The constitutional justification and the ethical arguments for granting enhanced HIV treatment for selected priority groups in South Africa’s antiretroviral treatment programme

VIVIAN BLACK*
COURTENAY SPRAGUE**
STU WOOLMAN***

1 Introduction – some are more equal than others

Napoleon and Snowball got it terribly wrong. Pigs, though certainly sharper than other barnyard animals, were no better placed to be the vanguard of their fellow creatures and to determine who, if anyone, deserved greater benefits from the policy. Why? None of God’s creatures per se could lay a greater claim to the legitimacy required to make such distinctions. That vision, after all, is what had originally led to the overthrow of man as ruler of the farm.

The South African government, with the assistance of the constitutional court, has finally started to get it right. Fine distinctions, legitimate forms of rationing and good faith efforts often justify the government’s distribution of greater amounts of certain basic socio-economic goods to specific classes of persons.

This paper is concerned with rationing, good faith efforts and making fine distinctions between the treatment of classes of persons with HIV in terms of the government’s new, enhanced 2010 HIV treatment policy. The question of moment, of course, is whether the fine discriminations (rationing and good faith efforts) reflected in the government’s newly revised antiretroviral treatment guidelines are constitutionally justifiable and ethically sound. We believe that they are. It follows that no constitutional challenge under section 9 or section 27 (or both) of the constitution ought to succeed and that no political challenge to these policies, in the near term, ought to cause the government to alter its current course.  

* Senior Clinical Manager, Department of Obstetrics and Gynaecology, University of the Witwatersrand.
** Associate Professor, University of the Witwatersrand, Graduate School of Business Administration.
*** Professor and Elizabeth Bradley Trust Chair of Ethics, Governance and Sustainable Development, University of the Witwatersrand.
1 Orwell Animal Farm (1946).
2 At this juncture, a casual reader might legitimately ask: “So what?” The answer lies, in large part, with the South African legal academy’s negative, reflexive response to virtually any policies that do not promise immediate, free, universal treatment to persons living with HIV. As academics and practitioners who work in this field, we believe it essential that state policies be challenged when unconstitutional, and lauded when they make a discernable difference in the lives of a South African public still very much in the grip of this pandemic.
2 The government's enhanced treatment guidelines for certain classes of persons living with HIV

Last year (on World AIDS Day), South Africa's president announced revised national guidelines for HIV treatment and prevention. The following classes of persons with HIV would qualify for enhanced antiretroviral therapy: (1) all pregnant women with a CD4 cell count at or below 350 cells/mm$^3$; (2) all individuals living with HIV and TB and a CD4 cell count at or below 350 cells/mm$^3$; (3) all children below the age of one regardless of CD4 count; (4) all children one to five years of age with a CD4 cell count below 25% or an absolute CD4 count of less than 750 cells/mm$^3$ or symptomatic (WHO Stage III or IV); (5) all children greater than five years of age with a CD4 cell count at or below 350 cells/mm$^3$ or symptomatic (WHO Stage III or IV) regardless of CD4 count; (6) persons with advanced HIV disease irrespective of CD4 cell count and (7) persons with multi or extensive drug resistant (MDR/XDR) TB regardless of CD4 cell count. This announcement constitutes a marked departure from pre-existing policy. From 2004 onwards, only individuals with AIDS-defining conditions or a CD4 cell count at or below 200 cells/mm$^3$ were eligible for the treatment.

The government's shift in policy is laudable and consistent with international best practice: in the same month, the World Health Organization (WHO) issued revised recommendations for the treatment in resource-limited settings. The defining feature of those revised guidelines is the initiation of the treatment when an individual's CD4 count falls to 350 or below (in contrast to 200). Both national policy and international recommendations are in line with the incontrovertible evidence that morbidity and mortality (illness and death) correlate with low CD4 cell counts: initiating the treatment for those persons living with HIV only after their CD4 cell counts have declined to 200 cells/mm$^3$ is often too late. Many individuals in low-resource settings who delay the treatment after their CD4 cell counts decline to 200 cells/mm$^3$ die during their first year on therapy. Put slightly differently, these individuals develop advanced HIV disease and die before they benefit from treatment. Similarly, recent studies indicate that the morbidity and the mortality of
people living with HIV can be significantly reduced by initiating the treatment at higher CD4 cell counts.\textsuperscript{10}

The public health benefits of initiating the treatment at the higher CD4 cell count ≤350 cells/mm\textsuperscript{3} are clear. They encompass the reduction of: (1) HIV-related mortality; (2) HIV-related morbidity; (3) new cases of HIV from both vertical and horizontal transmission; and (4) tuberculosis incidence. The individual health benefits of initiating the treatment at higher CD4 cell counts are equally apparent. They reflect a reduction in an individual’s risk of: (1) damage to the immune system; (2) end organ damage; (3) infection to partner; (4) morbidity; (5) mortality; and (6) vertical mother to child HIV transmission.

For South Africans, the expanded national HIV/AIDS treatment programme embodies a profoundly different (and far more positive) response to an entrenched public health epidemic. AIDS denialism married to claims that effective treatment is unaffordable has largely disappeared from public discourse. Given the increased numbers of South Africans living with HIV who will gain access to life-saving medications, the revised treatment policy and expanded treatment programme as a whole are important symbols of a commitment by the state to social justice and equity in health care.\textsuperscript{11}

3 Understanding rationing, fine distinctions, easy cases and good faith efforts in socio-economic rights analysis through the lens of the Khosa, Soobramoney, TAC, and Mazibuko cases

In assessing the constitutionality of the expanded treatment policy – its rationality in terms of section 9(1) of the constitution, its fairness in terms of the discrimination analysis undertaken in terms of section 9(3) and its reasonableness in terms of section 27 – we employ the Khosa, Soobramoney, TAC, and Mazibuko cases as framing devices. The Khosa case’s fine distinction between permanent residents and other non-citizens argues in favour of enhanced treatment and prevention for the classes of person identified above. In the Soobramoney case the court’s acknowledgment of limited public resources and the state’s obligation to make hard budgetary choices with respect to the distribution of goods in the public health system fits the distinction we make between those classes of persons who will receive the enhanced treatment now and those classes of persons who will not receive such treatment in the not too distant future. (The TAC case, on the other hand, reminds us that no such discriminations are justifiable where no issues of cost, of capacity or of efficacy arise.) The Mazibuko case, finally, reflects the court’s appreciation that good faith efforts by the state to discharge its responsibilities under section 27 will play an important role in meeting the desiderata for reasonableness established by the court in socio-economic rights cases.

