’.
127 The Star (5 April 2002).
There was no questioning of the safety of the drug or the validity of the trial results. Within hours of hearing of the withdrawal of the FDA application from the MCC, she distorted this information in an address to a public rally hosted by the National Association of People Living with HIV/AIDS (NAPWA). She claimed that new information suggested that the drug may be unsafe and that government’s caution with its use was justified.127 This also found its way into the State’s legal papers in a new affidavit filed hastily in the name of the Director General of the Health Department, suggesting that the ‘safety’ of the medicine was now at issue and that it was ‘not in the public interest that an order as prescriptive as the execution order be enforced. It is not inconceivable that the registration of Nevirapine may be withdrawn altogether’.128 Documents from the WHO and UNAIDS stating the contrary were available to the Minister, but were not offered to the Court. This deception was noticed by Krieger J, who went as far as to suggest that the Health Department was deliberately trying to mislead the Court.129

The Minister of Health also displayed a questionable attitude to democracy and principles of justice. The most startling example came in a television interview given on SABC News on 24 March 2002. When asked whether she would be prepared to follow what the court said, given these new concerns around the drug, she replied:

My own view is that the judiciary cannot prescribe from the bench – and that we have a regulatory authority in this country that is interacting with the regulatory authority FDA of the USA and I think we must allow them to assist us in reaching conclusions.

Interviewer: Mm, so you think it’s inappropriate that this is in court, but nevertheless it’s there. Will you stand by whatever the Court decides?

Minister: No. I think the court and the judiciary must also listen to the regulatory authority, both of this country and the regulatory authority of the US.

Interviewer: So you’re saying no?

Minister: I say no, I am saying no.130

In the fierce controversy that surrounded this statement, Presied Maduna, the Minister of Justice, was called in to rebuke the comment.

127 The decision by Both Robbielegan Leghlan to withdraw its application was communicated to the MCC, who then communicated it to the Minister in a letter of 20 March 2002. The letter from the MCC stated only that “information has been raised about the reporting and documentation of the HU612 study”. It said nothing about safety. An audit of HIVNET 012 had revealed deficiencies in documentation that would not have met the stringent requirements of the FDA. At the time TAC gave wide circulation to a number of important press statements that should have clarified the issue. See WHO/UNAIDS Joint Press Statement; WHO and UNAIDS Confirm Support Use of Nevirapine for Prevention of MTCT (21 March 2002); Statement by National Institute of Allergy and Infectious Disease Review of HIVNET 012 (22 March 2002); Centers for Disease Control (CDC) Media Q&A Response to the NIAID Statement on HIVNET 012 (21 March 2002); Rodrigues Effectiveness of Nevirapine and Lamivudine in Africa; the HU612 Trial (22 March 2002).

128 Answering Affidavit to the Application to Affirm Execution of Judgment Pending Appeal (21 March 2002) para 2.2.

129 See notes 173-50 below and accompanying text.

130 “More Damage Control after Mantu Says No” The Star (23 March 2002).

131 Ministry of Health Media Statement (27 March 2002).


133 NB Hlaele Founding Affidavit (note 12 above) Annexures CC 476-81.

134 “Death of an Activist” Mail and Guardian (15 April 2002).

X CONSTITUTIONAL ADVOCACY ON THE STREETS AND IN COURT

Sometimes, in the political circles of irrationality, the real life traumas that fed the case seemed to get lost. The people whose lives were being irreparably damaged seemed to have the quietest voices and on 14 April 2002 one of those voices was stilled. Sarah Hlaele had first encountered TAC in July 2001. She was a volunteer counsellor for Rambazani, a support group in the Vaal area. When she had heard about the pending legal case, she volunteered to depose an affidavit telling her own story.131 At the time she was very ill with AIDS. Her son had been born prematurely, failed to receive Nevaripine and remained in hospital for the first month of his life. The TAC case, together with access to medicines and care, literally brought Sarah back to life. She spoke at the first TAC press conference the day the papers were served, at that time unwilling to be identified. Several months later, with her health and dignity restored, Sarah’s story became symbolic of the case as a whole. She attended all the court hearings, often with her son, K. Tragically however she became seriously ill as a result of severe side-effects of the anti-retroviral medicines she was taking, and died in Johannesburg on 14 April.134
I gave you an opportunity to rebut it . . . . I will deal with it in a separate judgment if necessary. 138

