CONSTITUTIONAL COURT OF SOUTH AFRICA

Case CCT 8/02

MINISTER OF HEALTH First Appellant

versus

TREATMENT ACTION CAMPAIGN First Respondent

Heard on : 2, 3 and 6 May 2002
Decided on : 5 July 2002

JUDGMENT

THE COURT:

Introduction

[1] The HIV/AIDS pandemic in South Africa has been described as "an incomprehensible calamity" and "the most important challenge facing South Africa since the birth of our new democracy" and government's fight against "this scourge" as "a top priority". It "has claimed millions of lives, inflicting pain and grief, causing fear and uncertainty, and threatening the economy". These are not the words of alarmists but are taken from a Department of Health publication in 2000 and a ministerial foreword to an earlier departmental publication.[2]

[2] This appeal is directed at reversing orders made in a high court against government because of perceived shortcomings in its response to an aspect of the HIV/AIDS challenge. The court found that government had not reasonably addressed the need to reduce the risk of HIV-positive mothers transmitting the disease to their babies at birth. More specifically the finding was that government had acted unreasonably in (a) refusing to make an antiretroviral drug called nevirapine[3] available in

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2 *HIV/AIDS & STD strategic plan for South Africa 2000–2005* and an earlier report to which it refers.

3 Nevirapine is a fast-acting and potent antiretroviral drug long since used worldwide in the treatment of HIV/AIDS and registered in South Africa since 1998. In January 2001 it was approved by the World Health Organization for use against intrapartum mother-to-child transmission of HIV, i.e. transmission of the virus from mother to child at birth. It was also approved for such use in South Africa. The nature and precise date of such approval were contested and this led to some vigorously debated subsidiary issues, dealt with more fully below.

the public health sector where the attending doctor considered it medically indicated and (b) not setting out a timeframe for a national programme to prevent mother-to-child transmission of HIV.

[3] The case started as an application in the High Court in Pretoria on 21 August 2001. The applicants were a number of associations and members of civil society concerned with the treatment of people with HIV/AIDS and with the prevention of new infections. In this judgment they are referred to collectively as "the applicants". The principal actor among them was the Treatment Action Campaign (TAC). The respondents were the national Minister of Health and the respective members of the executive councils (MECs) responsible for health in all provinces save the Western Cape. They are referred to collectively as "the government" or "government".

[4] Government, as part of a formidable array of responses to the pandemic, devised a programme to deal with mother-to-child transmission of HIV at birth and identified nevirapine as its drug of choice for this purpose.[5] The programme imposes restrictions on the availability of nevirapine in the public health sector. This is where the first of two main issues in the case arose. The applicants contended that these restrictions are unreasonable when measured against the Constitution, which commands the state and all its organs to give effect to the rights guaranteed by the Bill of Rights. . . . At issue here is the right given to everyone to have access to public health care services and the right of children to be afforded special protection. These rights are expressed in the following terms in the Bill of Rights:

> "27(1) Everyone has the right to have access to –
>
> (a) health care services, including reproductive health care;
> . . . .
>
> (2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.
>
> . . . .
>
> 28(1) Every child has the right –
> . . . .
>
> (c) to basic nutrition, shelter, basic health care services and social services".

[5] The second main issue also arises out of the provisions of sections 27 and 28 of the Constitution. It is whether government is constitutionally obliged and had to be ordered forthwith to plan and implement an effective, comprehensive and progressive programme for the prevention

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[5] The drug is currently available free to government and its administration is simple: a single tablet taken by the mother at the onset of labour and a few drops fed to the baby within 72 hours after birth.

of mother-to-child transmission of HIV throughout the country. The applicants also relied on other provisions of the Constitution which, in view of our conclusions, need not be considered.

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Factual background

[10] The two principal issues had been in contention between the applicants and government for some considerable time prior to the launching of the application in the High Court. Thus, when the TAC in September 1999 pressed for acceleration of the government programme for the prevention of intrapartum mother-to-child transmission of HIV, it was told by the Minister that this could not be done because there were concerns about, among other things, the safety and efficacy of nevirapine. Nearly a year later (in August 2000), following the 13th International AIDS Conference in Durban and a follow-up meeting attended by the Minister and the MECs, the Minister announced that nevirapine would still not be made generally available. Instead each province was going to select two sites for further research and the use of the drug would be confined to such sites.

[11] Close to a year later, in a letter dated 17 July 2001 written by their attorney, the applicants placed on record that

> "[t]he Government has decided to make NVP [nevirapine] available only at a limited number of pilot sites, which number two per province.
>
> The result is that doctors in the public sector, who do not work at one of those pilot sites, are unable to prescribe this drug for their patients, even though it has been offered to the government for free."

At the same time they pointedly asked the Minister to:

> "(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* to undertake forthwith to make NVP available in the public health sector.
>
> (b) undertake to put in place a programme which will enable all medical practitioners in the public sector to decide whether to prescribe NVP for their pregnant patients, and to prescribe it where in their professional opinion this is medically indicated."

The Minister's reply dated 6 August 2001 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 nor refused outright. The meaning of the Minister's letter is, however, quite unmistakable. It details a series of governmental concerns regarding the safety and efficacy of nevirapine requiring continuation of government's research programme.

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[14] The letter from the Minister also lists a number of social, economic and public health implications of breastfeeding by HIV-positive mothers, emphasises the cultural and financial impact of formula-feeding as a substitute and outlines the overall complexity of providing a comprehensive package of care throughout the country. The Minister, although not responding directly to the undertakings sought on behalf of the applicants, quite clearly intimated that neither undertaking was or would be given. The decision was to confine the provision of nevirapine in the public sector to the research sites and their outlets.