\textsuperscript{10} When to Start Consortium “Timing of initiation of antiretroviral therapy in aids free HIV 1 infected patients: a collaborative analysis of 18 HIV cohort studies” 2009 Lancet 1352-1363.

3.1 The Khosa and other fine cases’ distinctions

The two sets of applicants, in separate matters heard in the high court, were Mozambican citizens who had acquired permanent residence status in South Africa almost two decades ago. Both cases mounted challenges to provisions of the Social Assistance Act 59 of 1992. In the first application, the permanent resident challenged section 3(c) of the act. Section 3 reserved social grants for aged South African citizens. In the second application, the permanent residents charged that sections 4(b)(ii) and 4B(b)(ii) of the act, as amended by the Welfare Laws Amendment Act 106 of 1997, were constitutionally infirm. Sections 4(b)(ii) and 4B(b)(ii) reserved child-support and care-dependency grants to South African citizens alone.

The court’s analysis proceeds along three discrete, though parallel, paths. First, the court asks whether, in fact, section 27 of the constitution grants a right of access to adequate social security to permanent residents and, if it does, whether that right has been violated by any or all of the above provisions. The court answers these questions in the following manner: (a) “Everyone” in section 27 clearly embraces citizen and non-citizen alike; (b) the right in section 27(1) has to be read in light of the internal limitations (read “reasonableness”) requirements of section 27(2); (c) the right to access to social security had to be read in light of the concomitant rights to equality and life. Of greater import for our analysis is a fourth observation made by the court. As Mokgoro J writes:

“What makes this case different to other [socio-economic rights] cases that have previously been considered by this Court is that, in addition to the rights to life and dignity, the social-security scheme put in place by the State to meet its obligations under s 27 of the Constitution raises the question of the prohibition of unfair discrimination. … It is also important to realise that even where the State may be able to justify not paying benefits to everyone who is entitled to those benefits under s 27 on the grounds that to do so would be unaffordable, the criteria upon which they choose to limit the payment of those benefits (in this case citizenship) must be consistent with the Bill of

---

12 Khosa v Minister of Social Development 2004 6 SA 505 (CC).
13 The shadow of the Grootboom case – and the basic framework it provides for the analysis of socio-economic rights cases – hangs over all such matters. That framework can be captured as follows: (1) Socio-economic rights do not, as a rule, embrace an individual entitlement to the immediate provision of any services or resources. (2) Socio-economic rights require the state to develop a systematic, comprehensive programme that is designed to realise these rights progressively within “available resources”. (3) Whether the state has discharged its duty to realise progressively any particular socio-economic right will be assessed in terms of the “reasonableness” of the programme concerned. (4) The reasonableness enquiry employed by the courts is not restricted to a closed list of criteria: the criteria, the courts have said, may vary depending upon the background of each matter. (5) Despite the absence of a closed list, courts are likely to consider several of the following criteria when assessing the state’s policy: the state (a) must ensure that “the appropriate financial and human resources are available”; (b) “must be capable of facilitating the realisation of the right”; (c) must be reasonable “both in its conception and its implementation”; (d) must be flexible; (e) must attend to “crises”; (f) must not exclude “a significant segment” of the affected population; and (g) must balance short, medium and long-term needs. Sprague and Woolman “Moral luck: exploiting South Africa’s policy environment to produce a sustainable national anti-retroviral treatment programme” 2006 SAJHR 337 355; Government of the Republic of South Africa v Grootboom 2001 1 SA 46 (CC). Recent judgments have added the requirement of “meaningful engagement” between the state and parties affected by a given policy to the kinds of criteria a court will employ when assessing the reasonableness of a programme designed to deliver, progressively, the material goods associated with a socio-economic right. Residents of Joe Slovo Community, Western Cape v Thubelisha Homes (Centre on Housing Rights and Evictions, Amici Curiae) 2010 3 SA 454 (CC) and Occupiers of 51 Olivia Road, Berea Township, and 197 Main Street, Johannesburg v City of Johannesburg 2008 3 SA 208 (CC).
14 Khosa case (n 12) par 36-44, and 46-47.
Rights as a whole. Thus if the means chosen by the Legislature to give effect to the State’s positive obligation under s 27 unreasonably limits other constitutional rights, that too must be taken into account.15

Second, the court, having opted not to analyse the matter in terms of section 27 alone,16 moved on to the question of whether the acts rationally or irrationally differentiate between citizens and non-citizens with respect to the distribution of social security benefits. The court states, quite appositely for our ultimate intent, that:

“It is necessary to differentiate between people and groups of people in society by classification in order for the State to allocate rights, duties, immunities, privileges, benefits or even disadvantages and to provide efficient and effective delivery of social services. However, those classifications must satisfy the constitutional requirement of ‘reasonableness’ in s 27(2). In this case, the State has chosen to differentiate between citizens and non-citizens. That differentiation, if it is to pass constitutional muster, must not be arbitrary or irrational nor must it manifest a naked preference. There must be a rational connection between that differentiating law and the legitimate government purpose it is designed to achieve. A differentiating law or action which does not meet these standards will be in violation of s 9(1) and s 27(2) of the Constitution.”17

The court then analyses the applicants’ history of entrance and permanent residence in South Africa against the backdrop of sections 9(1) and 27(1) of the constitution. The court concludes that since the constitution guarantees “everyone” access to social security in terms of section 9(1), and no rational basis exists for discriminating between citizen and permanent resident in terms of section 9(1), “the Constitution properly interpreted provides that a permanent resident need not be a citizen in order to qualify for access to social security”.18

Normally, one might think that conclusion sufficient to establish the unconstitutionality of the social security provisions found in the respective acts. However, as a bench that often likes to leave no argument unengaged, the court in the Khosa case then finds it necessary to ask whether the unconstitutional differentiation also amounts to unfair discrimination in terms of section 9(3) of the constitution. Although permanent residents are not a “specified group” – a classification that would have secured them somewhat more favourable analysis under sections 9(3) and 9(5) – the court identifies them as a vulnerable and historically disadvantaged class “analogous” to the classes enumerated in section 9(3). The acid question then: Does the distinction made between citizens and permanent residents constitute unfair discrimination? Given that permanent residents make identical contributions to the polity as citizens – save for the exercise of the franchise – and that they still remain (as these laws reflect) “outsiders” in terms of a variety of non-constitutional legal regimes, the court concludes that the impugned sections of the Social Assistance Act and the Welfare Laws Amendment Act constitute “unfair discrimination” on the grounds of “citizenship”. (The court then proceeds, as always, to state the

