CONSTITUTIONAL COURT OF SOUTH AFRICA

Minister of Health v Treatment Action Campaign (No 2) [2002] ZACC 15; 2002 (5) SA 721; 2002 (10) BCLR 1033

Case CCT 8/02

MINISTER OF HEALTH	First Appellant
MEMBER OF THE EXECUTIVE COUNCIL FOR HEALTH, EASTERN CAPE	Second Appellant
MEMBER OF THE EXECUTIVE COUNCIL FOR HEALTH, FREE STATE	Third Appellant
MEMBER OF THE EXECUTIVE COUNCIL FOR HEALTH, GAUTENG	Fourth Appellant
MEMBER OF THE EXECUTIVE COUNCIL FOR HEALTH, KWAZULU-NATAL	Fifth Appellant
MEMBER OF THE EXECUTIVE COUNCIL FOR HEALTH, MPUMALANGA	Sixth Appellant
MEMBER OF THE EXECUTIVE COUNCIL FOR HEALTH, NORTHERN CAPE	Seventh Appellant
MEMBER OF THE EXECUTIVE COUNCIL FOR HEALTH, NORTHERN PROVINCE	Eighth Appellant
MEMBER OF THE EXECUTIVE COUNCIL FOR HEALTH, NORTH WEST	Ninth Appellant

versus

TREATMENT ACTION CAMPAIGN	First Respondent
DR HAROON SALOOJEE	Second Respondent
CHILDREN'S RIGHTS CENTRE	Third Respondent

Together with

INSTITUTE FOR DEMOCRACY IN SOUTH AFRICA First Amicus Curiae

COMMUNITY LAW CENTRE Second Amicus Curiae
COTLANDS BABY SANCTUARY Third Amicus Curiae

Heard on : 2, 3 and 6 May 2002

Decided on : 5 July 2002

JUDGMENT

THE COURT:

Introduction

[1] The HIV/AIDS[1] 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]

---

[1] This is the term commonly used for the human immunodeficiency virus (HIV) leading to the acquired immune (or immuno-) deficiency syndrome (AIDS). Transmission of this disease, its progression and dire consequences are set out in lay language from para 11 onwards in the judgment of Ngcobo J in *Hoffmann v South African Airways* 2001 (1) SA 1 (CC); 2000 (11) BCLR 1211 (CC).

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

THE COURT

[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 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

[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.

executive councils (MECs) responsible for health in all provinces save the Western Cape.[4] 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. This duty is put thus by sections 7(2) and 8(1) of the Constitution respectively:

> "7(2) The state must respect, protect, promote and fulfil the rights in the Bill of Rights.
>
> . . . .
>
> 8(1) The Bill of Rights applies to all law, and binds the legislature, the executive, the judiciary and all organs of state."

[4] The Western Cape MEC was originally a party to the proceedings in the High Court. The applicants later withdrew the application against him. A dispute between the Premier and the MEC of KwaZulu-Natal arose at a later stage, when leave to appeal to this Court was being debated.

[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.

THE COURT

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 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.

[6] The affidavits lodged by the applicants addressed these two central issues from a variety of specialised perspectives, ranging from paediatrics, pharmacology and

epidemiology to public health administration, economics and statistics. The applicants' papers also include the testimony of doctors, nurses and counsellors confronted daily with the human tragedies of HIV-infected mothers and their babies. In addition there are poignant accounts of HIV-positive pregnant women's pleas for access to nevirapine for themselves and their babies at public health institutions where its supply is prohibited.

[7] The principal deponents to the government's answer are the Director-General of the national Department of Health, Dr Ayanda Ntsaluba, and Dr Nono Simelela, the Chief Director of the Department's HIV/AIDS programme, whose affidavits were signed on 20 October 2001. They are supported by a number of experts and by the administrative heads of the respective provincial health departments. 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.

[8] On 14 December 2001 the High Court made an order substantially in accord with the notice of motion as then worded. Its main provisions were the following:

> "1. It is declared that the first to ninth respondents are obliged to make Nevirapine available to pregnant women with HIV who give birth in the public health sector, and to their babies, in public health facilities to which the respondents' present programme for the prevention of mother-to-child transmission of HIV has not yet been extended, where in the judgment of the attending medical officer, acting in consultation with the medical

superintendent of the facility concerned, this is medically indicated, which shall at least include that the woman concerned has been appropriately tested and counselled.

2. The first to ninth respondents are ordered to make Nevirapine available to pregnant women with HIV who give birth in the public sector, and to their babies, in public health facilities to which the respondents' present programme for the prevention of mother-to-child transmission of HIV has not yet been extended, where in the opinion of the attending medical practitioner, acting in consultation with the medical superintendent of the facility concerned, this is medically indicated, which shall at least include that the woman concerned has been appropriately tested and counselled.

3. It is declared that the respondents are under a duty forthwith to plan an effective comprehensive national programme to prevent or reduce the mother-to-child transmission of HIV, including the provision of voluntary counselling and testing, and where appropriate, Nevirapine or other appropriate medicine, and formula milk for feeding, which programme must provide for its progressive implementation to the whole of the Republic, and to implement it in a reasonable manner.

4. The respondents are ordered forthwith to plan an effective comprehensive national programme to prevent or reduce the mother-to-child transmission of HIV, including the provision of voluntary counselling and testing, and where appropriate, Nevirapine or other appropriate medicine, and formula milk for feeding, which programme must provide for its progressive implementation to the whole of the Republic, and to implement it in a reasonable manner."

A number of supporting provisions and a costs order against the government were added.

THE COURT

[9] Because of the importance and urgency of the matter, an early date was allocated for the hearing of government's appeal against the order of the High Court. This was followed by an unsuccessful interim application to this Court by government aimed at staying the High Court's order pending the determination of this appeal. At the commencement of the appeal hearing we dismissed a belated application for admission as an additional amicus curiae and an application by an amicus to adduce evidence. The High Court had also granted an application by the Premier of KwaZulu-Natal to be substituted for his MEC for Health and that substitution gave rise to both an appeal to this Court and an application to present further evidence. These were heard immediately after argument in the main proceedings had ended and both were refused at the time, the reasons to follow. Then, some days after the hearing, the Court addressed an enquiry to the parties which, instead of enlightenment, unfortunately elicited a great deal of contention and yet another application to adduce further evidence, dealt with below. This judgment focuses on the principal issues and these minor matters will be dealt with either in passing or in separate judgments.