Three months later, on 5 July 2002, the judgments of the Court in the TAC case and related matters were handed down.139 Unanimously, the court decided that the government’s policy had not met its constitutional obligations to provide people with access to health care services in a manner that is reasonable and takes account of pressing social needs.140 Government’s arguments on the efficacy of Nevirapine were said to be contradictory.141 On safety (there was said to be no evidence justifying government’s claims), on resistance the court declared that when ‘the prospects of the child surviving if infected are so slim and the nature of the suffering so grave . . . the risk of some resistance manifesting at some time in the future is well worth running’.142 In addition the Court confirmed TAC’s view that the policy discriminated against poor people noting that ‘there is a difference in the positions of those who can afford to pay for services and those who cannot. State policy must take account of those differences’.143 Drawing on its own prior judgments and foreign jurisprudence the judgment confirmed the rights of the courts to issue instructions to government to amend policies, where policies were found to be unconstitutional.144 The judgment also insisted on the Court’s right to ‘ensure that effective relief is granted’ and exercise ‘supervisory jurisdiction’.145 Without contradicting Botha, it stopped short of setting timelines for government on the basis that it accepted the bona fides of commitments made by government ‘whose policy is now no longer as

136 Affidavit of Samuel Mkhize in the Application to be heard as an amicus curiae. In this affidavit Mkhize, revealed that he had recently proposed to the Minister of Health that the Ministry establish the MCC’s intentions in the light of the American developments, and I provided him with a suggested draft letter of inquiry, but time didn’t allow the execution of this proposal’ (para 49).
137 Personal notes taken during the Constitutional Court hearings (3 April; 3 May 2002).
138 Ibid.
139 In addition to the judgment in the Appeal, the Court handed down its decisions on; the application for leave to appeal to the Constitutional Court against the execution order (Minister of Health v TAC 2002 (10) BCLR 1075 (CC)); the late application to be admitted as amicus curiae by AIDS, disability Prof Mkhize (In Re Certain classes of Curiae relating to Minister of Health v TAC 2002 (10) BCLR 1023 (CC)), and the dispute between the Premier and MMC for Health in Ezwanile Nqululane (MCC for Health, Ezwanile Nqululane v Premier of KwaZulu-Natal 2002 (10) BCLR 1628 (CC)).
140 The Court stated: ‘The policies in the present case, therefore, insofar as they impose socio-economic rights are constitutionally invalid. Clearly they are. The question is whether the applicants have shown that the measures adopted by the government to provide access to health care services for HIV-positive mothers and their newborn babies fail short of its obligations under the Constitution’. Note 1 above, para 25. It went on to find that ‘failing a drug that has the potential to reduce mother-to-child transmission is available, it is sufficiently to be made available without delay to those who urgently need it’. Ibid para 130.
141 Note 1 above para 58.
142 Ibid para 39.
143 Ibid para 76.
144 Ibid paras 96-14.
145 Ibid para 106.
rigid as it was when the proceedings commenced. Instead, it ordered government ‘without delay’ to:

(a) Remove the restrictions that prevent nevirapine from being made available for the purpose of reducing the risk of mother-to-child transmission of HIV at public hospitals and clinics that are not research and training sites.

(b) Permit and facilitate the use of nevirapine for the purpose of reducing the risk of mother-to-child transmission of HIV and to make it available for this purpose at hospitals and clinics when in the judgment of the attending medical practitioner acting in consultation with the medical superintendence of the facility concerned this is medically indicated, which shall if necessary include that the mother concerned has been appropriately tested and counselled.

(c) Make provision if necessary for counsellors based at public hospitals and clinics other than the research and training sites to be trained for the counselling necessary for the use of nevirapine to reduce the risk of mother-to-child transmission of HIV.

