# Taking responsibilities seriously: The role of the state in preventing transmission of HIV from mother to child[1]

JONATHAN M BERGER

*International Programme on Reproductive and Sexual Health Law, University of Toronto Faculty of Law*[2]

## 1 INTRODUCTION

Mother-to-child transmission of the Human Immunodeficiency Virus (HIV),[3] the primary source of HIV infection in young children, takes place during pregnancy, labour, delivery, or even after childbirth during breastfeeding. Where breastfeeding has not been used, about two-thirds of infections occur around the time of delivery, with the majority of the remaining infections occurring during the last two months of pregnancy. In populations where breastfeeding is the norm, it accounts for more than one-third of all transmissions.[4]

Significant developments have recently started to reverse the trend. Clinical trials in 1994 showed that the use of the antiretroviral drug zidovudine[5] reduces mother-to-child transmission of HIV (MTCT) by about two-thirds in the absence of breastfeeding. At an average cost of US $1000 per pregnancy, however, the intervention was considered to be too expensive for widespread use in developing countries. But in the absence of any medical intervention, there remains a 25 to 35 per cent probability that a child born to a woman with HIV in such countries will become infected. This is of particular concern in Africa where about 90 per cent of the five million infants infected with HIV since the beginning of the AIDS pandemic have been born.[6]

A clinical trial concluded in Thailand in February 1998 showed that the use of zidovudine given during the last weeks of pregnancy alone cuts the rate of MTCT during childbirth by half, at less than a tenth of the cost of

1 The author would like to thank Rebecca Cook and Cathi Albertyn for comments on earlier drafts of this paper.

2 *Editor's note: The author has since been appointed as researcher at the AIDS Law Project, Centre for Applied Legal Studies, University of Witwatersrand.*

3 Mother-to-child transmission is also known as perinatal or vertical transmission.

4 Joint United Nations Programme on HIV/AIDS (UNAIDS) Technical Update 2000.

5 Zidovudine is more commonly known as AZT.

6 Joint United Nations Programme on HIV/AIDS (UNAIDS) Technical Update 2000.

the longer course.[7] Subsequent trials in Africa – using antiretroviral drugs such as zidovudine and nevirapine – have also yielded encouraging results.[8] More recently, trials carried out in Johannesburg – the results of which were released to the public at the XIII International AIDS Conference held in Durban in July 2000 – indicate comparable results using very short courses of nevirapine alone, with the added benefit of substantially reduced drug costs and complexity of administration.[9]

The Joint United Nations Programme on HIV/AIDS (UNAIDS) recommends that MTCT preventative interventions (MTCTP programmes) constitute a base level of care for pregnant women with HIV and their children, recognising that the benefit of decreasing MTCT "greatly outweighs any theoretical concerns related to development of drug resistance."[10] Significantly, UNAIDS does not prescribe the regimen to be adopted, allowing for a choice to be made in the context of regional variations, particularly in respect of the availability and quality of antenatal care, affordability and concerns relating to practical implementation.[11]

With an estimated 4.7 million people – or approximately one-in-nine – people living with HIV/AIDS, South Africa faces a crisis.[12] In particular, almost a quarter of all pregnant women using public health facilities in 2000 are estimated to be living with HIV/AIDS.[13] Yet despite these chilling statistics and the overwhelming scientific evidence supporting the introduction of MTCTP programmes, South Africa has been slow to act. While no longer ignoring the UNAIDS recommendations,[14] the South African government has yet to commit itself to a fully-fledged national MTCTP programme, preferring instead to set up 18 "pilot" sites to investigate issues relating to breast-feeding and drug resistance.[15] Indeed, not only are these pilot programmes not seen as the first step in the phased implementation of a national programme, but they have yet to be properly implemented.[16]

This paper takes as its starting point two premises: first, preventative interventions substantially reduce MTCT; and second, without public

7 Because the women were also given safe alternatives to breast milk, MTCT in the study population was reduced to nine per cent (ibid).

8 Ibid.

9 Gray et al 2000. Both high costs and complex administration regimes had been seen as obstacles to the introduction of MTCT preventative interventions.