15 Khosa case (n 12) par 44-45.
16 Khosa case par 48-52.
17 Khosa case par 53 (emphasis added).
18 Khosa case par 56.
19 Khosa case par 58. The court also rejected the state’s argument that the burden of social security for permanent residents would prove deleterious to the state’s efforts to realise progressively the various socio-economic rights in the constitution. It did so largely because the state proffered no meaningful evidence that the costs imposed would undermine any state programme related to social security or any other socio-economic right.
}

Somewhat ironically, the constitutional court’s penchant for answering every possible question regarding the constitutionality of an act – even when one is enough – yields the greatest fruit for our subsequent analysis of the preferential treatment afforded some classes of persons living with HIV.\footnote{The authors should not, as some interlocutors have suggested, be read as suggesting that the court employs a maximalist approach with respect to rights analysis (and most certainly not with respect to socio-economic rights analysis). Indeed, one of the authors has offered a rather animated critique of the constitutional court’s preference for a minimalist mode of analysis. Woolman “The amazing, vanishing bill of rights” 2007 SALJ 762. We should be read instead as offering a far more trite observation: the constitutional court tends to duplicate arguments already made under one right, when analysing the same issue under another right, or to duplicate, in its limitations analysis, arguments already dispatched at the rights stage of analysis. This latter form of duplication often occurs in cases that engage s 9(3), 25, 26(2) and 27(2) of the constitution. For example, a finding that unfair discrimination has occurred under s 9(3) makes s 36 limitations analysis superfluous. Woolman and Botha (n 20).}

The court in the 
\textit{Khosa} case held:

“It may be reasonable to exclude from the legislative scheme workers who are citizens of other countries, visitors and illegal residents, who have only a tenuous link with this country. The position of permanent residents is, however, quite different to that of temporary or illegal residents. They reside legally in the country and may have done so for a considerable length of time. Like citizens, they have made South Africa their home. While citizens may leave the country indefinitely without forfeiting their citizenship, permanent residents are compelled to return to the country (except in certain circumstances) at least once every three years. While they do not have the rights tied to citizenship, such as political rights and the right to a South African passport, they are, for all other purposes mentioned above, in much the same position as citizens. Once admitted as permanent residents they can enter and leave the country. Their homes, and no doubt in most cases their families too, are in South Africa.”\footnote{\textit{Khosa} case (n 12) par 59.}

The most important sentence in the preceding paragraph is: “The position of permanent residents is, however, quite different to that of temporary or illegal residents.”\footnote{\textit{Khosa} case (n 12) par 59.}

Having identified permanent residents closely with citizens in terms of rights, responsibilities and duties, the court now goes on to distinguish them – to the benefit of permanent residents – from other classes of persons resident in South Africa. As we shall see, the court’s willingness to secure preferential treatment for one class of resident over other classes of persons living with HIV will resonate quite profoundly with our claim that some classes of persons living with HIV ought to receive preferential treatment over other classes of persons living with HIV – at least with respect to the government’s revised HIV policy for selected priority groups.\footnote{Liebenberg Socio-Economic Rights Adjudication under a Transformative Constitution (2010); McLean Constitutional Deference, Courts and Socio-Economic Rights in South Africa (2009); Mbazira Litigating Socio-Economic Rights in South Africa: A Choice between Corrective and Distributive Justice (2009); Bichlitz Poverty and Fundamental Rights (2006) and Liebenberg “The interpretation of socio-economic rights” in Woolman et al (n 20) ch 33. As we note at n 55 below, the authors are persuaded by Bichlitz’s critique of “reasonableness” and the need for a minimum core. However, given that this article does not claim to be an intervention regarding the appropriate test to be employed in socio-economic rights cases, we believe that the constitutional court’s extant doctrine is sufficient to justify our claims.}
3.2 The *Soobramoney* and *TAC* cases: rationing and easy cases

One might ask why we would use the *Khosa* case – a social security case – instead of relying upon such health care cases as the *Soobramoney* and *TAC* cases? Legal reasoning – unlike empirical justifications in the social sciences – relies heavily upon analogy, and even metaphor. Law is, in large part, a set of rhetorical devices designed to win cases or, more benignly, to serve a particular conception of justice. Any insistence that we locate our argument against the background of the *Soobramoney* and *TAC* cases seems overly hide-bound and formalistic. The critical analogies for our defence of the revised and enhanced treatment policy drawn from the *Khosa* case are two-fold: (a) citizens and permanent residents alike are entitled to social security benefits because of their commitment to the commonweal; (b) temporary residents and other persons here legally and illegally are not entitled (in this matter) to the receipt of social security benefits. The *Khosa* case is, as a result, a socio-economic rights case that turns on a distinction between classes of individuals – and thus fair and unfair discrimination. It does quite a bit of heavy lifting in another socio-economic rights matter that turns on a distinction between classes of individual – who benefits from the government’s expanded treatment programme. That “*Khosa* is relevant … in relation to rationality and unfair discrimination in terms of s 9,” is more than sufficient for the purposes of our argument. The analogy holds. Whether the finding is *ratio* or *dicta* seems to us beside the point. The *Khosa* case clearly identifies a particular group of non-citizens as entitled to the same social security benefits as citizens. At the same time it makes it clear that such benefits are not required, by the constitution, to be extended to other groups of non-citizens. Permanent residents have committed themselves to living in South Africa and upholding their civic duties: taxes, rates and services and forms of public service. Of course, it withholds further pronouncement on matters not before the court. If that’s not *ratio*, but mere *dictum*, then it’s still pretty much the whole kit and caboodle.

That said, constitutional lawyers, like all lawyers, prefer clear rules and algorithms: and better still, precedents that appear to be directly in point. And so when they are confronted with a health care policy, they want to know whether it will pass constitutional muster when analysed in terms of section 27 of the constitution’s right to access to adequate health care. The first constitutional court health care case directly in point is *Soobramoney v Minister of Health, KwaZulu-Natal*.