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.

[12] Nevirapine had been registered in 1998 by the Medicines Control Council, a specialist body created by the Medicines and Related Substances Control Act 101 of 1965 to determine the safety of drugs before their being made available in South Africa. In terms of this Act registration of a drug by definition entails a positive finding as to its quality, safety and efficacy. In January 2001 the World Health Organization recommended the administration of the drug to mother and infant at the time of birth in order to combat HIV and between November 2000 and April 2001 the Medicines Control Council settled the wording of the package insert dealing with such use. The insert was formally approved by the Council in April 2001 and the parties treated that as the date of approval of the drug for the prevention of mother-to-child transmission of HIV.

[13] It was this date of approval that led to the Court's enquiry after the hearing and to the application to adduce further evidence relating to the date of the "registration"

of nevirapine for the prevention of mother-to-child transmission of HIV. At the time it appeared that this date might be relevant and that nevirapine may have been approved for the prevention of mother-to-child transmission earlier than April 2001. In the result, however, nothing turns on this. That being the case, further evidence directed to this issue is irrelevant. It follows that the application to adduce further evidence must be refused and no order be made in relation to the costs thereof.

[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.

[16] This point is also made in 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)* issued by government in April 2001:

> "There is however, a need to assess the operational challenges inherent in the introduction of anti-retroviral regimen for the reduction of vertical transmission in rural settings as well as in urban settings in South Africa. This is due in part because the introduction of ARV [antiretroviral] interventions needs to be accompanied by a series of other interventions such as the delivery of voluntary and confidential counseling and HIV testing, and revised obstetric practices and infant feeding practices. These require extensive capacity building, infrastructure development, improved management and community mobilization efforts. In order to gain better understanding of the operational challenges of introducing the intervention on a wider scale, MINMEC [a body consisting of the Minister of Health and the provincial MECs for Health] endorsed the establishment of two research sites in all nine Provinces for a period of two years."

[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. Some of the provinces had not yet established any test sites by the time the application was launched in late August 2001. The first sites were established only in May 2001 following a meeting the previous month at which government had endorsed the establishment of the sites for a period of two years. These sites were to be selected according to stated criteria, one in an urban and one in a rural community in each province. Whether the programme was to be maintained strictly until the last of the provincial test sites had been functioning for two years or could possibly be extended beyond that period does not appear from the papers. 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] The main response on behalf of government by Dr Ntsaluba and Dr Simelela is detailed and lengthy and raises numerous disputes, mostly as to emphasis, opinion or inference but occasionally also of fact. The reply on behalf of the applicants likewise raises many issues of one kind or another. Many of these disputes gave rise to a regrettable degree of animosity and disparagement, culminating in unsubstantiated and gratuitous allegations of untruthfulness being levelled at one of the attorneys on an insignificant side-issue. 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. Not only does it bedevil future relations between government and non-governmental agencies that will perforce have to join in combating the common enemy, but it could also have rendered the resolution of this case more difficult.

[21] Ultimately, however, we have found it possible to cut through the overlay of contention and arrive at a straightforward and unanimous conclusion. Most if not all

of the disputation is beside the point. The essential facts, as we see them, are not seriously in dispute.

[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.[6] 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.[7] It was stressed, however, that the obligations are subject to the qualifications expressed in sections 26(2) and 27(2). On the first occasion, in *Soobramoney*, the claim was dismissed because the applicant failed to

[6] *Soobramoney v Minister of Health, KwaZulu-Natal* 1998 (1) SA 765 (CC); 1997 (12) BCLR 1696 (CC); *Government of the Republic of South Africa and Others v Grootboom and Others* 2001 (1) SA 46 (CC); 2000 (11) BCLR 1169 (CC).

[7] *Soobramoney* above n 6 para 36; *Grootboom* above n 6 para 24 and 38.

establish that the state was in breach of its obligations under section 26 in so far as the provision of renal dialysis to chronically ill patients was concerned. In *Grootboom* the claim was upheld because the state's housing policy in the area of the Cape Metropolitan Council failed to make reasonable provision within available resources for people in that area who had no access to land and no roof over their heads and were living in intolerable conditions.

[24] In both cases the socio-economic rights, and the corresponding obligations of the state, were interpreted in their social and historical context.[8] The difficulty confronting the state in the light of our history in addressing issues concerned with the basic needs of people was stressed. Thus, in *Grootboom*, Yacoob J said:

> "This case shows the desperation of hundreds of thousands of people living in deplorable conditions throughout the country. The Constitution obliges the State to act positively to ameliorate these conditions. The obligation is to provide access to housing, health-care, sufficient food and water, and social security to those unable to support themselves and their dependants. The State must also foster conditions to enable citizens to gain access to land on an equitable basis. Those in need have a corresponding right to demand that this be done.
>
> I am conscious that it is an extremely difficult task for the State to meet these obligations in the conditions that prevail in our country. This is recognised by the Constitution which expressly provides that the State is not obliged to go beyond available resources or to realise these rights immediately. I stress however, that despite all these qualifications, these are rights, and the Constitution obliges the State

[8] *Soobramoney* above n 6 para 11; *Grootboom* above n 6 para 25.

> to give effect to them. This is an obligation that Courts can, and in appropriate circumstances, must enforce."[9]

[25] The question in the present case, therefore, is not whether socio-economic rights are justiciable. Clearly they are.[10] 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

---

9 Above n 6 para 93-4.

10 *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.

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'Ltre*. 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."[11]

[27] Support for this contention was sought in the language of the Constitution and attention was drawn to the differences between sections 9(2),[12] 24(b),[13] 25(5)[14] and 25(8)[15] on the one hand, and sections 26 and 27 on the other.