10 UNAIDS Press Release 2000.

11 Ibid. In addition to the use of antiretroviral drugs, prevention of MTCT is seen to require counselling, testing and various support services (ibid).

12 See South African Department of Health, *National HIV and Syphilis Sero-Prevalence Survey of women attending Public Antenatal Clinics in South Africa 2000* : para. 4.1.4.

13 24.5 per cent of all pregnant women using public health facilities in 2000 are estimated to be living with HIV/AIDS (ibid para 4.1.1).

14 On the day when the UNAIDS recommendations were released, the Minister of Health – Dr Manto Tshabalala-Msimang – was quoted as saying that "[t]here is a narrow view again that continues to associate prevention of mother to child transmission of HIV with the use of antiretrovirals only . . . We know there are other medical interventions . . . We know they [antiretrovirals] are toxic." – Reuters, "Govt sees scant role for key drugs in AIDS fight".

15 See "Minister M Tshabalala-Msimang at the UN's Special Session on HIV/AIDS."

16 See TAC Press Statement on Mother-to-Child Transmission.

sector intervention, access to MTCTP programmes remains impossible for the majority of pregnant women with HIV/AIDS in South Africa. Unlike much of the popular discourse on the topic, this paper focuses on the pregnant woman living with HIV/AIDS – on her rights and responsibilities – for at the heart of the matter is a woman's right to make choices concerning reproduction.[17]

A pregnant woman with HIV/AIDS will only be in a position to make an informed decision regarding her pregnancy if she has access to knowledge of her HIV status; information about the risks of MTCT and interventions to reduce such risks;[18] access to antiretroviral preventative interventions; access to formula feed; and information regarding abortion. Thus – at the very least – the introduction of MTCTP programmes will require pre- and post-HIV test counselling, HIV testing, counselling in respect of options regarding antiretroviral interventions, and information about and access to various feeding options.[19]

It is in the light of the proven efficacy of MTCTP programmes, the extent of the epidemic and the realisation that HIV/AIDS threatens to undermine our new democracy that this paper considers the extent to which the Constitution of the Republic of South Africa Act 108 of 1996 (the Constitution) obliges the state to take appropriate steps to reduce MTCT. To set the scene for the analysis, Part I of this paper examines the link between gender equality and reproductive choice, exploring the implications of the right to make choices concerning reproduction. Part II follows with an examination of whether the government is justified in refusing to commit resources to a fully-fledged MTCTP programme.

## 2 GENDER EQUALITY, REPRODUCTIVE CHOICE AND AIDS

Not only are women physiologically at greater risk of HIV transmission, but the social and economic inequality of their lives serves to increase their vulnerability to HIV infection.[20] Vulnerability, however, is largely dependent on the confluence between gender inequality and other factors such as race, class, religion and culture. The demographics of the South African epidemic highlight that risk of infection is highest amongst the more marginalised and vulnerable groups of women. Indeed, South Africans with HIV/AIDS "are not only more likely to be women; they are more likely to be poor, African women."[21]

This reality contrasts starkly with the vision set out in the Constitution, which proclaims South Africa to be a state founded on values such as human dignity, equality and non-sexism.[22] Underscored by the express

17 s12(2) of the Constitution.

18 This includes information about the risks of MTCT during breastfeeding, alternatives to breastfeeding, and mechanisms to reduce the dangers of MTCT should the pregnant woman be unable – for whatever reason – to use alternative feeding methods.

19 It is this minimum package of care that this paper considers to constitute a reasonable MTCTP programme.

20 Albertyn 2000: 1.

21 Ibid 3.

22 s1.

prohibition of unfair discrimination on grounds such as gender, sex, pregnancy and marital status, accompanied by the recognition that affirmative action measures "designed to protect or advance persons, or categories of persons, disadvantaged by unfair discrimination may be taken",[23] the commitment to a society based on values of human dignity and equality clearly sees the full and equal participation of women within all spheres of South African society as lying at the heart of the new constitutional order.[24]

Not only are particularly vulnerable groups of women more at risk of HIV infection, but they are also disproportionately affected by the epidemic.[25] Nowhere is this clearer than in relation to poor pregnant women with HIV. In many cases, early detection of a pregnant woman's positive HIV status will place her in the position where she is faced with the choice between terminating or continuing her pregnancy, with the knowledge that a continued pregnancy without access to MTCTP programmes carries with it a substantial chance of transmission of HIV to the new-born child. Given that South Africa has made a commitment to provide free health care for pregnant and breastfeeding women and for all children under five,[26] as well as having enacted legislation that in effect provides poor women with free abortion services,[27] without similar funding of MTCTP programmes, many poor women may effectively be coerced into deciding in favour of termination.