In the *Soobramoney* case, a 41-year-old man in the final, terminal stages of chronic renal failure was denied access by KwaZulu-Natal provincial health authorities to the renal dialysis treatment required to extend his life. He challenged the authority’s decision on the grounds that he was entitled, in terms of section 27(1)(a), to such care. The constitutional court rejected this claim (and others). The court in the *Soobramoney* case held that the obligations imposed on the state by section 27(1)(a) are contingent upon and subject to the resource constraints clearly identified in section 27. After noting that far more patients required renal dialysis than could be accommodated by the existing dialysis machines in the province, the court held that the KwaZulu-Natal health care guidelines were fair and rational. And in a portion

---

25 *Soobramoney v Minister of Health, KwaZulu-Natal* 1998 1 SA 765 (CC); *Minister of Health v Treatment Action Campaign No 2 2002 5 SA 721 (CC), 2002 10 BCLR 1023 (CC). For a critique of the *Soobramoney* case, see Moellendorf “Reasoning about resources: *Soobramoney* and the future of socio-economic rights claims” 1998 SAJHR 327. For apt observations on the *TAC* and *Grootboom* cases and socio-economic rights analysis generally, see Sunstein “Social and economic rights: lessons from South Africa” 2001 Constitutional Forum 123.

26 (n 25).
of their holding especially important to the policy at issue in this paper, the court in the *Soobramoney* case found that the guidelines benefitted the greatest number of patients possible. Such benefits, the court held, could be measured by the extent to which they saved or extended lives. Severe budgetary constraints meant that little overall benefit flowed to and from patients in the terminal stages of renal failure. Finally, the court contended that if all persons in terminal stages of renal failure were entitled to dialysis, the existing provincial renal dialysis programme would be unable to treat those persons for whom dialysis could provide the greatest benefit, would collapse and no one would receive its benefits. In a harbinger of socio-economic rights analysis to come, the court in the *Soobramoney* case held that “[t]here will be times when [limited state resources will] require [the state] to adopt an holistic approach [that gives priority] to the larger needs of society rather than to focus on the specific needs of particular individuals within society.”

The *Soobramoney* case was just such a case – and on the largely utilitarian grounds contemplated by section 27, the court found that the failure to provide renal dialysis to Mr Soobramoney did not represent a breach of the state’s obligations in terms of section 27(1)(a) of the constitution.

When we speak about fine distinctions, rationing and making hard choices between classes of persons, the *Soobramoney* case might appear to do some work. What looks like “reasonable realisation” of the right to access to adequate health care from one point of view – with increased treatment access – may appear to be “rationing” from another perspective. But that is word-play. Given that we are not talking about the court’s unwillingness to engage (minimally) a government department’s refusal to deploy scarce resources, but to make more and more resources available as time, money and capacity permit – and to make reasonable distinctions as it goes along – the *Soobramoney* case seems less likely to be dispositive or useful in any constitutional analysis of the government’s new, enhanced treatment policy.

The *TAC* case is a quintessentially easy case. It did not demand that the constitutional court make hard choices or fine distinctions between classes of persons. It raised no questions about rationing. The state had already committed itself to the use of nevirapine for pregnant women and infants. It had accepted, as policy, that it was safe and efficacious. Given that nevirapine had been made available to the state itself free of charge for five years, the state was hard pressed to show that it could not afford to administer the drug to all persons who required it. Indeed, the court in the *TAC* case rejected the proposition that finances, health system infrastructure, drug efficacy and drug safety in any way undermined the claimants’ rights under section 27(1)(a).

With respect to the “enhanced” policy under scrutiny in this paper, the government is expanding – of its own accord – the treatment to categories of persons living with HIV. It seems unlikely that a court will substitute the government and civil society’s well-considered judgments for one of its own. To put it differently, the expanded rollout – unlike the policies successfully challenged in the *TAC* case – is not likely to be one in which the government will be hung by its own petard.

27 *Soobramoney* case (n 25) par 31.
28 (n 25).
3.3 The Mazibuko case\(^{29}\) and good faith efforts

Though not a terribly popular case with progressive human rights advocates, the constitutional court’s rather recent decision in the Mazibuko case suggests how the bench will approach cases in which the state has been faced with hard choices and applied its mind to fine distinctions made by the state between classes of persons notionally entitled to a given socio-economic right.

The Mazibuko case raised, for the first time in fifteen years, the right of access to water under section 27(1) of the constitution. The Phiri community in Soweto challenged the constitutionality of a new water provision system supplied by the City of Johannesburg. In order to ensure payment for this service and to address substantial water losses in this area, Johannesburg adopted a water provision known as Operation Gcin’amanzi. The plan gave Phiri residents a choice between access to “the provision of a tap in the yard of a household that has a restricted water flow [of] only 6 kilolitres of water … monthly”\(^{30}\) or a prepayment meter [with] a set amount of free water per month and access to further water pre-paid by the resident. However, in terms of the second option, the pre-paid meter, the water supply is terminated when the pre-paid credits run out and is restored only at the beginning of the next month when the basic amount of free water would again be made available. The constitutional court found the City of Johannesburg’s plan constitutional. The primary grounds for this finding were that the municipality had consulted members of the community with regard to their individual and collective preferences and consistently explored new methods of water delivery that would discharge its constitutional duties (even as the litigation wound its way through the court system). In sum, what the 6,000-page record told the court in the Mazibuko case was that the City of Johannesburg had engaged in a good faith effort to provide water to its denizens and that such a good faith effort was sufficient to discharge its constitutional mandate.\(^{31}\)

4 Ethical arguments that buttress the constitutional justifications for initiating the treatment at a higher CD4 cell count in some (but not other) classes of persons

Given the obvious benefits that accrue to South African society and its denizens, one might have thought that the government would roll out the treatment to the entire HIV-positive population with a CD4 count $\leq 350$ cells/mm\(^3\). Unfortunately, the cost of such an expanded universal rollout currently exceeds the available resources in the South African health budget. The additional R3 billion allocated by the government for HIV/AIDS programmes in 2010 is still insufficient for an expanded universal rollout.\(^{32}\) Apart from budgetary constraints, two additional challenges hinder universal, free treatment provision for all persons with HIV in South Africa who qualify for the treatment at the higher CD4 cell count.

First, an already overwhelmed public health system could buckle under the strain of an increased burden of patient care. The number of staff currently dedicated to

---

\(^{29}\) Mazibuko v City of Johannesburg 2010 4 SA 1 (CC).