[15] It can be accepted that an important reason for this decision was that government wanted to develop and monitor its human and material resources nationwide for the delivery of a comprehensive package of testing and counselling, dispensing of nevirapine and follow-up services to pregnant women attending at public health institutions. Where bottle-feeding was to be substituted for breastfeeding, appropriate methods and procedures had to be evolved for effective implementation, bearing in mind cultural problems, the absence of clean water in certain parts of the country and the increased risks to infants growing up with inadequate nutrition and sanitation. At the same time, data relating to administrative hitches and their solutions, staffing, costs and the like could be gathered and correlated. All of this obviously makes good sense from the public health point of view. These research and training sites could provide vital information on which in time the very best possible prevention programme for mother-to-child transmission could be developed.

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[17] The crux of the problem, however, lies elsewhere: what is to happen to those mothers and their babies who cannot afford access to private health care and do not have access to the research and training sites? It is not clear on the papers how long it is planned to take before nevirapine will be made available outside these sites. . . . What is plain, though, is that for a protracted period nevirapine would not be supplied at any public health institution other than one designated as part of a research site.

The issues

[18] The founding affidavit, signed by the TAC deputy-chairperson, Ms Siphokazi Mthathi, commences with a useful summary of the case presented by the applicants. In paragraphs 20 and 21 of her affidavit the two principal issues are stated thus:

> "20. The first issue is whether the Respondents are entitled to refuse to make Nevirapine (a registered drug) available to pregnant women who have HIV and who give birth in the public health sector, in order to prevent or reduce the risk of transmission of HIV to their infants, where in the judgment of the attending medical practitioner this is medically indicated.

21. The second issue is whether the Respondents are obliged, as a matter of law, to implement and set out clear timeframes for a national programme to prevent mother-to-child transmission of HIV, including voluntary counselling and testing, antiretroviral therapy, and the option of using formula milk for feeding."

[19] Then, in paragraph 22, she summarises the applicants' case in the following terms:

"22. In summary, the Applicants' case is as follows:

22.1 The HIV/AIDS epidemic is a major public health problem in our country, and has reached catastrophic proportions.

22.2 One of the most common methods of transmission of HIV in children is from mother to child at and around birth. Government estimates are that since 1998, 70 000 children are infected in this manner every year.

22.3 The Medicines Control Council has the statutory duty to investigate whether medicines are suitable for the purpose for which they are intended, and the safety, quality and therapeutic efficacy of medicines.

22.4 The Medicines Control Council has registered Nevirapine for use to reduce the risk of mother-to-child transmission of HIV. This means that Nevirapine has been found to be suitable for this purpose, and that it is safe, of acceptable quality, and therapeutically efficacious.

22.5 The result is that doctors in the private profession can and do prescribe Nevirapine for their patients when, in their professional judgment, it is appropriate to do so.

22.6 In July 2000 the manufacturers of Nevirapine offered to make it available to the South African government free of charge for a period of five years, for the purposes of reducing the risk of mother-to-child transmission of HIV.

22.7 The government has formally decided to make Nevirapine available only at a limited number of pilot sites, which number two per province.

22.8 The result is that doctors in the public sector, who do not work at one of those pilot sites, are unable to prescribe this drug for their patients, even though it has been offered to the government for free.

22.9 The Applicants are aware of the desirability of a multiple-strategy approach to the prevention of mother-to-child transmission. However, they cannot and do not accept that this provides a rational or lawful basis for depriving patients at other sites of the undoubted benefits of Nevirapine, even if at

this stage the provision can not be done as part of a broader integrated strategy – a point that is not conceded.

22.10 To the extent that there may be situations in which the use of Nevirapine is not indicated, this is the situation in both the private and the public sector. Whether or not to prescribe Nevirapine is a matter of professional medical judgment, which can only be exercised on a case-by-case basis. It is not a matter which is capable of rational or appropriate decision on a blanket basis.

22.11 There is no rational or lawful basis for allowing doctors in the private sector to exercise their professional judgment in deciding when to prescribe Nevirapine, but effectively prohibiting doctors in the public sector from doing so.

22.12 In addition to refusing to make Nevirapine generally available in the public health sector, the government has failed over an extended period to implement a comprehensive programme for the prevention of mother-to-child transmission of HIV.

22.13 The result of this refusal and this failure is the mother-to-child transmission of HIV in situations where this was both predictable and avoidable.

22.14 This conduct of the government is irrational, in breach of the Bill of Rights, and contrary to the values and principles prescribed for public administration in section 195 of the Constitution. Furthermore, government conduct is in breach of its international obligations as contained in a number of conventions that it has both signed and ratified."

[20] . . . In our country the issue of HIV/AIDS has for some time been fraught with an unusual degree of political, ideological and emotional contention. This is perhaps unavoidable, having regard to the magnitude of the catastrophe we confront. Nevertheless it is regrettable that some of this contention and emotion has spilt over into this case. . . .

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[22] In their argument counsel for the government raised issues pertaining to the separation of powers. This may be relevant in two respects – (i) in the deference that courts should show to decisions taken by the executive concerning the formulation of its policies; and (ii) in the order to be made where a court finds that the executive has failed to comply with its constitutional obligations. These considerations are relevant to the manner in which a court should exercise the powers vested in it under the Constitution. It was not contended, nor could it have been, that they are relevant to the question of justiciability.