---

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

12 Section 9(2) provides:

> "Equality includes the full and equal enjoyment of all rights and freedoms. To promote the achievement of equality, legislative and other measures designed to protect or advance persons, or categories of persons, disadvantaged by unfair discrimination may be taken."

13 Section 24(b) provides that everyone has the right

> "to have the environment protected, for the benefit of present and future generations, through reasonable legislative and other measures that –
>
> (i) prevent pollution and ecological degradation;
> (ii) promote conservation; and
> (iii) secure ecologically sustainable development and use of natural resources while promoting justifiable economic and social development."

14 Section 25(5) provides:

> "The state must take reasonable legislative and other measures, within its available resources, to foster conditions which enable citizens to gain access to land on an equitable basis."

15 Section 25(8) provides:

> "No provision of this section may impede the state from taking legislative and other measures to achieve land, water and related reform, in order to redress the results of

[28] It was contended that section 25(5), which obliges the state to "take reasonable legislative and other measures, within its available resources" towards "access to land", imposes an obligation on the state, but is not associated with a self-standing right to have access to land. Section 24(b), on the other hand, confers on everyone a right "to have the environment protected . . . through reasonable legislative and other measures", but is not coupled with a separate duty on the state to take such measures. Sections 9(2) and 25(8) contain permissive powers to take reasonable measures but no obligation to do so. In the case of sections 26 and 27, however, rights and obligations are stated separately. There is accordingly a distinction between the self-standing rights 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.

---

past racial discrimination, provided that any departure from the provisions of this section is in accordance with the provisions of section 36(1)."

THE 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 which deals with health care services, including reproductive health care, sufficient food and water, and social security, including, if persons are unable to support themselves and their dependants, appropriate social assistance. Subsection (1) refers to the right everyone has to have "access" to these services; and subsection (2) obliges the state to take "reasonable legislative and other measures, within its available resources, to

achieve the progressive realisation of each of these rights". The rights requiring progressive realisation are those referred to in sections 27(1)(a), (b) and (c).

[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*."[16]

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*.[17] It is made clear in that judgment that sections 26(1) and 26(2) "are related and must be read together".[18] Yacoob J said:

> "The section has been carefully crafted. It contains three subsections. The first confers a general right of access to adequate housing. The second establishes and delimits the scope of the positive obligation imposed upon the State . . ."[19]

---

16 Above n 6 para 11 (emphasis added).

17 Above n 6 para 46.

18 Id para 34.

19 Id para 21.

It is also made clear that "[s]ection 26 does not expect more of the State than is achievable within its available resources"[20] and does not confer an entitlement to "claim shelter or housing immediately upon demand"[21] 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".[22]

[33] In *Grootboom* reliance was also placed on the provisions of the Covenant. Yacoob J held that in terms of our Constitution the question is

> "whether the measures taken by the State to realise the right afforded by s 26 are reasonable."[23]

[34] Although Yacoob J indicated that evidence in a particular case may show that there is a minimum core of a particular service that should be taken into account in determining whether measures adopted by the state are reasonable,[24] the socio-economic rights of the Constitution should not be construed as entitling everyone to demand that the minimum core be provided to them. Minimum core was thus treated

---

20 Id para 46.

21 Id para 95.

22 Id para 94.

23 Id para 33.

24 Id.

as possibly being relevant to reasonableness under section 26(2), and not as a self-standing right conferred on everyone under section 26(1).[25]

[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. In *Grootboom* the relevant context in which socio-economic rights need to be interpreted was said to be that

> "[m]illions of people are living in deplorable conditions and in great poverty. There is a high level of unemployment, inadequate social security, and many do not have access to clean water or to adequate health services. These conditions already existed when the Constitution was adopted . . ."[26]

[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

---

25 Id.

26 Id para 25, quoting from *Soobramoney* above n 6 para 8.

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".[27]

[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. As was said in *Soobramoney*:

> "The State has to manage its limited resources in order to address all these claims. There will be times when this requires it to adopt a holistic approach to the larger needs of society rather than to focus on the specific needs of particular individuals within society."[28]

[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

---

27 Id para 41.

28 Above n 6 para 31.

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. In particular, government adopted an *HIV/AIDS & STD strategic plan for South Africa 2000–2005*. This was followed by a number of HIV/AIDS-related policy guidelines that deal with various aspects of the strategic plan. These included guidelines on managing HIV in children, prevention of mother-to-child transmission and management of HIV-positive pregnant women, feeding of infants of HIV-positive mothers and testing for HIV. It is not necessary to refer in any detail to these documents and the policies embodied in them. Where particular matters are relevant, they will be referred to in the judgment.

Government policy was also the subject of discussion at the meetings of the Department of Health's National Steering Committee on Prevention of Mother-to-Child Transmission and at meetings of Minmec.

[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. This programme entailed the provision of voluntary HIV counselling and testing to pregnant women, the provision of nevirapine and the offer of formula feed to HIV-positive mothers who chose this option of feeding. The implementation of this programme was to be confined to selected sites in each province for a period of two years. As pointed out earlier, these pilot sites were to be used primarily to evaluate the use of nevirapine, monitoring and evaluating its impact on the health status of the children affected as well as the feasibility of such an intervention on a countrywide basis. Information gathered from these sites was to be used in developing a national policy for the extension of this programme to other public facilities outside the pilot sites. Nevirapine was not to be made available to public facilities outside the pilot sites.

[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 two questions are interrelated and a consequence of government's policy as it was when these proceedings were instituted. The use of nevirapine to reduce the risk of mother-to-child transmission of HIV was confined to mothers and newborn children at hospitals and clinics included in the research and training sites. At all other public hospitals and clinics the use of nevirapine for this purpose was not provided for. Public hospitals and clinics outside the research and training sites were not supplied with nevirapine for doctors to prescribe for the prevention of mother-to-child transmission. Only later would a decision be taken as to whether nevirapine and the rest of the package would be made available elsewhere in the health system. That decision would depend upon the results at the research and training sites. The applicants contend that this is 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.