Yet it is the very lack of control over women's reproductive lives that prohibits their full and equal participation in society.[28] The real significance of the right to make freely informed decisions about when and how many children to have is that it frees women to make other choices,[29] allowing them to plan for the families for which they can provide, and to make informed choices regarding work and home commitments.[30] But without the means, reproductive freedom is of little benefit.[31] Quite clearly,

---

23 Subsections (2), (3) and (4), respectively, of s 9 of the Constitution.

24 For further discussion on gender equality in a South African context, see *President of the Republic of South Africa v Hugo* 1997 (4) SA 1 (CC) and *Harksen v Lane NO* 1998 (1) SA 300 (CC).

25 Albertyn 2000.

26 See Mandela 1994 . See also Fonn et al 1998b: 22 where the authors point out that access to such services is not uniform across the country. While access to services may not yet be a reality for many pregnant women, the right nevertheless exists in policy and in law, which cannot be said for MTCTP programmes.

27 See the Choice on Termination of Pregnancy Act 92 of 1996, particularly the preamble.

28 The crucial link between the full and equal participation of women in society and reproductive freedom finds expression in the plurality opinion in *Planned Parenthood of Southeastern Pennsylvania v Casey* (1992) 505 US 833, where O'Connor J observes that the "ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives." (Ibid. 856). Similarly, Maja Eriksson sees reproductive freedom as the "*sine qua non* for the attainment of any real equality between women and men." (Eriksson 2000: 166, emphasis in original). See also Benshoof 2000 and Kohm and Holmes 2000.

29 Eriksson 2000.

30 See West 1990.

31 Key to the right of reproductive freedom is the concept of reproductive health. For a detailed definition of reproductive health, see Beijing Declaration and the Platform for Action: Fourth World Conference on Women 1996: 58. See also Fathalla 1998: 1284-85; Eriksson 2000:167; and Packer 1996:14-15.

choice means much more than "the abstract ability to reach a decision in one's mind" – it includes "an uncoerced selection of one course of action over another and the ability to follow one's chosen course."[32]

Section 12(2)(a) of the Constitution guarantees a right "to make decisions regarding reproduction".[33] At a minimum, this prevents the state from taking any action that directly interferes with a woman's decision to undergo treatment aimed at the prevention of MTCT, such as prohibiting health care workers from carrying out the intervention. What remains less clear is whether the right prevents the state from implementing and funding certain reproductive health services (such as abortion) while simultaneously refusing to fund other services (such as MTCTP programmes). Nevertheless, while such coercive practices may indeed violate the right, what lies at the heart of the MTCTP debate is the ability to implement freely taken choices concerning reproduction, and the impact of a lack of means on informed decision-making.

The right to make choices concerning reproduction is actionable against a state founded on the values of "[h]uman dignity, the achievement of equality and the advancement of human rights and freedoms",[34] a state constitutionally obliged to "respect, protect, promote and fulfil the rights in the Bill of Rights",[35] and a state which has a further duty to "take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation [of] . . . the right to have access to health care services, including reproductive health care."[36] It is this web of mutually supporting rights that both informs and underpins the scope of the right in question and the corresponding obligations of the state to intervene.

In addition, South Africa is a signatory to and has ratified the Convention on the Elimination of All Forms of Discrimination Against Women (the Women's Convention).[37]

In particular, South Africa has committed itself to "take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning",[38] and

32 Roberts 1992: 309.

33 s12(2)(a).

34 s1(a).

35 s7(2).

36 s27, subsections (1) and (2).