(d) Take reasonable measures to ensure that testing and counselling facilities at hospitals and clinics throughout the public health sector are facilitated and ensure that the use of nevirapine for the purpose of reducing the risk of mother-to-child transmission of HIV is not hindered.

Ironically, in light of the April Cabinet resolution, this was arguably a more intrusive order than Botha’s had been. Timesframes and an instruction to return to court were replaced by instructions requiring immediate action. Despite this, some observers have argued that given the life and death nature of the human rights issues and history of government’s conduct in the case, a supervisory order was both justified and necessary. They argue that such an order would have made it easier to monitor and oversee compliance.

XI CONCLUSION

The Constitutional Court judgment leaves no room for doubt that the case involved a notorious breach by government of its human rights obligations and legal duties. The consequences of the policy for doctors who felt an ethical duty to have access to Nevirapine in order to reduce the risk to infants were such that it is not far-fetched to suggest that there are parallels between the government’s PMTCT policy and the other great toughness that is evoked in discussions about medical ethics: the Tuskegee experiment. In 1972 the New York Times exposed the conduct of doctors of the US Public Health Service who acted unethically by deceiving 399 black men and by withholding treatment for syphilis for nearly forty years. It described Tuskegee as “the longest non-therapeutic experiment on human beings in history.” As a result between 25 and 100 men died and hundreds of people and their families were harmed. By contrast, in the South African case, the decision to deny pregnant women medicine was not taken by researchers but by elected political officials. The effect however was the same. Doctors all over South Africa were instructed to act against their consciences and ethically by withholding medicine. This policy was devised by politicians who seemed to ignore information and act directly contrary to advice given to them by senior officials in the Department of Health, organised professional medical bodies such as SAPA and multilateral institutions like the WHO. For example, the slide below, which formed part of a presentation on an MTCT programme made by a Deputy Director in the Health Department, is just one example of the evidence that politicians were advised of the benefits of implementing a large-scale intervention to prevent MTCT.

This slide suggests that, in the history of medical ethics, the South African experiment ranks far worse than Tuskegee. Despite knowledge that up to 250 000 children per annum were at risk of HIV infection, and that ‘approximately 100 000 HIV-positive babies are born each year, most of whom die by the age of five’ the government took a decision to

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144 Ibid para 118. See also para 132 where the court says: ‘Government policy is now evolving. Additional sites where nevirapine is provided with a full package to combat mother-to-child transmission of HIV are being added. In the Western Cape, Gugulethu and KwaZulu Natal, programmes have been adopted to extend the supply of Nevirapine for such purposes throughout the province. What we reserve is for the other provinces to follow suit. The order that we make will facilitate this.

145 Ibid para 135.


151 C Serres, Deputy Director HIV/AIDS and STIs, Department of Health ‘Preventing Mother to Child Transmission of HIV Programme’ (presented at an internal presentation) included in the TAC’s Reclaim Our Future (note 1 above) 341-65.

152 PC Opejobi, a member of the MCC, depoted an affidavit on behalf of the government that sought to create confusion about the nature of the organization the MCC had granted for the use of Nevirapine. His affidavit is reference to an article he had co-authored in the J. Medical Journal, in which he had written that “Anti-retrovirals for mother-to-child transmission should form part of an integrated approach to maternal and infant health care,” A Mbowa; P Makhubu; S Reddy & P Opejobi ‘AIDS Management Options for South Africa’ (2000) SAIMF 621-63. The TAC referred to this article, resenting Opejobi’s outstanding views, in its Reclaim Our Future (note 23 above) 1992-94 The reasons for Opejobi’s about-turn are unclear.

153 Projected national transmission without intervention: 900 000 births x 24.5% HIV prevalence x 35% MTCT = 77 175 infants infected PA

154 Projected national transmission with intervention: 900 000 births x 24.5% HIV prevalence x 13% MTCT x 90% uptake = 28 665 infants infected PA (at 14-16w based on SAINT)
limit access to a potentially life-saving medicine to ten per cent of pregnant women and to consciously refuse the medicine to women who requested it outside the 'plot sites'.