THE COURT

[46] In *Grootboom*, relying on what is said in the *First Certification Judgment*,[29] 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 or impairing the right of access to adequate housing."[30]

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. He says:

---

[29] Above n 10 para 78:
> "At the very minimum, socio-economic rights can be negatively protected from improper invasion."

[30] Above n 6 para 34.

> "I admit that the medicine has been offered to the first to ninth respondents for free for a period of five years by the manufacturer. The driving cost for the provision of Nevirapine however is not the price to be attached to the medicine but the provision of the formula feeding for those persons who are not in a position to afford formula feeds in order to discourage breast feeding and other costs incurred to provide operational structures which are appropriately and properly geared toward counselling and testing persons who are candidates for the administration of Nevirapine."

He also says that

> "[t]he public health sector hospitals, as it is, are under tremendous pressure, and while it may be ideal for such doctors to go on to provide Nevirapine with the appropriate advice, counselling and follow-up care, is presently not immediately attainable. It is imperative that appropriate support structures for counselling, follow-up etc. be put in place to ensure that Nevirapine is effective and that it delivers the promised benefits."

[49] The costs that are of concern to the government are therefore the costs of providing the infrastructure for counselling and testing, of providing formula feed, 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.

THE COURT

[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 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. How this comes about requires some discussion.

THE COURT

[58] The challenge was first expressed in the Minister's letter of 6 August 2001 which precipitated these proceedings.[31] The first of a number of what the Minister called "[o]ur most pressing concerns" was put in the following terms:

> "There is evidence that NVP is effective in the prevention of intra-partum transmission. However, there is also evidence that a percentage of the babies who, as a result of the use of NVP, are born HIV negative, nevertheless sero-convert and become HIV positive in the months that follow their birth. For this reason, the registered claim for NVP in South Africa is not that it can prevent MTCT but that it can prevent intra-partum transmission.
>
> It appears from the data at hand that the most compelling reason for this sero-conversion is the fact that the HIV positive mothers were breast-feeding their babies."

The letter adds that

> "although we do not have the formal results [of a test reported a year before], we have reason to believe that breastfeeding continues to pose a risk which reverses the benefits of medical intervention."

Then, in the answering affidavit of Dr Ntsaluba, this doubt about the efficacy of intrapartum administration of nevirapine is repeated:

> "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

[31] See para 11 above.

> 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 the Minister in her letter and 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

THE COURT

[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.

[61] There is also cogent South African endorsement of the safety of nevirapine in general and specifically for the prevention of mother-to-child transmission. As indicated earlier, the Medicines Control Council registered nevirapine in 1998 (affirming its quality, safety and efficacy) and later expressly approved its administration to mother and infant at the time of birth in order to combat HIV. Although it recommends that if this is done the infant should be bottle-fed and not breastfed, that is to enhance the efficacy of nevirapine and not because it is considered to be dangerous. The risk to be guarded against is the transmission of HIV from mother to child through breastfeeding. That is a risk that exists whether nevirapine is administered or not. Far from being harmful, there is evidence that even with breastfeeding the risk of infection is materially reduced by administering nevirapine at birth.

[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. In any event, the research and training sites are intended primarily to train staff and to study the operational problems of the comprehensive prevention of mother-to-child transmission package. As to the research component at these sites, it is intended to focus on the efficacy of the treatment rather than its safety. There is no evidence to suggest that a single dose of nevirapine administered at birth is likely to harm children during the first two years of their lives. The risk of nevirapine causing harm to infants in the public health sector outside the research and training sites can be no greater than the risk that exists at such a site or where it is administered by medical practitioners in the private sector.

[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] In *Grootboom* this Court held that

> "[t]o be reasonable, measures cannot leave out of account the degree and extent of the denial of the right they endeavour to realise. Those whose needs are the most urgent and whose ability to enjoy all rights therefore is most in peril, must not be ignored by the measures aimed at achieving realisation of the right."[32]

[32] Above n 6 para 44.

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."[33]

[69] The applicants do not suggest that nevirapine should be administered indiscriminately to mothers and babies throughout the public sector. They accept that the drug should be administered only to mothers who are shown to be HIV-positive and that it should not be administered unless it is medically indicated and, where necessary, counselling is available to the mother to enable her to take an informed decision as to whether or not to accept the treatment recommended. Those conditions form part of the order made by the High Court.

---

[33] Id para 43.

THE COURT

[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.[34]

[71] The cost of nevirapine for preventing mother-to-child transmission is not an issue in the present proceedings. It is admittedly within the resources of the state. The relief claimed by the applicants on this aspect of the policy, and the order made by the High Court in that regard, contemplate that nevirapine will only be administered for the prevention of mother-to-child transmission at those hospitals and clinics where testing and counselling facilities are already in place. Therefore this aspect of the claim and the orders made will not attract any significant additional costs.

[72] In evaluating government's policy, regard must be had to the fact that this case is concerned with newborn babies whose lives might be saved by the administration of nevirapine to mother and child at the time of birth. The safety and efficacy of

[34] Id para 35-7.

nevirapine for this purpose have been established and the drug is being provided by government itself to mothers and babies at the pilot sites in every province.

[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.

Children's rights

[74] There is another consideration that is material. This case is concerned with newborn children. Sections 28(1)(b) and (c) of the Constitution provide that

> "[e]very child has the right –
>
> (a) . . . .
>
> (b) to family care or parental care, or to appropriate alternative care when removed from the family environment;
>
> (c) to basic nutrition, shelter, basic health care services and social services".

The applicants and the amici curiae relied on these provisions to support the order made by the High Court.

[75] In *Grootboom* it was held that paragraphs (b) and (c) must be read together.

THE COURT

> "They ensure that children are properly cared for by their parents or families, and that they receive appropriate alternative care in the absence of parental or family care. The section encapsulates the conception of the scope of care that children should receive in our society. Subsection 1*(b)* defines those responsible for giving care while ss 1*(c)* lists various aspects of the care entitlement.
> It follows from ss 1*(b)* that the Constitution contemplates that a child has the right to parental or family care in the first place, and the right to alternative appropriate care only where that is lacking."[35]

[76] Counsel for the government, relying on these passages in the *Grootboom* judgment, submitted that section 28(1)(c) imposes an obligation on the parents of the newborn child, and not the state, to provide the child with the required basic health care services.