Enforcement of socio-economic rights

[23] This Court has had to consider claims for enforcement of socio-economic rights on two occasions [citing *Soobramoney* and *Grootboom*. On both occasions it was recognised that the state is under a constitutional duty to comply with the positive obligations imposed on it by sections 26 and 27 of the Constitution. It was stressed, however, that the obligations are subject to the qualifications expressed in sections 26(2) and 27(2). . . .

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[25] The question in the present case, therefore, is not whether socio-economic rights are justiciable. Clearly they are.[6] 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 fall short of its obligations under the Constitution.

Minimum core

[26] Before outlining the applicants' legal submissions, it is necessary to consider a line of argument presented on behalf of the first and second amici. It was contended that section 27(1) of the Constitution establishes an individual right vested in everyone. This right, so the contention went, has a minimum core to which every person in need is entitled. The concept of "minimum core" was developed by the United Nations Committee on Economic, Social and Cultural Rights which is charged with monitoring the obligations undertaken by state parties to the International Covenant on Economic, Social and Cultural Rights. According to the Committee

> "a State party in which any significant number of individuals is deprived of essential foodstuffs, of essential primary health care, of basic shelter and housing, or of the most basic forms of education is, *prima facie*, failing to discharge its obligations under the Covenant. If the Covenant were to be read in such a way as not to establish such a minimum core obligation, it would be largely deprived of its *raison d'être*. By the same token, it must be noted that any assessment as to whether a State has discharged its minimum core obligations must also take account of resource constraints applying within the country concerned. Article 2(1) obligates each State party to take the necessary steps 'to the maximum of its available resources'. In order for a State party to be able to attribute its failure to meet at least its minimum core obligations to a lack of available resources it must demonstrate that every effort has been made to use all resources that are at its disposition in an effort to satisfy, as a matter of priority, those minimum obligations."[7]

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[28] [The amici point out that] rights and obligations are stated separately [in ss 26 and 27 of the Constitution. They contend that there is, accordingly,] a distinction between the self-standing rights

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6 *Ex Parte Chairperson of the Constitutional Assembly: In re Certification of the Constitution of the Republic of South Africa, 1996* 1996 (4) SA 744 (CC); 1996 (10) BCLR 1253 (CC) para 78.

7 CESCR General Comment 3 "The nature of States parties obligations (Art. 2, par.1)" 14/12/90 para 10.

in sections 26(1) and 27(1), to which everyone is entitled, and which in terms of section 7(2) of the Constitution "[t]he state must respect, protect, promote and fulfil", and the independent obligations imposed on the state by sections 26(2) and 27(2). This minimum core might not be easy to define, but includes at least the minimum decencies of life consistent with human dignity. No one should be condemned to a life below the basic level of dignified human existence. The very notion of individual rights presupposes that anyone in that position should be able to obtain relief from a court.

[29] In effect what the argument comes down to is that sections 26 and 27 must be construed as imposing two positive obligations on the state: one an obligation to give effect to the 26(1) and 27(1) rights; the other a limited obligation to do so progressively through "reasonable legislative and other measures, within its available resources". Implicit in that contention is that the content of the right in subsection (1) differs from the content of the obligation in subsection (2). This argument fails to have regard to the way subsections (1) and (2) of both sections 26 and 27 are linked in the text of the Constitution itself, and to the way they have been interpreted by this Court in *Soobramoney* and *Grootboom*.

[30] Section 26(1) refers to the "right" to have access to housing. Section 26(2), dealing with the state's obligation in that regard, requires it to "take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of this right". The reference to "this right" is clearly a reference to the section 26(1) right. Similar language is used in section 27 . . . .

[31] In *Soobramoney* it was said:

> "What is apparent from these provisions is that the obligations imposed on the State by ss 26 and 27 in regard to access to housing, health care, food, water and social security are dependent upon the resources available for such purposes, *and that the corresponding rights themselves are limited by reason of the lack of resources*."

The obligations referred to in this passage are clearly the obligations referred to in sections 26(2) and 27(2), and the "corresponding rights" are the rights referred to in sections 26(1) and 27(1).

[32] This passage is cited in *Grootboom*. It is made clear in that judgment that sections 26(1) and 26(2) "are related and must be read together". . . . It is also made clear that "[s]ection 26 does not expect more of the State than is achievable within its available resources" and does not confer an entitlement to "claim shelter or housing immediately upon demand" and that as far as the rights of access to housing, health care, sufficient food and water, and social security for those unable to support themselves and their dependants are concerned, "the State is not obliged to go beyond available resources or to realise these rights immediately".

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[35] A purposive reading of sections 26 and 27 does not lead to any other conclusion. It is impossible to give everyone access even to a "core" service immediately. All that is possible, and

all that can be expected of the state, is that it act reasonably to provide access to the socio-economic rights identified in sections 26 and 27 on a progressive basis. . . .

[36] The state is obliged to take reasonable measures progressively to eliminate or reduce the large areas of severe deprivation that afflict our society. The courts will guarantee that the democratic processes are protected so as to ensure accountability, responsiveness and openness, as the Constitution requires in section 1. As the Bill of Rights indicates, their function in respect of socio-economic rights is directed towards ensuring that legislative and other measures taken by the state are reasonable. As this Court said in *Grootboom*, "[i]t is necessary to recognise that a wide range of possible measures could be adopted by the State to meet its obligations".

[37] It should be borne in mind that in dealing with such matters the courts are not institutionally equipped to make the wide-ranging factual and political enquiries necessary for determining what the minimum-core standards called for by the first and second amici should be, nor for deciding how public revenues should most effectively be spent. There are many pressing demands on the public purse. . . .