\(^{30}\) Mazibuko case (n 29) par 14.

\(^{31}\) For a rather scathing indictment of the court’s analysis, see Roithmayr “Lessons from Mazibuko: shifting from rights to commons” 2010 Constitutional Court Review 000.

HIV services across the country is, as things stand, inadequate.\textsuperscript{33} A more extensive rollout would require an increased number of health personnel to manage expanded levels of care. In some provinces, up to 50\% of doctor and nurse posts remain un-filled.\textsuperscript{34} The extant, fragile infrastructure required for an ongoing, uninterrupted supply of ARVs, increased virological monitoring, antibiotics and other medications will be hard pressed to meet even the new, more limited, distribution demands. Second, as a result of the operational constraints just adumbrated, individuals with CD4 cell counts of less than 200 cells/mm\textsuperscript{3} and people living with HIV with AIDS-defining conditions could be displaced by a wider (universal) rollout, and be unable to secure access to life-saving treatment (because the state currently lacks the necessary financial and human resources).\textsuperscript{35}

Thus far, this article has relied upon the constitutional court’s general approach to fine distinctions, rationing and good faith efforts in socio-economic rights cases to defend the new policy’s constitutionality. (Recall that the crisp question of law is why, as an interim measure, should the following classes of person living with HIV receive the enhanced treatment?: (1) all pregnant women with a CD4 cell count at or below 350 cells/mm\textsuperscript{3}; (2) all individuals living with HIV and TB and a CD4 cell count at or below 350 cells/mm\textsuperscript{3}; (3) all children below the age of one regardless of CD4 count; (4) all children one to five years of age with a CD4 cell count below 25\% or an absolute CD4 count of less than 750 cells/mm\textsuperscript{3} or symptomatic (WHO Stage III or IV); (5) all children greater than five years of age with a CD4 cell count at or below 350 cells/mm\textsuperscript{3} or symptomatic (WHO Stage III or IV) regardless of CD4 count;\textsuperscript{36} (6) persons with advanced HIV disease irrespective of CD4 cell count and (7) persons with multi- or extensive drug resistant (MDR/XDR) TB regardless of CD4 cell count.\textsuperscript{37}

But even if we were to state compellingly the justification for the enhanced treatment in terms of extant South African constitutional doctrine, giving priority to any group remains controversial when it comes to the distribution of benefits that so clearly determine health, development and survival outcomes. The proper constitutional response to the process of justification is to ensure that any policy determination employs a fair and a transparent process guided by well-articulated ethical


\textsuperscript{34} Health Systems Trust \textit{Health Link Data by District and Province} (2008) http://www.healthlink.org.za (12-06-2010).

\textsuperscript{35} “The problem with ‘displacement’ is that the initiation of all HIV positive individuals onto the treatment at a CD4 cell count of 200 would flood the system. This (alternative) policy risks displacing those persons who are more vulnerable and in more urgent need of treatment. Displacement is a critical concern. Our public health system is simply not equipped to handle the full demand that would be generated with universal treatment initiative at a CD4 cell count of 200.”


HIV is the leading cause of death in South African children and women of reproductive age. The role of gender in HIV transmission in women of reproductive age in South Africa warrants particular attention. A toxic mix of biological features and social factors contributes to increase the risk of HIV acquisition, morbidity and mortality in women of reproductive age. Biologically, women are more susceptible to the contraction of sexually transmitted infections (STIs), including HIV, due to the greater area of mucous membrane exposed during sex (especially for young women whose genital tracts are not fully developed), the larger quantity of fluids transferred from men to women during sex, and the higher viral content in male sexual fluids. Women are twice as likely to contract HIV as men after an episode of unprotected sex. UNAIDS Basic Facts about the AIDS Epidemic and Its Impact: UNAIDS Questions & Answers (2004); Johnson “Treatment for women and prevention for infants: can’t we do both?” http://www.thebody.com/content/news/art51962.html (10-06-2010); National Department of Health HIV & AIDS and STI Strategic Plan for South Africa: 2007-2011 (2007); WHO “Women and HIV/AIDS” (2008), http://www.who.int/%20gender/hiv_aids/en/ (15-06-2010); Dunkle, Jewkes, Brown, Gray, McIntyre and Harlow “Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa” 2004 Lancet 1415 and Sprague “Women’s health, HIV/AIDS and the workplace in South Africa” 2008 African Journal of AIDS Research 341. Structural factors, such as poverty, reliance on male partners for economic survival and lack of educational opportunities, all render women more vulnerable to HIV infection. Thus, a primary goal of the revised guidelines is to enable women to initiate the treatment for their own health, well-being and development (ideally through triple combination therapy). For more on cultural and social norms affecting South African women’s vulnerability to HIV, see Klugman “Sexual rights in Southern Africa: a Beijing discourse or a strategic necessity?” 2000 Health and Human Rights 132-159; Matthews “Reducing sexual risk behaviours: theory and research, successes and challenges” in Karim and Karim (eds) HIV/AIDS in South Africa (2005) 143-165 and Ackermann and de Klerk “Social factors that make South African women vulnerable to HIV infection” 2002 Health Care for Women International 163-172.


One could look further afield – and draw on such attempts to mediate Kantian deontological thought and Millian utilitarian analysis. See Rawls A Theory of Justice (1971); Sen Development as Freedom (1999) or Sen The Idea of Justice (2010). So Rawls’ location – “the difference principle” – could do some work here. Rawls (151) conceived of the difference principle as a mechanism that would require that social and economic inequalities – in democratic welfare states – would be re-arranged in such a manner that remunerative actions undertaken by the most well off would always “be of the greatest benefit to the least-advantaged members of society”. In other words, an unequal distribution is viewed as “just” when it maximises the benefit to those who are most vulnerable and possess the most miniscule distribution of welfare resources. Sen extends Rawls’ analysis by asking us to look harder at those persons within groups who, on the surface, appear to possess identical claims to being the worst-off. In terms of Sen’s version of capability theory, we might find that a particular individual deserves preferential treatment when it comes to the distribution of a particular good because her claim is more compelling in two different ways: (1) she is actually worse off than her apparent peers; and (2) she is more likely to be able to use the good distributed to her to pursue a “life worth valuing”.