Tuskegee involved the exploitation of a vulnerable group, so did MTCT. Tuskegee denied a group of people access to medically proven medicines, so did MTCT. Tuskegee caused irreparable harm to the lives of those affected, so did MTCT. The difference is a qualitative one of context and scale. Tuskegee implicated the actions of a small group of government researchers, abusing their position to act unethically against several hundred vulnerable subjects. MTCT was the policy of South Africa’s Cabinet. Unethical behaviour was defended at great cost in lives and resources through a legal battle that could have been avoided. The social costs are too great to determine, because they are not being measured. Unlike Thalidomide or Tuskegee, there is no list of MTCT parents and babies, because most of the victims of this policy are children too young to have a voice or parents too poor or legally illiterate to pursue further action.

The judgment of the Constitutional Court has not ended the disputes over the provision of MTCT services. In the words of Budlender, the judgment ‘was simply the conclusion of a battle that TAC had already won outside the courts, but with the skilled use of the courts as part of a broader struggle’. Further, the case demonstrated that ‘social and economic rights are only as strong as the willingness of civil society to enforce them’.

Afterwards pressure continued to be necessary to get provinces to comply with the Court’s order. TAC held meetings with MECs in the three least compliant provinces, with the Director General of the Health department, and with the Deputy President of South Africa. In September 2002 a decision to launch rolling legal action through contempt of court proceedings against individual provinces was taken by the TAC NEC, and communicated to the Director General. This led to the first serious attempt to provide TAC with the information that the Constitutional Court had said government had a duty to make available. It was inadequate, but it reflected a creeping compliance that benefited parents and children. For example, on 16 October 2002, an e-mail was received from a doctor in Limpopo Province saying the Provincial Health Department had ‘at long last’ given ‘permission for the implementation of the PMTCT program. I think this was due to pressure from TAC/ courts. The initiative came from their side this time and they seem to be in quite a hurry to get the program up and running’.

The MTCT case was not closed and indeed in December 2002 contempt of court proceedings were filed against the National Minister of Health and the MEC for Health in Mpumalanga. But the Constitutional Court’s decision meant that it was possible for TAC to switch to other campaigns, buoyed particularly by the recognition of the Constitutional Court that:

The magnitude of the HIV/AIDS challenge facing the country calls for a concerted, co-ordinated and co-operative national effort in which government in each of its three spheres and the paraprofessionals and skills of civil society are marshalled, inspired and led. This can be achieved only if there is proper communication, especially by government. In order for it to be implemented optimally, a public health programme must be made known effectively to all concerned, down to the district nurse and patient. Indeed, for a public programme such as this to meet the constitutional requirement of rancourlessness, its contents must be made known appropriately.

MARK HEYWOOD
Head, AIDS Law Project
Centre for Applied Legal Studies
University of the Witwatersrand

135 Personal e-mail received from Dr A He, Tshabalala Hospital (name withheld on request).

136 TAC v MEC for Health (Mpumalanga) Case no 1527/02. See also M Heywood ‘Contempt or Compliance? The TAC Case after the Constitutional Court Judgement’ (2003) 4(1) EJLP Review 5-16.
137 Note 1 above, para 133.
138 The author is the National Secretary of the TAC and was substantially involved in TAC’s advocacy and legal campaigns to try to persuade the government to develop and implement a nationwide programme to prevent MTCT. Although this paper occasionally provides information that was only gathered because of the author’s close proximity to the case, it attempts at all times to base its conclusions or objective information and on medical facts that have been accepted in peer-reviewed medical journals or social facts that were endorsed in this case by the Constitutional Court. It is, of course, difficult to be dispassionate about a conflict over policy that has forged many lives. The author would like to acknowledge the following people who contributed and advised on drafts of this paper: Gilbert Marcon, Patrim Boman, Marlies Richter, Edwin Cameron, Sandy Liddénberg. This paper is dedicated to Sarah Hilde.