[38] Courts are ill-suited to adjudicate upon issues where court orders could have multiple social and economic consequences for the community. The Constitution contemplates rather a restrained and focused role for the courts, namely, to require the state to take measures to meet its constitutional obligations and to subject the reasonableness of these measures to evaluation. Such determinations of reasonableness may in fact have budgetary implications, but are not in themselves directed at rearranging budgets. In this way the judicial, legislative and executive functions achieve appropriate constitutional balance.

[39] We therefore conclude that section 27(1) of the Constitution does not give rise to a self-standing and independent positive right enforceable irrespective of the considerations mentioned in section 27(2). Sections 27(1) and 27(2) must be read together as defining the scope of the positive rights that everyone has and the corresponding obligations on the state to "respect, protect, promote and fulfil" such rights. The rights conferred by sections 26(1) and 27(1) are to have "access" to the services that the state is obliged to provide in terms of sections 26(2) and 27(2).

Government policy on the prevention of mother-to-child transmission of HIV

[40] Government's policy for the treatment of HIV/AIDS including mother-to-child transmission of HIV is dealt with in various documents. . . .

[41] Following the 13th International Conference on HIV/AIDS held in Durban in July 2000, government took a decision to implement a programme for the prevention of mother-to-child transmission of HIV/AIDS. . . .

[42] This programme was to be implemented in accordance with the *Protocol for providing a*

comprehensive package of care for the prevention of mother to child transmission of HIV in South Africa, draft version 4 of which was adopted in April 2001. This protocol made provision for a comprehensive package of care for the prevention of mother-to-child transmission of HIV. It was based on two propositions: first, the acceptance that there is enough scientific evidence confirming the efficacy of various antiretroviral drugs for reducing the transmission of HIV from mother to child; and second, that there is a need to assess the operational challenges inherent in the introduction of an antiretroviral regimen for the reduction of mother-to-child transmission of HIV in South Africa in both rural and urban settings. The protocol recognised that appropriately trained staff is a prerequisite for the successful implementation of any programme. To this end, provision was made in the protocol for the development of materials for the required training of staff, including training in counselling, testing for HIV, the medical and obstetric interventions necessary to reduce mother-to-child transmission at the time of birth and other related matters.

[43] The protocol contemplated that the programme would be introduced at two sites, one rural and one urban, in each of the provinces. A full package of care would be available at these sites and the progress made by the infants receiving the treatment would be carefully monitored for a period of two years.

The applicants' contentions

[44] It is the applicants' case that the measures adopted by government to provide access to health care services to HIV- positive pregnant women were deficient in two material respects: first, because they prohibited the administration of nevirapine at public hospitals and clinics outside the research and training sites; and second, because they failed to implement a comprehensive programme for the prevention of mother-to-child transmission of HIV.

[45] . . . The applicants contend that [these features are] not reasonable and that government ought to have had a comprehensive national programme to prevent mother-to-child transmission of HIV, including voluntary counselling and testing, antiretroviral therapy and the option of substitute feeding.

[46] In *Grootboom*, relying on what is said in the *First Certification Judgment*,[8] this Court held that

> "[a]lthough [section 26(1)] does not expressly say so, there is, at the very least, a negative obligation placed upon the State and all other entities and persons to desist from preventing

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[8] Above n 10 para 78:

> "At the very minimum, socio-economic rights can be negatively protected from improper invasion."

or impairing the right of access to adequate housing."[9]

That "negative obligation" applies equally to the section 27(1) right of access to "health care services, including reproductive health care". This is relevant to the challenges to the measures adopted by government for the provision of medical services to combat mother-to-child transmission of HIV.

[47] The applicants' contentions raise two questions, namely, is the policy of confining the supply of nevirapine reasonable in the circumstances; and does government have a comprehensive policy for the prevention of mother-to-child transmission of HIV.

The policy confining nevirapine to the research and training sites

[48] In deciding on the policy to confine nevirapine to the research and training sites, the cost of the drug itself was not a factor. This is made clear in the affidavit of Dr Ntsaluba. . . .

[49] [It appears that] the costs that are of concern to the government are . . . the costs of providing the infrastructure for counselling and testing, of providing formula feed [because breast-feeding can transmit the virus], vitamins and an antibiotic drug and of monitoring, during bottle-feeding, the mothers and children who have received nevirapine. These costs are relevant to the comprehensive programme to be established at the research and training sites. They are not, however, relevant to the provision of a single dose of nevirapine to both mother and child at the time of birth.

[50] The implementation of a comprehensive programme to combat mother-to-child transmission of HIV, such as that provided at the research and training sites, is no doubt the ideal. The real dispute between the parties on this aspect of the case is not, however, whether this optimum was feasible but whether it was reasonable to exclude the use of nevirapine for the treatment of mother-to-child transmission at those public hospitals and clinics where testing and counselling are available and where the administration of nevirapine is medically indicated.

[51] In substance four reasons were advanced in the affidavits for confining the administration of nevirapine to the research and training sites. First, concern was expressed about the efficacy of nevirapine where the "comprehensive package" is not available. The concern was that the benefits of nevirapine would be counteracted by the transmission of HIV from mother to infant through breastfeeding. For this reason government considered it important to provide breastmilk substitutes to the mother and a "package" of care for mother and infant including vitamin supplements and antibiotics. They considered it necessary to establish a system and to put in place the infrastructure necessary for that purpose, to provide advice and counselling to the mothers to ensure that the substitute and supplements were used properly and to monitor progress to determine the

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9 Above n 6 para 34.

effectiveness of the treatment. There are significant problems in making this package available. There are problems of resources in so far as counselling and testing are concerned and budgetary constraints affecting the expansion of facilities at public hospitals and clinics outside the research and training sites. There is a cultural objection to bottle-feeding that has to be overcome, and in rural areas there are also hazards in bottle-feeding by mothers who do not have access to clean water. There are still millions of people living in such circumstances and effective treatment of infants by the provision of nevirapine at birth by no means resolves all difficulties.