37 South Africa ratified the Women's Convention – with effect from 14 January 1996 – on 15 December 1995. When interpreting the Bill of Rights, courts and tribunals are obliged in terms of section 39(1)(b) to 'consider international law'. In *Government of the Republic of South Africa v Grootboom* 2000 (1) SA 46 (CC), the Constitutional Court held that "[t]he relevant international law can be a guide to interpretation but the weight to be attached to any particular principle or rule of international law will vary. However, where the relevant principle of international law binds South Africa, it may be directly applicable" (ibid para 26). Quite clearly, even non-binding rules of international law are relevant to the interpretation process. See also *S v Makwanyane* 1995 (3) SA 391 (CC) para 35.

38 Article 12(1).

has made a further commitment to "ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, *granting free services where necessary*, as well as adequate nutrition during pregnancy and lactation."[39]

In giving content to such international obligations,[40] the Committee on the Elimination of Discrimination against Women (CEDAW) recognises "an obligation on state parties to take appropriate legislative, judicial, administrative, *budgetary*, economic and other measures to the maximum extent of their available resources *to ensure that women realise their rights to health care.*"[41] In addition, CEDAW sees the Women's Convention as expressly extending the obligations to include the means to be able to make decisions concerning reproduction.[42] Under international law, therefore, a right to make choices concerning reproduction gives rise to a corresponding duty on the part of the state to ensure that the right is realised.[43] On this argument, the South African state is quite clearly obliged to implement MTCTP programmes.

## 3 JUSTIFICATION ANALYSIS

The failure of government to ensure access to MTCTP programmes raises issues relating to the reasonable and equitable allocation of scarce resources within the health care sector. Read in the light of the right of access to health care services, the right to make choices concerning reproduction places an obligation on government to take all reasonable steps in ensuring that all pregnant women are in a position to exercise their reproductive rights. The issue to address, therefore, is whether a decision not to implement a comprehensive MTCTP programme can be considered as unreasonable, as lacking 'plausible justification.'[44]

Central to the justification analysis is that the lack of a comprehensive public sector MTCTP programme has a disproportionate impact on poor

39 Article 12(2) (emphasis added).

40 CEDAW *General Recommendation No. 24: Women and Health (Article 12)* 1999: chapter 1.

41 Ibid. para 17 (emphasis added).

42 Ibid. para 28. Such a finding is based on the recognition that Article 16(1)(e) of the Women's Convention "requires States parties to ensure that women have the same rights as men to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise those rights." (ibid.).

43 See also CESCR *General Comment No. 14: The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights* (2000). In its general comment dealing with the implementation of the right to the highest attainable standard of health in article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), the Committee on Economic, Social and Cultural Rights (CESCR) comes to similar conclusions regarding positive state obligations. While South Africa has yet to ratify the ICESCR, obligations arising under that covenant are nevertheless important to the interpretation of obligations arising under the Constitution (*Grootboom supra* note 37).

44 Mureinik 1993: 41. See also 1994: 32 where the author argues that the Bill of Rights is about "a culture of justification – a culture in which every exercise of power is expected to be justified; in which the leadership given by government rests on the cogency of the case offered in defence of its decisions".

black women with HIV, a severely stigmatised, vulnerable and marginalised group. This strikes at the heart of the new constitutional order which recognises that "[t]he very reason for establishing the new legal order, and for vesting the power of judicial review of all legislation in the courts, was to protect the rights of minorities and others who cannot protect their rights adequately through the democratic process."[45] Indeed, the Constitutional Court in *Makwanyane* expressly held that the protection of everyone's rights is reliant on a "willingness to protect the worst and the *weakest* amongst us".[46]

The justification analysis is a flexible process, taking numerous factors into consideration in assessing whether, on balance, government is justified in not implementing an MTCTP programme. These factors include the institutional capacity of the judiciary and judicial deference, the costs of implementing and sustaining a programme, the weakness of the existing health care system, the impact on existing health care services, the negative consequences of intervention, and a focus on high-technology and drugs. These will now be considered in turn.