[77] While the primary obligation to provide basic health care services no doubt rests on those parents who can afford to pay for such services, it was made clear in *Grootboom* that

> "[t]his does not mean . . . that the State incurs no obligation in relation to children who are being cared for by their parents or families."[36]

[78] The provision of a single dose of nevirapine to mother and child for the purpose of protecting the child against the transmission of HIV is, as far as the children are concerned, essential. Their needs are "most urgent" and their inability to

---

35 Id para 76-7.

36 Id para 78.

have access to nevirapine profoundly affects their ability to enjoy all rights to which they are entitled. Their rights are "most in peril" as a result of the policy that has been adopted and are most affected by a rigid and inflexible policy that excludes them from having access to nevirapine.

[79] The state is obliged to ensure that children are accorded the protection contemplated by section 28[37] that arises when the implementation of the right to parental or family care is lacking.[38] Here we are concerned with children born in public hospitals and clinics to mothers who are for the most part indigent and unable to gain access to private medical treatment which is beyond their means. They and their children are in the main dependent upon the state to make health care services available to them.

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

37 Id para 78.

38 Id para 77.

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.

[83] Because of the policy restricting the use of nevirapine, the counsellors at the hospitals and clinics outside the research and training sites have had no training in its use for the prevention of mother-to-child transmission of HIV. That, however, should not be a major concern. According to the *National programme for the prevention of*

mother to child transmission of HIV (MTCT): Trainer's guide, the total training time required to prepare counsellors for the mother-to-child transmission programme is 15 hours spread over 10 sessions of 1½ hours each. For counsellors who are already trained in the programme and merely need to be updated regarding the use of nevirapine, the time must be very much shorter.

[84] It is therefore important to know what facilities exist outside the research and training sites for testing and counselling. The applicants alleged in the founding affidavit that testing and counselling were not comprehensively available outside the research and training sites. This allegation was not substantiated by any direct evidence and most of the evidence was directed to government's policy concerning nevirapine, the central issue in the case. The allegation that there was no programme dealing with mother-to-child transmission outside the research and training sites was denied by Dr Ntsaluba. He referred to a number of policy documents which deal with this topic. These documents include the *HIV/AIDS & STD strategic plan for South Africa 2000–2005*. Various goals and strategies are set out in this plan. Strategies include introducing counselling services in all new testing sites, expanding the use of rapid testing methods, increasing the proportion of workplaces that have counselling services and promoting access to such services.

[85] Reference is also made to a policy document dealing with managing HIV in children. This document is dated March 2000 and includes a section on reducing mother-to-child transmission which deals with a number of interventions. These include voluntary counselling and HIV testing of pregnant women. It is stated that "all pregnant women should be offered counselling and an HIV test" and a detailed rationale is given.

[86] Another policy document dated May 2000 states explicitly that "[v]oluntary testing and counselling must be made available to *all* pregnant women" (emphasis added). It goes on to say that the benefits to a woman of knowing her HIV status include the ability to make informed choices about feeding options, earlier access to care for both mother and child, the opportunity to terminate pregnancy where desired and legal, and the ability to make informed decisions about sexual practices and future fertility.

[87] In August of the same year there was a further policy document dealing with the feeding of infants of HIV-positive mothers. It proceeds on the assumption that voluntary counselling and testing for HIV are necessary. In the same month policy guidelines for such testing were prescribed. It is made clear that testing cannot be carried out without informed consent, including pre-test counselling. It does not focus on where or to what extent counselling should be available, except to say that where a

health facility lacks the appropriate pre- or post-test counselling facilities, the patient should be referred to an agency or facility that can provide the counselling.

[88] In their replying affidavits the applicants do not seek to contradict these policy documents, but say that if correct they show latent capacity outside the research and training sites to prescribe nevirapine for prevention of mother-to-child transmission where it is medically indicated. They also introduce an affidavit by Professor Schneider to show that testing and counselling facilities, though not available throughout the public health sector, are in fact widely available at hospitals and clinics outside the research and training sites. Government does not dispute this but says that such counsellors are not trained in counselling for the use of nevirapine for the reduction of mother-to-child transmission.

[89] The affidavits by the heads of the provincial health departments deal with their budgets and the difficulties confronting them in expanding existing facilities for addressing mother-to-child transmission and in training counsellors. What is apparent from these affidavits is that some provinces had more extensive facilities for testing and counselling than others; also that at the time the proceedings commenced the budgets of most of the health departments were strained, and in many parts of the country there were problems in implementing health policies.

THE COURT

Testing and counselling

[90] The evidence shows that at the time of the commencement of these proceedings there was in place a comprehensive policy for testing and counselling of HIV-positive pregnant women. The policy was not, however, implemented uniformly. Professor Schneider's research is the only evidence on record concerning the extent of the testing and counselling facilities at fixed clinics[39] in the provinces. She refers to a number of studies – particularly two surveys conducted by the Health Systems Trust in 1998 and 2000. Her conclusions on the basis of these surveys were as follows:

Province	*Percentage of fixed clinics offering HIV testing*	*Percentage of fixed clinics offering HIV counselling*
Eastern Cape	44,0	91,2
Free State	87,5	96,0
Gauteng	100,0	92,9
KwaZulu-Natal	40,0	80,0
Mpumalanga	79,0	60,7
Northern Cape	100,0	91,7
Northern Province	14,6	68,8
North West	53,1	71,9
Western Cape	100,0	96,7

[39] Fixed clinics are contrasted with mobile clinics concerning which there are no statistics on the record.

It is not clear whether these statistics include facilities at public hospitals, or whether it is assumed that such facilities exist there and that what was being addressed was the extent of the facilities at places other than hospitals. The statistics are relevant in any event because a significant proportion of pregnant women are counselled at clinics and treated there. Indeed, over 84% of South African women deliver in the health system, that is, under the supervision of a health professional.