[52] Secondly, there was a concern that the administration of nevirapine to the mother and her child might lead to the development of resistance to the efficacy of nevirapine and related antiretrovirals in later years.

[53] Thirdly, there was a perceived safety issue. Nevirapine is a potent drug and it is not known what hazards may attach to its use.

[54] Finally, there was the question whether the public health system has the capacity to provide the package. It was contended on behalf of government that nevirapine should be administered only with the "full package" and that it was not reasonably possible to do this on a comprehensive basis because of the lack of trained counsellors and counselling facilities and also budgetary constraints which precluded such a comprehensive scheme being implemented.

[55] Related to this was a submission raised in argument that from a public health point of view, there is a need to determine the costs of providing the breastmilk substitute, the supplementary package and the necessary counselling and monitoring. Without knowing the full extent of these costs and the efficacy of the treatment, it would be unwise for government to commit itself to a wide-ranging programme for treating mother-to-child transmission that might prove to be neither efficacious nor sustainable.

[56] We deal with each of these issues in turn.

Efficacy

[57] First, the concern about efficacy. It is clear from the evidence that the provision of nevirapine will save the lives of a significant number of infants even if it is administered without the full package and support services that are available at the research and training sites. Mother-to-child transmission of HIV can take place during pregnancy, at birth and as a result of breastfeeding. The programme in issue in this case is concerned with transmission at or before birth. Although there is no dispute about the efficacy of nevirapine in materially reducing the likelihood of transmission at birth, the efficacy of the drug as a means of combating mother-to-child transmission of HIV is nevertheless challenged. . . .

[58] * * * [For example,] in the answering affidavit of Dr Ntsaluba, this doubt about the efficacy

of intrapartum administration of nevirapine is [raised]:

> "Breastfeeding is contra-indicated where Nevirapine is used to reduce or prevent MTCT of the HIV. It must be remembered that MTCT of HIV-1 through breastmilk negates all the gains of the use of Nevirapine in the mother during delivery and in the newborn child within 72 hours after birth. Thus, it is not safe to expose a largely breastfeeding populace to Nevirapine, unless certain stringent measures are taken to ensure that breastfeeding would not occur when the medicine is taken to treat MTCT of the HIV."

These allegations . . . by Dr Ntsaluba are, however, not supported by the data on which Dr Ntsaluba relies. Indeed, the wealth of scientific material produced by both sides makes plain that sero-conversion of HIV takes place in some, but not all, cases and that nevirapine thus remains to some extent efficacious in combating mother-to-child transmission even if the mother breastfeeds her baby.

Resistance

[59] As far as resistance is concerned, the only relevance is the possible need to treat the mother and/or the child at some time in the future. Although resistant strains of HIV might exist after a single dose of nevirapine, this mutation is likely to be transient. At most there is a possibility of such resistance persisting, and although this possibility cannot be excluded, its weight is small in comparison with the potential benefit of providing a single tablet of nevirapine to the mother and a few drops to her baby at the time of birth. The prospects of the child surviving if infected are so slim and the nature of the suffering so grave that the risk of some resistance manifesting at some time in the future is well worth running.

Safety

[60] The evidence shows that safety is no more than a hypothetical issue. The only evidence of potential harm concerns risks attaching to the administration of nevirapine as a chronic medication on an ongoing basis for the treatment of HIV-positive persons. There is, however, no evidence to suggest that a dose of nevirapine to both mother and child at the time of birth will result in any harm to either of them. According to the current medical consensus, there is no reason to fear any harm from this particular administration of nevirapine. That is why its use is recommended without qualification for this purpose by the World Health Organization.

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[62] The decision by government to provide nevirapine to mothers and infants at the research and training sites is consistent only with government itself being satisfied as to the efficacy and safety of the drug. These sites cater for approximately 10% of all births in the public sector and it is unthinkable that government would gamble with the lives or health of thousands of mothers and

infants. . . .

[63] In any event the main thrust of government's case was that nevirapine should be administered in circumstances in which it would be most effective, not that it should not be administered because it is dangerous. Dr Ntsaluba seems to acknowledge this in his affidavit where he says:

> "As I have pointed out earlier, to extend the programme to every hospital in each province is practically and financially not feasible. It would have been ideal but while that is a goal that the First to Ninth Respondents are working towards, it is not implementable at once."

[64] It is this that lies at the heart of government policy. There are obviously good reasons from the public health point of view to monitor the efficacy of the "full package" provided at the research and training sites and determine whether the costs involved are warranted by the efficacy of the treatment. There is a need to determine whether bottle-feeding will be implemented in practice when such advice is given and whether it will be implemented in a way that proves to be more effective than breastfeeding, bearing in mind the cultural problems associated with bottle-feeding, the absence of clean water in certain parts of the country and the fact that breastfeeding provides immunity from other hazards that infants growing up in poor households without access to adequate nutrition and sanitation are likely to encounter. However, this is not a reason for not allowing the administration of nevirapine elsewhere in the public health system when there is the capacity to administer it and its use is medically indicated.