## 3.1 Institutional capacity of the judiciary and judicial deference

Traditionally, courts in common law jurisdictions have been reluctant to interfere with what they perceive to be the province of the legislative branch of government. For example, in dismissing an appeal to overturn a health authority decision not to fund a certain treatment for leukaemia, the British Court of Appeal held that "[d]ifficult and agonising judgments have to be made as to how a limited budget is best allocated to the maximum advantage of the maximum number of patients. That is not a judgment which the court can make."[47] Similarly, the Nova Scotia Court of Appeal held that its "role is limited to requiring that those who make and administer the policy follow their own rules", finding that "Charter considerations aside, as long as their decisions are reached in good faith and are not shown to be clearly wrong, we have no power to overturn them."[48]

While acknowledging that decisions regarding public spending are rightly to be made by those better placed than courts to make such decisions,[49] the Constitution does not allow for as deferential an approach as

45 *Makwanyane* (note 36 above) para 88 (emphasis added).

46 Ibid.

47 *Ex Parte B* [1995] 2 All ER 129 (CA) 137.

48 *Cameron v Nova Scotia (Attorney General)* (1999) 177 DLR (4th) 611, para 100. Stradiotto and Boudreau 2000: 44 argue that "[c]ourts will defer ... to the opinion of provincial governments in allocating health resources if the discrimination is ... rationally connected to the objective of providing universal health care coverage within limited resources and minimally impairs Charter rights. Indeed, this is how they make sense of *Cameron*.

49 What must be remembered is that many budgetary decisions are not the result of lively debates in Parliament, with rational, elected officials agonising over difficult choices. Indeed, it remains unclear the extent to which (if any) democratic processes had an impact on the 'decision' not to implement fully-fledged interventions. In this regard, see Porter 1999:76, where the author describes the history leading up to the landmark *Eldridge v British Columbia (Attorney General)* [1997] 3 SCR 624 decision as "a familiar

*[continued on next page]*

followed by other jurisdictions. While this paper does not advance the argument that courts should intervene in policy-making, it is nevertheless based on the premise that the Constitution grants to courts the power to review the reasonableness of budgetary decisions taken. Indeed, Yacoob J held in *Grootboom* that a "reasonable programme . . . must clearly allocate responsibilities and tasks to the different spheres of government and *ensure that the appropriate financial and human resources are available.*"[50]

In essence, such review is not about making an order that has budgetary implications, but rather about making an order 'about how to spend.'[51]

## 3.2 Costs of implementing and sustaining a programme

The implementation of a public sector MTCTP programme would involve the commitment of substantial resources, estimated at 0.5 percent of South Africa's annual health care budget.[52] A number of factors, however, mitigate the seemingly high costs of intervention.[53] First, the antiretroviral drug nevirapine has been donated to all developing countries for use in the prevention of MTCT for a period of five years.[54] Second, the costs of implementation include costs that would serve to improve the health care system as a whole (and the fight against HIV/AIDS in particular), including better distribution procedures for dispensing drugs and improved counselling and HIV testing services. Third, the cost effectiveness of a short-course antiretroviral intervention would rival most other public health interventions currently funded by the Department of Health.[55] Finally, the implementation of MTCTP programmes may actually save money,[56] given the high costs of treating children born with HIV under the already existing programme of providing free care to those children under five in need of such care.[57]

The real issue, as Benatar points out, is not the costs of the intervention in the long term, but rather the need to expend scarce resources

---

story of government officials showing little understanding of, or inclination to attend to the needs of, a disadvantaged minority". In fact, Porter points out, "[t]he issue never reached the floor of the legislature" (ibid). In *Eldridge*, the Supreme Court of Canada held that a failure of the British Columbia health insurance plan to cover sign language translation services violated the right to equality.

50 *Grootboom* (above note 37) para 39 (footnotes omitted and emphasis added).

51 See Mureinik 1992: 466 (emphasis added).

52 Söderlund et al 1999.

53 This is not to argue that but for the mitigating factors, the high costs would justify non-intervention. Such a scenario does not exist and therefore lies outside the scope of this paper.