Formula-feeding

[1] Some of the policy documents also refer to the substitution of formula-feeding for breastfeeding without setting that as policy. The *HIV/AIDS policy guideline on prevention of mother-to-child HIV transmission and management of HIV positive pregnant women (May 2000)* states in its introduction that appropriate alternatives to breastfeeding should be made available and affordable for HIV-positive women. Professor Schneider's research shows that many hospitals and clinics have stocks of formula feed to be provided as a substitute for breastfeeding where appropriate. It is not clear, however, that a policy commitment is made to achieving this. In none of the policy documents is it said that government will actually provide the formula feed. The furthest that the policy on the provision of feeding substitutes seems to go is the statement in the *HIV/AIDS policy guideline on feeding of infants of HIV positive mothers (August 2000)* which indicates that the policy concerning the provision of breastmilk substitutes (such as infant formula feed) by the health care services needs

to be taken up by the provincial authorities and by any other relevant authority. The point is made here that the cost of providing breastmilk substitutes must also be compared with or offset by the savings in preventing newborn babies being infected with HIV and consequently needing care.

Summary of the relevant evidence

[2] To sum up, the position when the application was launched was this. Two research and training sites had been selected at hospitals in each province to use nevirapine for the prevention of mother-to-child transmission of HIV.[40] These research and training sites were linked to access points at satellite clinics. There were approximately 160 access points. (During the course of the proceedings these had increased to over 200.) At the project hospitals and satellite clinics a full package for the treatment of mother-to-child transmission was to be available. This included testing, counselling, nevirapine if medically indicated, the provision of formula feed as a substitute for breastfeeding, aftercare including the provision of vitamins and antibiotics, and monitoring of the progress of the children. At all other public hospitals and clinics nevirapine would not be available. There was, however, to be a programme for testing and counselling, including counselling on matters related to breastfeeding. Formula feed was available at some hospitals and clinics but it was not a requirement of the programme to combat mother-to-child transmission outside the

[40] The Western Cape adopted a programme for the progressive expansion of the supply of nevirapine for such use at its hospitals and clinics.

research and training sites that it be made available to HIV-positive mothers of newborn babies who would like to avoid breastfeeding but cannot afford the formula feed. Although the programme envisaged the progressive establishment of testing and counselling facilities at all hospitals and clinics, progress had been slow in certain parts of the country, particularly in clinics in the Northern Province, Mpumalanga, the Eastern Cape and KwaZulu-Natal. The bulk of the rural population lives in these provinces where millions of people are still without access to clean water or adequate sanitation.

Findings concerning government's programme

[3] 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."

[4] 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.

[5] 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

THE COURT

[6] 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.

[7] 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.

[8] 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.[41] All arms of government

[41] *Ferreira v Levin NO and Others; Vryenhoek and Others v Powell NO and Others* 1996 (1) SA 984 (CC); 1996 (1) BCLR 1 (CC) para 180 and 183; *South African Association of Personal Injury Lawyers v Heath and Others* 2001 (1) SA 883 (CC); 2001 (1) BCLR 77 (CC) para 46; *Soobramoney* above n 6 para 29; *Grootboom* above n 6 para 41; *Dawood and Another v Minister of Home Affairs and Others; Shalabi and Another v Minister of Home Affairs and Others; Thomas and Another v Minister of Home Affairs and Others* 2000 (3) SA 936 (CC); 2000 (8) BCLR 837 (CC) para 63-4; *National Coalition for Gay and Lesbian Equality and Others v Minister of Home Affairs and Others* 2000 (2) SA 1 (CC); 2000 (1) BCLR 39 (CC) para 66.

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.

[9] The primary duty of courts is to the Constitution and the law, "which they must apply impartially and without fear, favour or prejudice".[42] The Constitution requires the state to "respect, protect, promote, and fulfil the rights in the Bill of Rights".[43] 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,[44] 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

---

[42] Section 165(2) of the Constitution.

[43] Section 7(2).

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

several months. Also, in the case of *August*[45] 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.

[10] The rights that the state is obliged to "respect, protect, promote and fulfil" include the socio-economic rights in the Constitution. In *Grootboom* this Court stressed that in so far as socio-economic rights are concerned

> "[t]he State is required to take reasonable legislative *and* other measures. Legislative measures by themselves are not likely to constitute constitutional compliance. Mere legislation is not enough. The State is obliged to act to achieve the intended result, and the legislative measures will invariably have to be supported by appropriate, well-directed policies and programmes implemented by the Executive. These policies and programmes must be reasonable both in their conception and their implementation. The formulation of a programme is only the first stage in meeting the State's obligations. The programme must also be reasonably implemented. An otherwise reasonable programme that is not implemented reasonably will not constitute compliance with the State's obligations."[46]

[11] 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.

---

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

[46] Above n 6 para 42.

THE COURT

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".[47]

[12][In *Fose v Minister of Safety and Security*[48] this Court held that

> "[a]ppropriate relief will in essence be relief that is required to protect and enforce the Constitution. Depending on the circumstances of each particular case the relief may be a declaration of rights, an interdict, a *mandamus* or such other relief as may be required to ensure that the rights enshrined in the Constitution are protected and enforced. If it is necessary to do so, the courts may even have to fashion new remedies to secure the protection and enforcement of these all-important rights."[49]

The judgment (per Ackermann J) went on to state:

> "I have no doubt that this Court has a particular duty to ensure that, within the bounds of the Constitution, effective relief be granted for the infringement of any of the rights entrenched in it. In our context an appropriate remedy must mean an effective remedy, for without effective remedies for breach, the values underlying and the right entrenched in the Constitution cannot properly be upheld or enhanced. Particularly in a country where so few have the means to enforce their rights through the courts, it is essential that on those occasions when the legal process does establish that an infringement of an entrenched right has occurred, it be effectively vindicated. The

---

47 Section 172(1)(b).

48 1997 (3) SA 786 (CC); 1997 (7) BCLR 851 (CC).