Capacity

[65] According to Dr Simelela, there have been significant problems even at the research and training sites in providing a comprehensive programme using nevirapine for the prevention of mother-to-child transmission. A lack of adequately trained personnel, including counsellors, a shortage of space for conducting counselling and inadequate resources due to budgetary constraints made it impossible to provide such a programme.

[66] Although the concerns raised by Dr Simelela are relevant to the ability of government to make a "full package" available throughout the public health sector, they are not relevant to the question whether nevirapine should be used to reduce mother-to-child transmission of HIV at those public hospitals and clinics outside the research sites where facilities in fact exist for testing and counselling.

Considerations relevant to reasonableness

[67] 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.

[68] . . . The fact that the research and training sites will provide crucial data on which a comprehensive programme for mother-to-child transmission can be developed and, if financially feasible, implemented is clearly of importance to government and to the country. So too is ongoing research into safety, efficacy and resistance. This does not mean, however, that until the best programme has been formulated and the necessary funds and infrastructure provided for the implementation of that programme, nevirapine must be withheld from mothers and children who do not have access to the research and training sites. Nor can it reasonably be withheld until medical research has been completed. A programme for the realisation of socio-economic rights must

> "be balanced and flexible and make appropriate provision for attention to . . . crises and to short, medium and long term needs. A programme that excludes a significant segment of society cannot be said to be reasonable." [citing *Grootboom*]

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[70] In dealing with these questions it must be kept in mind that this case concerns particularly those who cannot afford to pay for medical services. To the extent that government limits the supply of nevirapine to its research sites, it is the poor outside the catchment areas of these sites who will suffer. 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 these differences.

* * *

[73] The administration of nevirapine is a simple procedure. Where counselling and testing facilities exist, the administration of nevirapine is well within the available resources of the state and, in such circumstances, the provision of a single dose of nevirapine to mother and child where medically indicated is a simple, cheap and potentially lifesaving medical intervention.

* * *

Evaluation of the policy to limit nevirapine to research and training sites

[80] Government policy was an inflexible one that denied mothers and their newborn children at public hospitals and clinics outside the research and training sites the opportunity of receiving a single dose of nevirapine at the time of the birth of the child. A potentially lifesaving drug was on offer and where testing and counselling facilities were available it could have been administered within the available resources of the state without any known harm to mother or child. In the circumstances we agree with the finding of the High Court that the policy of government in so far as it confines the use of nevirapine to hospitals and clinics which are research and training sites constitutes a breach of the state's obligations under section 27(2) read with section 27(1)(a) of the Constitution.

[81] Implicit in this finding is that a policy of waiting for a protracted period before taking a decision on the use of nevirapine beyond the research and training sites is also not reasonable within

the meaning of section 27(2) of the Constitution.

Does government have a comprehensive plan to combat mother-to-child transmission of HIV?

[82] The issues relating to the alleged failure to implement a comprehensive national programme for the prevention of mother-to-child transmission are intertwined with the averments concerning the refusal to permit nevirapine to be prescribed at public hospitals and clinics outside the research and training sites. Foundational to all aspects of the case was the challenge to the policy concerning the use of nevirapine.

* * *

Findings concerning government's programme

[93] In the present case this Court has the duty to determine whether the measures taken in respect of the prevention of mother-to-child transmission of HIV are reasonable. We know that throughout the country health services are overextended. HIV/AIDS is but one of many illnesses that require attention. It is, however, the greatest threat to public health in our country. As the government's *HIV/AIDS & STD strategic plan for South Africa 2000–2005* states:

> "During the last two decades, the HIV pandemic has entered our consciousness as an incomprehensible calamity. HIV/AIDS has claimed millions of lives, inflicting pain and grief, causing fear and uncertainty, and threatening the economy."

[94] We are also conscious of the daunting problems confronting government as a result of the pandemic. And besides the pandemic, the state faces huge demands in relation to access to education, land, housing, health care, food, water and social security. These are the socio-economic rights entrenched in the Constitution, and the state is obliged to take reasonable legislative and other measures within its available resources to achieve the progressive realisation of each of them. In the light of our history this is an extraordinarily difficult task. Nonetheless it is an obligation imposed on the state by the Constitution.

[95] The rigidity of government's approach when these proceedings commenced affected its policy as a whole. If, as we have held, it was not reasonable to restrict the use of nevirapine to the research and training sites, the policy as a whole will have to be reviewed. Hospitals and clinics that have testing and counselling facilities should be able to prescribe nevirapine where that is medically indicated. The training of counsellors ought now to include training for counselling on the use of nevirapine. As previously indicated, this is not a complex task and it should not be difficult to equip existing counsellors with the necessary additional knowledge. In addition, government will need to take reasonable measures to extend the testing and counselling facilities to hospitals and clinics throughout the public health sector beyond the test sites to facilitate and expedite the use of nevirapine for the purpose of reducing the risk of mother-to-child transmission of HIV.

The powers of the courts

[96] Counsel for the government contended that even if this Court should find that government policies fall short of what the Constitution requires, the only competent order that a court can make is to issue a declaration of rights to that effect. That leaves government free to pay heed to the declaration made and to adapt its policies in so far as this may be necessary to bring them into conformity with the court's judgment. This, so the argument went, is what the doctrine of separation of powers demands.

[97] In developing this argument counsel contended that under the separation of powers the making of policy is the prerogative of the executive and not the courts, and that courts cannot make orders that have the effect of requiring the executive to pursue a particular policy.