54 News Centre, 28 November 2000.

55 Söderlund, G Gray and K Zwi 1998.

56 See *e.g.* Elliot Marseille et al 'Cost effectiveness of single-dose nevirapine regimen for mothers and babies to decrease vertical HIV-1 transmission in sub-Saharan Africa' *The Lancet* 354:9181 (4 September 1999) 803; Söderlund et al 1999; Skordis and Nattrass 2001.

57 Benatar 1999: 213 notes that there is a 91 percent mortality rate by the age of eight years for children infected during childbirth or infancy. See also iClinic article reporting that almost 90 percent of HIV-infected children in Africa fail to survive until their third birthday.

immediately.[58] His argument that the intervention "could save money that may be spent in the future on HIV positive children"[59], however, seems to imply some future uncertain date. The reality is that these costs cannot be considered as belonging to the future: children born with HIV today will very soon start to require health services not required by uninfected children. It would thus be very difficult for government to show that it cannot afford to make the required investment in the health care system at present when the same government has committed itself to providing health care services for children under five.

## 3.3 Weakness of the existing health care system

Apartheid's legacy includes a public health system characterised by 'disorganised and fragmented services' and low morale among health care workers.[60] Since 1994, however, substantial progress has been made. South Africa has moved towards a district-based primary health care system, with an understanding that comprehensive services – including reproductive health care services – are to be made available at the primary health care level. However, while official policy may tell one story, reality on the ground very often means something else – access to health care services is not uniform across the country, and there seems to be little clarity regarding which services (and the manner in which such services) are to be provided.[61]

Nevertheless, it would be misleading to argue that the primary health care infrastructure, crucial to the implementation of any MTCTP programme, is at such a level as to prevent the implementation of programmes at all.[62] Similar problems confronted the Department of Health when it was faced with the implementation of the Choice on Termination of Pregnancy Act.[63] Assented to by former President Mandela on 22 November 1996, the Choice on Termination of Pregnancy Act came into force shortly thereafter on 1 February 1997.[64] If the health care system were at such a level to justify the non-implementation of MTCTP programmes, one would have expected that the Choice on Termination of Pregnancy Act could not have been implemented with such haste.[65] A weak health care system may necessitate phased implementation of new programmes, but cannot be used as an excuse to delay making a firm commitment to the full implementation of MTCTP programmes. If a weak

58 Benatar 1999: 215.
59 Ibid.
60 Fonn et al 1998.
61 Ibid. 22 – 23.
62 McIntyre 1998: 138 argues that "the short-course regimens, if effective, are feasible in [South Africa's] health service."
63 Above note 27.
64 *Government Gazette* GN R8 of 22 January 1997.
65 For an analysis of the Choice on Termination of Pregnancy Act's implementation, see Fonn et al 1998a; Fonn and Varkey 1999. In both articles, despite the obstacles to implementation and non-uniform access, it is shown that a significant degree of implementation has nevertheless been achieved.

system were to serve as justification in this instance, there is nothing stopping government from invoking the same excuse in relation to the provision of any new service, particularly in under-serviced rural areas.[66]

## 3.4 Impact on existing health care services

Implicit in the judicial review of budgetary allocations is that a court's decision may directly result in the reallocation of resources, potentially resulting in the termination of some services. With such an understanding, Benatar argues that the implementation of new health care initiatives – such as MTCTP programmes – would have the effect of the diversion of resources "either on an ongoing basis from tertiary services, with all the implications this has for health care and health care education in the country, or by delaying the development of the highly desired primary care services".[67]

While it is hard to believe that the only source for these additional funds required in the short term[68] would be at the expense of such programmes, this attempt to preserve the *status quo* provides no justification for the continued entrenchment of unjust and inequitable distribution and allocation of resources. Indeed, even if Benatar were correct, given the emergency of the AIDS epidemic and the nature and importance of the rights at stake, it is difficult to see what type of programme would justify interfering with existing allocations of resources if MTCTP programmes did not qualify. If Benatar is correct, the implications of his argument would be to prevent government from introducing *any* new programme in the absence of an increased health budget.