The role of gender in HIV transmission in women of reproductive age in South Africa warrants particular attention. A toxic mix of biological features and social factors contributes to increase the risk of HIV acquisition, morbidity and mortality in women of reproductive age. Biologically, women are more susceptible to the contraction of sexually transmitted infections (STIs), including HIV, due to the greater area of mucous membrane exposed during sex (especially for young women whose genital tracts are not fully developed), the larger quantity of fluids transferred from men to women during sex, and the higher viral content in male sexual fluids. Women are twice as likely to contract HIV as men after an episode of unprotected sex. UNAIDS Basic Facts about the AIDS Epidemic and Its Impact: UNAIDS Questions & Answers (2004); Johnson “Treatment for women and prevention for infants: can’t we do both?” http://www.thebody.com/content/news/art51962.html (10-06-2010); National Department of Health HIV & AIDS and STI Strategic Plan for South Africa: 2007-2011 (2007); WHO “Women and HIV/AIDS” (2008), http://www.who.int/%20gender/hiv_aids/en/ (15-06-2010); Dunkle, Jewkes, Brown, Gray, McIntyre and Harlow “Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa” 2004 Lancet 1415 and Sprague “Women’s health, HIV/AIDS and the workplace in South Africa” 2008 African Journal of AIDS Research 341. Structural factors, such as poverty, reliance on male partners for economic survival and lack of educational opportunities, all render women more vulnerable to HIV infection. Thus, a primary goal of the revised guidelines is to enable women to initiate the treatment for their own health, well-being and development (ideally through triple combination therapy). For more on cultural and social norms affecting South African women’s vulnerability to HIV, see Klugman “Sexual rights in Southern Africa: a Beijing discourse or a strategic necessity?” 2000 Health and Human Rights 132-159; Matthews “Reducing sexual risk behaviours: theory and research, successes and challenges” in Karim and Karim (eds) HIV/AIDS in South Africa (2005) 143-165 and Ackermann and de Klerk “Social factors that make South African women vulnerable to HIV infection” 2002 Health Care for Women International 163-172.
reproductive age.\textsuperscript{41} Those women who die from HIV-related complications usually die shortly after delivery and from AIDS-related conditions.\textsuperscript{42} Maternal mortality in South Africa cannot be addressed unless pregnant women with HIV have access to and timely delivery of treatment. The equity argument, to the extent it is not made obvious above, is that pregnant women with HIV are at a far greater risk of dying – from both pregnancy and HIV – than non-pregnant women with HIV.\textsuperscript{43} That palpable difference justifies the greater access to the treatment that pregnant women with HIV receive under the new South African Department of Health guidelines.

What of other arguments from equity? Infants with HIV represent an extremely vulnerable class due to a high risk of mortality.\textsuperscript{44} Their lack of autonomy and their general inability to exercise their rights underpin the contention that they ought to receive preferential treatment and protection from HIV infection. Moreover, section 28 grants children the immediate realisation of the right to health and health care services. (This last point applies to all three classes of children identified in the guidelines.) Adults, on the other hand, are entitled only to the progressive realisation of that right in terms of section 27.

4.1.2 Utility

South Africa currently has the greatest number of cases of mother-to-child HIV transmission (MTCT) of any country.\textsuperscript{45} The vast majority of children living with HIV in South Africa acquire HIV as a result of MTCT during pregnancy, labour, delivery and breast feeding.\textsuperscript{46} The treatment of pregnant women with a CD4 cell count $\leq 350$ cells/mm$^3$ will reduce the risk of MTCT.\textsuperscript{47} Programmes to prevent mother to child HIV transmission (PMTCT) in Africa and elsewhere have demonstrated that simple, short-course, cost-effective combination treatment regimens can reduce the risk of transmission from mother to child to less than 2%.\textsuperscript{48} The virtual elimination


\textsuperscript{42} Black et al (n 41).

\textsuperscript{43} Pattinson “Presentation at the perinatal priorities conference” 10-13 March 2009 (South Africa).

\textsuperscript{44} Violari, Cotton, Gibb, Babiker, Steyn, Jean-Philippe and McIntyre (CHER Study Team) “Early antiretroviral therapy and mortality among HIV infected infants” 2008 New England Journal of Medicine 2233.

\textsuperscript{45} Chopra, Daviaud, Pattinson, Fonn and Lawn “Health in South Africa 2, saving the lives of South Africa’s mothers, babies and children: can the health system deliver?” 2009 Lancet 835-846.


\textsuperscript{47} Far too little attention in PMTCT has been given to the health of South African women and to the structural drivers of HIV transmission in women of reproductive age. HIV infection increases the risk of maternal death ten-fold and is now the leading cause of maternal death (38%). Pattinson “Presentation at child health priorities conference” 4-5 Dec 2008; South Africa Every Death Counts Writing Group “Every death counts: use of mortality audit data for decision making to save the lives of mothers, babies, and children in South Africa” 2008 Lancet 1294-1304; Rosenfield and Figgie “Where is the M in MTCT? The broader issues in mother-to-child transmission of HIV” 2001 American Journal of Public Health 703-704; McIntyre “Comment” 2009 Lancet 1141-1142; Rosenfield, Min and Freedman “Making motherhood safe in developing countries” 2007 New England Journal of Medicine 1391-1397.

of HIV infection in infants through MTCT can be achieved by employing cost-effective and uncomplicated regimens.\(^{49}\) So goes one line of argument from utility. Another utility argument supports prioritising pregnant women: not only will more infants be born HIV negative, they have a greater chance to remain HIV negative so long as their mothers receive the treatment. A final argument from utility is that women remain the foundation of family life in South Africa. The ability of children both to survive and to thrive is contingent upon healthy mothers.\(^{50}\) Treating HIV in pregnant women goes a long way towards ensuring that children are not orphaned (thus eliminating the attendant costs of orphaned children borne by the state and society).

4.2 Individuals with TB and HIV co-infection

Individuals with TB and HIV co-infection and a CD4 cell count at or below 350 cells/mm\(^3\) have a high mortality rate. Indeed, individuals living with HIV in South Africa die primarily of TB.\(^{51}\) As a group, they constitute the “worst-off”: that is, they are the class of persons living with HIV with the greatest need. However, a utilitarian justification supports this portion of the new guidelines. The presence of untreated and extreme, drug-resistant TB poses one of the greatest health threats to South Africa’s populace. The ability to treat, simultaneously, TB and HIV for a greater cohort of patients will likely result in the slower spread of TB (and HIV) to the general population. Enhanced treatment of individuals with TB and HIV co-infection is, then, an unalloyed public good.