[98] This Court has made it clear on more than one occasion that although there are no bright lines that separate the roles of the legislature, the executive and the courts from one another, there are certain matters that are pre-eminently within the domain of one or other of the arms of government and not the others. All arms of government should be sensitive to and respect this separation. This does not mean, however, that courts cannot or should not make orders that have an impact on policy.

[99] The primary duty of courts is to the Constitution and the law, "which they must apply impartially and without fear, favour or prejudice". The Constitution requires the state to "respect, protect, promote, and fulfil the rights in the Bill of Rights". Where state policy is challenged as inconsistent with the Constitution, courts have to consider whether in formulating and implementing such policy the state has given effect to its constitutional obligations. If it should hold in any given case that the state has failed to do so, it is obliged by the Constitution to say so. In so far as that constitutes an intrusion into the domain of the executive, that is an intrusion mandated by the Constitution itself. There is also no merit in the argument advanced on behalf of government that a distinction should be drawn between declaratory and mandatory orders against government. Even simple declaratory orders against government or organs of state can affect their policy and may well have budgetary implications. Government is constitutionally bound to give effect to such orders whether or not they affect its policy and has to find the resources to do so. Thus, in the *Mpumalanga* case,[41] this Court set aside a provincial government's policy decision to terminate the payment of subsidies to certain schools and ordered that payments should continue for several months. Also, in the case of *August*[42] the Court, in order to afford prisoners the right to vote, directed the Electoral Commission to alter its election policy, planning and regulations, with manifest cost implications.

[100] The rights that the state is obliged to "respect, protect, promote and fulfil" include the socio-

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41 *Premier, Mpumalanga, and Another v Executive Committee, Association of State-Aided Schools, Eastern Transvaal* 1999 (2) SA 91 (CC); 1999 (2) BCLR 151 (CC).

42 *August and Another v Electoral Commission and Others* 1999 (3) SA 1 (CC); 1999 (4) BCLR 363 (CC).

economic rights in the Constitution. . . .

[101] A dispute concerning socio-economic rights is thus likely to require a court to evaluate state policy and to give judgment on whether or not it is consistent with the Constitution. If it finds that policy is inconsistent with the Constitution it is obliged in terms of section 172(1)(a) to make a declaration to that effect. But that is not all. Section 38 of the Constitution contemplates that where it is established that a right in the Bill of Rights has been infringed a court will grant "appropriate relief". It has wide powers to do so and in addition to the declaration that it is obliged to make in terms of section 172(1)(a) a court may also "make any order that is just and equitable".

* * *

[104] The power to grant mandatory relief includes the power where it is appropriate to exercise some form of supervisory jurisdiction to ensure that the order is implemented. . . .

* * *

[106] We thus reject the argument that the only power that this Court has in the present case is to issue a declaratory order. Where a breach of any right has taken place, including a socio-economic right, a court is under a duty to ensure that effective relief is granted. The nature of the right infringed and the nature of the infringement will provide guidance as to the appropriate relief in a particular case. Where necessary this may include both the issuing of a mandamus and the exercise of supervisory jurisdiction.

[107] An examination of the jurisprudence of foreign jurisdictions on the question of remedies shows that courts in other countries also accept that it may be appropriate, depending on the circumstances of the particular case, to issue injunctive relief against the state. In the United States, for example, frequent use has been made of the structural injunction – a form of supervisory jurisdiction exercised by the courts over a government agency or institution. Most famously, the structural injunction was used in the case of *Brown v Board of Education*[58] where the US Supreme Court held that lower courts would need to retain jurisdiction of *Brown* and similar cases. These lower courts would have the power to determine how much time was necessary for the school boards to achieve full compliance with the Court's decision and would also be able to consider the adequacy of any plan proposed by the school boards "to effectuate a transition to a racially nondiscriminatory school system".[59]

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[58] *Brown et al v Board of Education of Topeka et al* 347 US 483 (1954) (*Brown I*) and *Brown et al v Board of Education of Topeka et al* 349 US 294 (1955)(*Brown II*).

[59] *Brown II* id 300-1. See too *Swann et al v Charlotte-Mecklenburg Board of Education et al* 402 US 1 (1971) where the Supreme Court gave some general guidelines to assist courts and school authorities in the implementation of school desegregation – focusing on various techniques which could be employed to ensure that desegregation took place more expeditiously.

* * *

[109] South African courts have a wide range of powers at their disposal to ensure that the Constitution is upheld. These include mandatory and structural interdicts. How they should exercise those powers depends on the circumstances of each particular case. Here due regard must be paid to the roles of the legislature and the executive in a democracy. What must be made clear, however, is that when it is appropriate to do so, courts may – and if need be must – use their wide powers to make orders that affect policy as well as legislation.

[110] A factor that needs to be kept in mind is that policy is and should be flexible. It may be changed at any time and the executive is always free to change policies where it considers it appropriate to do so. The only constraint is that policies must be consistent with the Constitution and the law. Court orders concerning policy choices made by the executive should therefore not be formulated in ways that preclude the executive from making such legitimate choices.

Circumstances relevant to the order to be made

[111] The finding made concerning the restricted use of nevirapine has implications for government's policy on the prevention of mother-to-child transmission of HIV. If nevirapine is now made available at all state hospitals and clinics where there are testing and counselling facilities, that will call for a change in policy. The policy will have to be that nevirapine must be provided where it is medically indicated at those hospitals and clinics within the public sector where facilities exist for testing and counselling.