## 3.5 Negative consequences of intervention

Benatar raises two concerns relating to the consequences of MTCTP programmes: the long-term survival of orphans and the impact on the pregnant women undergoing the 'treatment'.[69] First, while he is correct to raise concerns regarding the lack of treatment afforded pregnant woman with HIV, such legitimate concerns cannot be used as an excuse to make decisions on their behalf. Rather, the concerns highlight the importance of providing access to treatment for all people with HIV/AIDS. Second, as mentioned above, UNAIDS recommends that the benefit of decreasing MTCT "greatly outweighs any theoretical concerns related to development of drug resistance."[70] Third, the prognosis for children with HIV is so bad that unless and until medical evidence is forthcoming showing that the

66 It is also interesting to note that concerns about infrastructure, as a justification for non-intervention, are only being made in relation to HIV/AIDS and antiretroviral drugs – similar arguments are not advanced in respect of other primary health care interventions.

67 Benatar 1999: 215.

68 Until the savings generated from reductions in health care expenditure on children under five materialise.

69 Benatar 1999: 216.

70 UNAIDS (above note 4).

interventions are indeed harmful to children, there is no justification for delay on the basis that something worse, as yet unknown and unclear, is being guarded against.[71] This is pure speculation, not grounded in sound medical evidence.

## 3.6 High-technology and a focus on drugs

Benatar raises concerns about the scepticism of a 'high-technology approach' to HIV/AIDS.[72] While his analysis may serve to explain certain government actions, it does not serve to justify such action (or inaction, as the case may be). His concern about "an intensely biomedical approach deflect[ing] attention from broader considerations affecting health", is indeed worrying.[73]

First, his concern seems to suggest that only basic public health interventions are workable in a developing world context. The continued characterisation of the developing world as a context hostile to the implementation of the benefits of medical advances only serves to perpetuate misconceptions and negative stereotypes, which hardly provides any impetus to strengthen and improve health care systems. While the obstacles to implementation may indeed be greater in developing countries, there is no evidence to suggest that biomedical approaches adopted in the industrialised world cannot work in the developing world, either with or without adaptation. If any good is to come from the AIDS pandemic, it is perhaps that it will force the rapid reform and development of health care systems in the developing world so as to be able to take advantage of scientific progress.

Second, Benatar's concern mischaracterises the debate: the implementation of MTCTP programmes is not premised on the belief that drugs are a panacea for all evils, but rather that they may effectively be used in stimulating people's agency in combating the epidemic. Where drugs are shown to be both affordable and efficacious, particularly in a context wherein very little else has been shown to be effective, there is no good reason to stall their use. The implementation of MTCTP programmes need not be at the expense of other public health initiatives. Indeed, experience has shown that there is a strong link between the implementation of such programmes and broader efforts to stem the rising tide.[74]

---

71 Mofenson 2000 argues that "[g]iven the fatal nature of HIV infection, any long-term risk entailed by the in utero or neonatal exposure of children to antiretroviral drugs would have to be profound, occur early in life, and occur in a substantial proportion of those exposed in order to outweigh the proven benefit of antiretroviral prophylaxis in reducing perinatal transmission of HIV", finding that "the risk of potential toxic effects is clearly outweighed by the benefit of reducing perinatal transmission ... by 40 to 50 percent with short-course antiretroviral interventions."

72 Benatar 1999: 216-17. Benatar raises concerns about the motives of the drug industry in poor countries and the "regrettably common theft of drugs in developing countries" (ibid). The latter concern, verging on the racist, cannot honestly be entertained – the former concern, while valid, cannot and should not be used as an excuse not to use those drugs which are affordable, safe and efficacious.

73 Ibid.

74 See *e.g.* Goemaere 2000. Goemaere chronicles the positive impact of the provincial MTCT programme in the Cape Town township Khayelitsha: increased voluntary HIV

*[continued on next page]*

## 4 CONCLUSION

This paper has shown that the benefits of MTCTP programmes clearly outweigh any possible negative effects. In addition, such programmes are cost-effective (if not cost-saving), efficacious, bolster efforts to contain the spread of HIV not only between mother and child but also in the community at large, and help to make improvements in a health care system sorely needed for all health care interventions. Given the stakes at hand, the rights that continued non-intervention limit and the lack of justification for limiting such rights, the continued failure of the South African government fully to implement MTCTP programmes unjustifiably limits the right to make choices concerning reproduction.