49 Id para 19 (footnote omitted).

courts have a particular responsibility in this regard and are obliged to 'forge new tools' and shape innovative remedies, if needs be, to achieve this goal."[50]

[13] In *Mohamed v President of the RSA*,[51] this Court dealt with an argument similar to that addressed to us by counsel for the appellants, in these terms:

"Nor would it necessarily be out of place for there to be an appropriate order on the relevant organs of State in South Africa to do whatever may be within their power to remedy the wrong here done to Mohamed by their actions, or to ameliorate at best the consequential prejudice caused to him. To stigmatise such an order as a breach of the separation of State power as between the Executive and the Judiciary is to negate a foundational value of the Republic of South Africa, namely supremacy of the Constitution and the rule of law. The Bill of Rights, which we find to have been infringed, is binding on all organs of State and it is our constitutional duty to ensure that appropriate relief is afforded to those who have suffered infringement of their constitutional rights."[52]

[14] 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. In *Pretoria City Council v Walker*,[53] Langa DP said:

"[T]he respondent could, for instance, have applied to an appropriate court for a declaration of rights or a *mandamus* in order to vindicate the breach of his s 8 right.

---

50 Id para 69 (footnote omitted).

51 *Mohamed and Another v President of the Republic of South Africa and Others (Society for the Abolition of the Death Penalty in South Africa and Another Intervening)* 2001 (3) SA 893 (CC); 2001 (7) BCLR 685 (CC).

52 Id para 71 (footnotes omitted).

53 1998 (2) SA 363 (CC); 1998 (3) BCLR 257 (CC) para 96.

> By means of such an order the council could have been compelled to take appropriate steps as soon as possible to eliminate the unfair differentiation and to report back to the Court in question. The Court would then have been in a position to give such further ancillary orders or directions as might have been necessary to ensure the proper execution of its order."

[15] This Court has said on other occasions that it is also within the power of courts to make a mandatory order against an organ of state[54] and has done so itself. For instance, in the *Dawood* case, a mandamus was issued directing the Director-General of Home Affairs and immigration officials to exercise the discretion conferred upon them in a manner that took account of the constitutional rights involved.[55] In the *August* case a mandatory order, coupled with an injunction to submit a detailed plan for public scrutiny, was issued by this Court against an organ of state – the Electoral Commission.[56]

[16] 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

---

[54] *Sanderson v Attorney-General, Eastern Cape* 1998 (2) SA 38 (CC); 1997 (12) BCLR 1675 (CC) para 39; *New National Party of South Africa v Government of the Republic of South Africa and Others* 1999 (3) SA 191 (CC); 1999 (5) BCLR 489 (CC) para 46.

[55] Above n 41 para 67 and 70.

[56] Above n 45.

will provide guidance as to the appropriate relief in a particular case.[57] Where necessary this may include both the issuing of a mandamus and the exercise of supervisory jurisdiction.

[17][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]

---

[57] *Hoffmann* above n 1 para 45.

[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.

THE COURT

[18][Even a cursory perusal of the relevant Indian case law demonstrates a willingness on the part of the Indian courts to grant far-reaching remedial orders. Most striking in this regard is the decision in *M.C. Mehta v State of Tamil Nadu and Others*[60] where the Supreme Court granted a wide-ranging order concerning child labour that included highly detailed mandatory and structural injunctions.

[19] Although decisions of the German Federal Constitutional Court are mostly in the form of declaratory orders, the Court also has the power to prescribe for a temporary period which steps have to be taken in order to create a situation in conformity with the Basic Law.[61] The most far-reaching execution order was probably that made by the Court in the *Second Abortion Case*,[62] declaring several provisions of the Criminal Code unconstitutional and void and replacing them by a detailed interim law to remain in place until new legislation came into force.

[20] In Canada, it appears that both the supreme and the lower courts have the power to issue mandatory orders against organs of state.[63] Canadian courts have, however, tended to be relatively cautious in this regard. For example, in *Eldridge v*

---

60 [1996] 6 SCC 756.

61 This power is derived from Article 35 of the Federal Constitutional Court Act which reads:
> "In its decision the Federal Constitutional Court may state by whom it is to be executed; in individual instances it may also specify the method of execution."

62 *BVerfGE* 88, 208.

63 See for example, the Supreme Court's decision in *Reference re: Manitoba Language Rights* (1985) 19 DLR (4th) 1 and the decision of the High Court of Ontario in *Marchand v Simcoe County Board of Education et al* (1986) 29 DLR (4th) 596.

British Columbia (Attorney General),[64] the Supreme Court of Canada considered a declaration of unconstitutionality preferable to "some kind of injunctive relief" on the basis that "there are myriad options available to the government that may rectify the unconstitutionality of the current system". The Canadian courts have also tended to be wary of using the structural injunction.[65]

[21] In the United Kingdom, although injunctive relief may be granted against officers of the Crown, the House of Lords has held that this should only be done in the

> "most limited circumstances. In the majority of situations so far as final relief is concerned, a declaration will continue to be the appropriate remedy on an application for judicial review involving officers of the Crown. As has been the position in the past, the Crown can be relied upon to co-operate fully with such declarations."[66]

[22] What this brief survey makes clear is that in none of the jurisdictions surveyed is there any suggestion that the granting of injunctive relief breaches the separation of powers. The various courts adopt different attitudes to when such remedies should be granted, but all accept that within the separation of powers they have the power to

---

64 (1997) 151 DLR (4th) 577 (SCC) para 96.

65 See *Doucet-Boudreau v Nova Scotia (Department of Education)* (2001) 203 DLR (4th) 128 para 50 where the Nova Scotia Court of Appeal refused to exercise supervisory jurisdiction on the basis that there is no

> "history in this country . . . of occasions when the administrative or legislative branches of government have refused to comply with court ordered remedies under the *Charter*."

66 *In re M.* [1994] 1 AC 377 (HL) at 422-3. Where it would be more convenient to leave it to the applicant to return to court with a complaint that government's duties, as declared by the court, had not been complied with, it was considered preferable to give mere declaratory relief, rather than a mandamus. See for example *R. v Secretary of State for the Home Department, Ex parte Anderson* [1984] 1 QB 778 at 795.

make use of such remedies – particularly when the state's obligations are not performed diligently and without delay.

[23] 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.

[24] 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

[25] 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.