A recent volume of *The Lancet* and the new WHO Recommendations substantiate this statement.\(^{52}\) Subsequent to the publication of the 2004 department of health guidelines, it became clear that an early start on the treatment can reduce the incidence of tuberculosis in people infected with HIV. The 2009 WHO recommendation to initiate the treatment at less than 350 CD4 cells/mm\(^3\) replaces the earlier recommended threshold of 200 cells/mm\(^3\) and addresses the urgency associated with TB and HIV co-infection.\(^{53}\)

The evidence base indicates that HIV-infected patients with TB co-infection are five to nine times more likely to die than their TB-uninfected counterparts. In addition, death due to TB, among those who are HIV infected, is linked to CD4 cell counts. The lower the CD4 cell count, the greater the risk of mortality. Several studies have shown a substantial decrease in mortality rates following the introduction of HA treatment among HIV-TB co-infected patients. TB accelerates the progres-


\(^{50}\) For research on the interconnections between gender inequality and maternal deprivation on the one hand, and, on the other, the health of children (of either sex) and of the adults that they ultimately become (again, of either sex), see Osmani and Sen “The hidden penalties of gender inequality: fetal origins of ill-health” 2003 Economics and Human Biology 105; Robinson, “The fetal origins of adult disease. No longer just a hypothesis and may be critically important in South Asia” 2001 British Medical Journal 322, 375. Osmani and Sen’s work indicates that women’s deprivation in terms of nutrition and healthcare undermines the overall welfare of society as a whole in the form of ill-health of their offspring – males and females alike – both as children and as adults.


\(^{52}\) Lawn, Wood, De Cock, Kranzer, Lewis and Churchyard “Antiretrovirals and isoniazid preventive therapy in the prevention of HIV-associated tuberculosis in settings with limited health-care resources” 2010 Lancet Infectious Diseases 489-498.

\(^{53}\) Editorial “The deadly synergy of HIV and tuberculosis” 2010 Lancet Infectious Diseases 441.
sion of HIV and makes patients susceptible to other opportunistic illnesses. Treating TB co-infected patients at a higher CD4 cell count will have a significant impact on HIV- and TB-associated morbidity and mortality.\textsuperscript{54}

The same line of reasoning applies to individuals living with multi- or extensive drug-resistant (MDR/XDR) TB regardless of CD4 cell count. They too would fall into the “worst-off” category. In addition, their treatment would benefit South African society as a whole by slowing the spread of (MDR/XDR) TB.

4.3 Persons with advanced HIV disease irrespective of CD4 cell count

Individuals with advanced HIV disease generally have an extremely high mortality rate. As a group, they – like both classes of individuals living with both HIV and TB mentioned above – fall into the class of persons living with HIV with the greatest need.

5 Conclusion

The government’s decision to give enhanced treatment to pregnant women, children and individuals with TB and HIV appears constitutionally (and ethically) justified – especially by reference to the sections 9 and 27 analytical framework set out by the constitutional court in the \textit{Khosa, Soobramoney, TAC and Mazibuko} cases.

As in the \textit{Khosa} case, the seven classes identified for enhanced, priority treatment seem to possess similarly compelling reasons for the enhanced treatment as those classes of persons who already receive the treatment. In other words, the seven classes are, quite obviously, analogous to the permanent residents in the \textit{Khosa} case. At the same time, the differentiation between the classes identified for enhanced treatment and other persons living with HIV looks a lot like the distinction made by the court in the \textit{Khosa} case between permanent residents and other resident non-citizens. As in the \textit{Soobramoney} case, the basis for not extending the enhanced treatment to all persons with HIV who might notionally benefit from enhanced treatment is both rational and reasonable. For reasons of limited resources and delivery capacity, other similarly situated groups should receive the treatment from the government when the public health care system has the requisite infrastructure and budget to handle the increased volume of patients. As in the \textit{Mazibuko} case, the government’s “meaningful engagement” or good faith efforts to construct the new policy with all interested actors suggests that it has done what it can – for now. However, as in the \textit{TAC} case, once the government has established that it has further resources, and the public health care system has the necessary capacity, the enhanced treatment programme should be extended to similarly situated groups.

That, at least to our collective understanding, is how matters look through the prism of the socio-economic rights doctrines articulated by the constitutional court. But neither the text of the constitution nor the cases decided by the court in terms of section 27 inevitably determine the outcomes in future matters as yet unheard. Moreover, the fluidity of the reasoning in socio-economic rights cases – the basis for

\textsuperscript{54} Mugusi, Mehta, Villamor, Urassa, Saathoff, Bosch and Fawzi “Factors associated with mortality in HIV-infected and uninfected patients with pulmonary tuberculosis” 2009 \textit{BMC Public Health} 409.
critique and reconstruction by a number of legal academics\textsuperscript{55} – suggests that anyone who argues on behalf of or against a particular programme must buttress their legal arguments with justifications from other domains. They can be moral, economic or political. The point, in short, is that the constitutional arguments only take us so far. And the court itself has been motivated in various cases by considerations that fall beyond extant doctrine.

This new enhanced treatment policy seems, as we noted in part 4 of this piece, to satisfy the desiderata of moral reasoning in terms of the two dominant strains of modern moral thought: equity and utility. First: the favoured party possesses characteristics that appear to entitle them to receipt of the same benefits as those parties who already receive the benefits (the argument from equity). Granting the favoured party the benefit in question redounds to the immediate benefit of society as a whole (the argument from utility). Second: many of the traditional “high-risk” groups identified for HIV treatment and prevention – prisoners, for example – would be less successful in employing arguments from equity in attempting to secure enhanced treatment. Similarly, employing utility arguments – for other traditionally high-risk groups – truck drivers, sex workers or injecting drug users – are also unlikely to convince a decision-maker that enhanced treatment would reap immediate profit for the commonweal.