[112] At the time the proceedings were instituted, the provincial health authorities charged with the responsibility of implementing the programme for testing and counselling attributed their failure to do this to constraints relating to capacity. There were financial constraints owing to limited budgets and there was also a shortage of suitably trained persons to undertake testing and counselling. The question whether budgetary constraints provided a legitimate reason for not implementing a comprehensive policy for the use of nevirapine, including testing and counselling, was disputed. It was contended that the use of nevirapine would result in significant savings in later years because it would reduce the number of HIV-positive children who would otherwise have to be treated in the public health system for all the complications caused by that condition.

[113] In the view that we take of this matter it is not necessary to deal with that issue. Conditions have changed since these proceedings were initiated. This is relevant to the order that should follow upon the findings now made.

[114] During the course of these proceedings the state's policy has evolved and is no longer as rigid as it was when the proceedings commenced. By the time this appeal was argued, six hospitals and three community health care centres had already been added in Gauteng to the two research and training sites initially established and it was contemplated that during the course of this year

nevirapine would be available throughout the province for the treatment of mother-to-child transmission. Likewise, in KwaZulu-Natal there was a change of policy towards the supply of nevirapine at public health institutions outside the test sites. . . .

[115] These developments clearly demonstrate that, provided the requisite political will is present, the supply of nevirapine at public health institutions can be rapidly expanded to reach many more than the 10% of the population intended to be catered for in terms of the test site policy.

[116] But more importantly, we were informed at the hearing of the appeal that the government has made substantial additional funds available for the treatment of HIV, including the reduction of mother-to-child transmission. The total budget to be spent mainly through the departments of Health, Social Development and Education was R350 million in 2001/2. It has been increased to R1 billion in the current financial year and will go up to R1,8 billion in 2004/5. This means that the budgetary constraints referred to in the affidavits are no longer an impediment. With the additional funds that are now to be available, it should be possible to address any problems of financial incapacity that might previously have existed.

[117] We have earlier referred to section 172(1)(a) of the Constitution, which requires a court deciding a constitutional matter to "declare that any law or conduct that is inconsistent with the Constitution is invalid to the extent of its inconsistency". A declaration to that effect must therefore be made in this matter. The declaration must be in a form which identifies the constitutional infringement. Whether remedial action must also be specified is a separate question involving a different enquiry.

[118] In the present case we have identified aspects of government policy that are inconsistent with the Constitution. The decision not to make nevirapine available at hospitals and clinics other than the research and training sites is central to the entire policy. Once that restriction is removed, government will be able to devise and implement a more comprehensive policy that will give access to health care services to HIV-positive mothers and their newborn children, and will include the administration of nevirapine where that is appropriate. The policy as reformulated must meet the constitutional requirement of providing reasonable measures within available resources for the progressive realisation of the rights of such women and newborn children. This may also require, where that is necessary, that counsellors at places other than at the research and training sites be trained in counselling for the use of nevirapine. We will formulate a declaration to address these issues.

* * *

Relief

* * *

[128] We do not consider it appropriate to deal with the use of formula feed in the order. Whether it is desirable to use this substitute rather than breastfeeding raises complex issues, particularly when

the mother concerned may not have easy access to clean water or the ability to adopt a bottle-feeding regimen because of her personal circumstances. The result of the studies conducted at the research and training sites may enable government to formulate a comprehensive policy in this regard. In the meantime this must be left to health professionals to address during counselling. We do not consider that there is sufficient evidence to justify an order that formula feed must be made available by the government on request and without charge in every case.

[129] The order made by the High Court included a structural interdict requiring the appellants to revise their policy and to submit the revised policy to the court to enable it to satisfy itself that the policy was consistent with the Constitution. In *Pretoria City Council* this Court recognised that courts have such powers. . . . We do not consider, however, that orders should be made in those terms unless this is necessary. The government has always respected and executed orders of this Court. There is no reason to believe that it will not do so in the present case.

* * *

Orders

[135] We accordingly make the following orders:

1. The orders made by the High Court are set aside and the following orders are substituted.

2. It is declared that:

    a) Sections 27(1) and (2) of the Constitution require the government to devise and implement within its available resources a comprehensive and co-ordinated programme to realise progressively the rights of pregnant women and their newborn children to have access to health services to combat mother-to-child transmission of HIV.

    b) The programme to be realised progressively within available resources must include reasonable measures for counselling and testing pregnant women for HIV, counselling HIV-positive pregnant women on the options open to them to reduce the risk of mother-to-child transmission of HIV, and making appropriate treatment available to them for such purposes.

    c) The policy for reducing the risk of mother-to-child transmission of HIV as formulated and implemented by government fell short of compliance with the requirements in subparagraphs (a) and (b) in that:

        i) Doctors at public hospitals and clinics other than the research and training sites were not enabled to prescribe nevirapine to reduce the

risk of mother-to-child transmission of HIV even where it was medically indicated and adequate facilities existed for the testing and counselling of the pregnant women concerned.

ii) The policy failed to make provision for counsellors at hospitals and clinics other than at research and training sites to be trained in counselling for the use of nevirapine as a means of reducing the risk of mother-to-child transmission of HIV.

3. Government is ordered 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 superintendent 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 extend the testing and counselling facilities at hospitals and clinics throughout the public health sector to facilitate and expedite the use of nevirapine for the purpose of reducing the risk of mother-to-child transmission of HIV.

4. The orders made in paragraph 3 do not preclude government from adapting its policy in a manner consistent with the Constitution if equally appropriate or better methods become available to it for the prevention of mother-to-child transmission of HIV.

* * *

Chaskalson CJ		Langa DCJ
Ackermann J	Du Plessis AJ	Goldstone J
Kriegler J	Madala J	Ngcobo J
O'Regan J	Sachs J	Skweyiya AJ