[26] 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.

[27] 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.

[28] 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. According to a statement by the provincial MEC for Health referred to by Dr Ntsaluba at the time of the interlocutory proceedings:

> "The proposal that we will table is that of a phased approach consisting of three phases, in which the current study is the first phase. . . .
>
> The second phase will be the provision of this service at all major hospitals in every district, in total 27 of them. This we believe will bring access of this service to the majority of the people of our province while at the same time ensuring that the programme is not interrupted and remains sustainable. We are targeting that all these must have commenced by August. . . . The remaining hospitals they will only be given attention by March 2003. . . . These hospitals will be given 6 months to work out whatever teething problems and settle in the programme before phasing the second phase, March 2003.
>
> The third phase to complete the roll out of the programme incorporating all institutions in the province and their feeder clinics, will also be approached in the same manner."

[29] 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.

[30] 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.

[31] 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.

[32] 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.

Transparency

[33] Three of the nine provinces[67] have publicly announced programmes to realise progressively the rights of pregnant women and their newborn babies to have access to nevirapine treatment. As for the rest, no programme has been disclosed by either the Minister or any of the other six MECs, this notwithstanding the pertinent request

[67] Western Cape, Gauteng and KwaZulu-Natal.

from the TAC in July 2001[68] and the subsequent lodging of hundreds of pages of affidavits and written legal argument. This is regrettable. 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 panoply of resources 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 patients. Indeed, for a public programme such as this to meet the constitutional requirement of reasonableness, its contents must be made known appropriately.

Relief

[34] What remains to be considered is whether it is appropriate in the circumstances of the present case to grant further relief. We have come to the conclusion that it is appropriate to do so, though in terms differing from the orders made by the High Court.

[35] It is essential that there be a concerted national effort to combat the HIV/AIDS pandemic. The government has committed itself to such an effort. We have held that its policy fails to meet constitutional standards because it excludes those who could reasonably be included where such treatment is medically indicated to combat mother-

[68] Quoted in para 11 above.

to-child transmission of HIV. That does not mean that everyone can immediately claim access to such treatment, although the ideal, as Dr Ntsaluba says, is to achieve that goal. Every effort must, however, be made to do so as soon as reasonably possible. The increases in the budget to which we have referred will facilitate this.

[36] We consider it important that all sectors of the community, in particular civil society, should co-operate in the steps taken to achieve this goal. In our view that will be facilitated by spelling out the steps necessary to comply with the Constitution.

[37] We will do this on the basis of the policy that government has adopted as the best means of combating mother-to-child transmission of HIV, which is to make use of nevirapine for this purpose. Government must retain the right to adapt the policy, consistent with its constitutional obligations, should it consider it appropriate to do so. The order that we make has regard to this.

[38] 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,[69] 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

[69] See conclusions and recommendations regarding infant feeding in the WHO Technical Consultation entitled *New data on the prevention of mother-to-child transmission of HIV and their policy implications* approved 15 January 2001.

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.

[39][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*[70] this Court recognised that courts have such powers. In appropriate cases they should exercise such a power if it is necessary to secure compliance with a court order. That may be because of a failure to heed declaratory orders or other relief granted by a court in a particular case. 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.

[40] The anxiety of the applicants to have the government move as expeditiously as possible in taking measures to reduce the transmission of HIV from mother to child is understandable. One is dealing here with a deadly disease. Once a drug that has the

[70] Above n 53 para 96.

potential to reduce mother-to-child transmission is available, it is desirable that it be made available without delay to those who urgently need it.

[41] We do not underestimate the nature and extent of the problem facing government in its fight to combat HIV/AIDS and, in particular, to reduce the transmission of HIV from mother to child. We also understand the need to exercise caution when dealing with a potent and a relatively unknown drug. But the nature of the problem is such that it demands urgent attention. Nevirapine is a potentially lifesaving drug. Its safety and efficacy have been established. There is a need to assess operational challenges for the best possible use of nevirapine on a comprehensive scale to reduce the risk of mother-to-child transmission of HIV. There is an additional need to monitor issues relevant to the safety and efficacy of and resistance to the use of nevirapine for this purpose. There is, however, also a pressing need to ensure that where possible loss of life is prevented in the meantime.

[42] 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, Gauteng and KwaZulu-Natal, programmes have been adopted to extend the supply of nevirapine for such purpose throughout the province. What now remains is for the other provinces to follow suit. The order that we make will facilitate this.

THE COURT

[43] It is necessary that the government programme, as supplemented to comply with the requirements of this judgment, be communicated to health caregivers in all public facilities and to the beneficiaries of the programme. Having regard to the nature of the problem, the steps that have to be taken to comply with the order that we make should be taken without delay.

Costs

[44] The applicants had an order of the High Court in their favour and they were entitled to defend that order in this Court. The issues raised in these proceedings are of considerable importance. The applicants have also been substantially successful in relation to those issues. The order that we make differs from that made by the High Court. Yet it addresses similar issues, albeit in different terms, and we do not consider the differences to be sufficient reason for depriving the applicants of their costs. These are to include the costs occasioned by the Court's enquiry after the conclusion of the argument, save for the costs of the application by government to adduce further evidence, which are to be borne by the respective parties.

Orders

[45] We accordingly make the following orders:

THE COURT

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

THE COURT

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.

5. The government must pay the applicants' costs, including the costs of two counsel.

6. The application by government to adduce further evidence is refused.

Chaskalson CJ Langa DCJ

Ackermann J Du Plessis AJ Goldstone J

THE COURT

Kriegler J

Madala JNgcobo J

O'Regan J

Sachs JSkweyiya AJ

THE COURT

THE COURT

For the Respondents:	GJ Marcus SC, B Majola, GM Budlender instructed by the Legal Resources Centre, Johannesburg
For the 1st and 2nd Amici Curiae:	W Trengove SC, N Bawa, A Dodson, K Pillay instructed by Owen Incorporated Attorneys, Cape Town and Mallinicks Attorneys, Cape Town
For the 3rd Amicus Curiae:	S Cowen instructed by the Wits Law Clinic, Johannesburg