Of course, the clear constitutionality of providing enhanced treatment for the selected priority groups ought not to prevent us from identifying new classes of persons with HIV who would likely benefit from enhanced treatment and prevention once the public health system has absorbed this new group of patients. Indeed, we would agree with SANAC’s initial proposal that, all things being equal and our

\textsuperscript{55} Bilchitz “Giving socio-economic rights teeth: the minimum core and its importance” 2001 \textit{SALJ} 484; Bilchitz “Towards a reasonable approach to the minimum core: laying the foundations for future socio-economic rights jurisprudence” 2003 \textit{SAJHR} 1 and Bilchitz “Health” in Woolman et al (n 20): “The Court’s ‘reasonableness approach’ has attracted a number of important academic critiques. The primary problem raised is that the vague notion of reasonableness fails to provide adequate content to socio-economic rights. … In sum, the Court has approached socio-economic rights cases by asserting that the test in terms of the Final Constitution is whether the measures adopted by the government are reasonable. This approach fails to integrate Final Constitution s 27(2) and 27(1); it focuses the entire enquiry on Final Constitution s 27(2) without providing a role for Final Constitution s 27(1). Yet, Final Constitution s 27(1) is, in fact, the primary statement of the right, and the Final Constitution directs us to evaluate the reasonableness of government policy in relation to an understanding of what the right in question demands of the State. … The distinctive role of rights, however, is not simply to draw attention to a failure in the justification of government policy. It is a particular type of failure that we are concerned with: a failure to address adequately certain vital interests. One of the main theoretical defects of [the reasonableness] approach to adjudicating socio-economic rights is the failure to place the fundamental interests of individuals at the centre of its enquiry. Instead, the Court has attempted to focus the enquiry on more abstract and procedural concerns that can tend to obscure the vulnerabilities of individuals. But it is difficult to find adequate reasons for including socio-economic rights in the Final Constitution without recognizing that they are designed to protect the fundamental interests of individuals in having access to such essential goods as housing, food, water and health care. Thus, the roots of the reasonableness approach do not clearly correlate with the intention behind including socio-economic rights in the Final Constitution” ch 54A, 55–19 to 55–22.
resources being greater, all persons living with HIV with CD4 cell counts ≤ 350 cells/mm³ ought to receive enhanced treatment. The government is not faced with a Hobson’s choice. However, its decisions do determine the health outcomes of millions of individuals. In defending the state’s choices for enhanced treatment and prevention, we have demonstrated that the seven classes in question reflect a mix of equality and utility considerations that separate them from other classes of persons with HIV with a CD4 cell count at or below 350 cells/mm³. That distinction – both rational and fair – does not mean that the state is not obliged to roll out enhanced treatment to other vulnerable groups as soon as physical infrastructure, human capacity and fiscal resources allow.

SAMEVATTING

DIE GRONDWETLIKE REGVERDIGING EN ETIESE ARGUMENT VIR DIE TOEKENNING VAN UITGEBREIDE ANTIRETROVIRALE BEHANDELING VIR GESELEKTEERDE GROEPE IN SUID-AFRIKA

Die Suid-Afrikaanse regering, met behulp van die konstitusionele hof, het deur middel van die omvattende hersiening van die nasionale HIV-beleid begin verseker dat alle Suid-Afrikaners wat HIV onder lede het, antiretrovirale behandeling (ARB) mag ontvang. Sommige Suid-Afrikaners sal egter die behandeling eerder as ander ontvang. Die implikasie hiervan is dat diegene wat sulke behandeling nie ontvang nie, mag sick word of selfs voortydig te sterwe kan kom. Daar bestaan stawende getuenis dat die lewensverwagting van pasiënte wat wel die behandeling ontvang in hul eerste jaar ‘n verlaging van hul CD4 setelling ervaar tot so laag as onder 200 selle/mm³. Die openbare en individuele gesondheidsvoordele wanneer die behandeling eerder kan begin, is ooglopend. Stawende getuenis dui daarop dat baie pasiënte wat behandeling uitstel tot nadat hul CD4-setelling onder 200 selle/mm³ gedaal het, binne die eerste jaar van behandeling sterf. Die outeurs sou graag aanvaar dat die staat ‘n belang sou hé om die behandeling beskikbaar te stel aan die totale bevolking wat met sodanige setelling moet leef. Ongelukkig is die koste verbonde aan ‘n algemene uitrol van die program oorweldigend en oorskry dit beide die kapasiteit van die openbare gesondheidsorg en die gesondheidsbegroting. Noukeurige onderlinge, verdedigbare vorms van rantsoenering en optrede in goeie trou mag die regering se verspreiding van meerdere sosio-ekonomiese goedere aan spesifieke groepe van die bevolking, regverdig.

In hierdie artikel behandel die outeurs die regverdiging van rantsoenering van uitgebreide behandeling aan identifiseerde voorkeur-groepe. Die grondwetlik-verantwoordbaarheid van hierdie hersiening berus op die rasionalisering daarvan ingevolge artikel 9(1) van die grondwet, die billikheid daarvan ingevolge die diskriminasie-analise wat op grond van artikel 9(2) van die grondwet gedoen is, en die verantwoordbaarheid daarvan ingevolge artikel 27 van die grondwet. Die Khosa, Soobramoney, TAC- en Mazibuko-sake dien as raamwerk vir sodanige standpunt. Die grondwetlike hof hanteer fynere onderskeiding, rantsoenering en goeie trou as pogings (in sosio-ekonomiese regte-aangeleenthede) deur die nuwe beleid te verdedig van ‘n hersiene HIV-beleid, naamlik die fundamentele etiese argument wat prioritisering ondersteun. Die outeurs oorweeg argumente van billikheid en utiliteit. Die outeurs kom tot die slotsom dat deur die kernvaag van die artikel te sentraliseer, naamlik ‘n onderzoek na die verduidelikings van die regering se onlangse hersiening van die HIV-riglyne aan die hand van ‘n beoordeling van die konstitusionele regverdigbaarheid en etiese gronde daarvan, ‘n antwoord moontlik is. Die gevolg hiervan is dat geen grondwetlike aanslag onder artikels 9 of 27 van die grondwet behoort te slaag nie en dat geen politieke aanvegting van hierdie beleid in die nabye toekoms redes hoeft te bied vir die regering om hierdie beleid te verander nie.

56 The HIV treatment literature – upon which the South African government and civil society have drawn in devising this policy – engages such pressing ethical issues as rationing, equity, and policy process. Daniels “How to achieve fair distribution of the treatments in 3 by 5: fair process and legitimacy in patient selection” WHO Background Paper for the Consultation on Equitable Access to Treatment and Care for HIV/AIDS (2004); Macklin “Ethics and equity in access to HIV treatment – 3 by 5 initiative” WHO Background Paper for the Consultation on Equitable Access to Treatment and Care for HIV/AIDS (2004).