The full implementation of MTCTP programmes in South Africa – whether immediate or phased – may very well provide the impetus needed to turn the tide against the epidemic, to allow for hope to return, for 'ignorance, fear and hatred . . . to subside.'[75] Rather than being seen as a diversion of limited resources, it should properly be characterised as a key pin in a holistic rights-based approach to the epidemic. In addition to the lives that such interventions will improve and save, the implementation of MTCTP programmes will also serve as a symbol of government's *bona fides* in taking its responsibilities seriously.

### Sources

"Govt sees scant role for key drugs in AIDS fight" *Reuters* (25 October 2000) available at http://www.iclinic.co.za/oct00/reuters/aidsdrugs25.htm

"Minister M Tshabalala-Msimang at the UN's Special Session on HIV/AIDS" available at http://www.polity.org.za/govdocs/speeches/2001/sp0625a.html

"Most untreated African HIV+ children will die by age three – report" *iClinic* article available at http://www.iclinic.co.za/dec00/reuters/aids-kids27.htm

"Preventing Vertical HIV Transmission: The Controversy in South Africa" (1999-00) 1 *J Women's Health & L* 213 at 215

Albertyn C "Using Rights and the Law to Reduce Women's Vulnerability to HIV/AIDS: A Discussion Paper" Putting Third First – Critical Legal Issues and HIV/AIDS, AIDS Law Project (South Africa) (UNAIDS and Canadian HIV/AIDS Legal Network Satellite Conference, XIII International AIDS Conference, Durban, 7 July 2000) available at http://www.aidslaw.ca/durban2000/womenfinal.pdf

*Beijing Declaration and the Platform for Action* Fourth World Conference on Women, Beijing, China 4-15 September 1995 (1996)

Benatar S "Preventing Vertical HIV Transmission: The Controversy in South Africa" (1999-00) 1 *J Women's Health & L* 213

testing, the rapid development of HIV/AIDS support groups in the poverty-stricken community and the decrease in stigma associated with HIV/AIDS are but a few of the positive developments following the implementation of the programme.

75 See Cameron 2000.

Benshoof J "'The Truth About Women's Rights" (2000) 6 *Wm & Mary J Women & L* 423

Cameron E "Involvement of People Living with HIV/AIDS–How to Make it More Meaningful" (Second National Conference for People Living with AIDS, Durban, South Africa, 10 March 2000) available at http://www.cptech.org/ip/health/sa/cameron.html

CEDAW *General Recommendation No. 24: Women and Health (Article 12)* UN HCHROR 20th Session, UN Doc A/54/38/Rev.1, chapter 1 (1999) available at http://www.unhchr.ch/tbs/doc.nsf/MasterFrameView/77bae3190a903f8d80256785005599ff?Opendocument

CESCR *General Comment No. 14: The right to the highest attainable standard of health* (article 12 of the International Covenant on Economic, Social and Cultural Rights) UN ESCOR, 22nd Session, UN Doc E/C.12/2000/4, CESCR (2000) available at http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4,+CESCR+General+comment+14.En?OpenDocument

Department of Health *National HIV and Syphilis Sero-Prevalence Survey of Women attending Public Antenatal Clinics in South Africa* 2000 available at http://196.36.153.56/doh/aids/index.html

Eriksson MK *Reproductive Freedom: In the Context of International Human Rights and Humanitarian Law* (2000)

Fathalla MF "Research Needs in Human Reproduction" in Special Programme of Research, Development, and Research Training in Human Reproduction (World Health Organization) *Research in human reproduction, biennial report* (1988) 30, cited in Sandra Coliver "The Right to Information Necessary for Reproductive Health and Choice under International Law" (1995) 44 *Am Univ LR* 1279

Fonn S and Varkey S "Chapter 26: Termination of Pregnancy" in *South African Health Review* 5 ed (1999) available at http://www.hst.org.za/sahr/99/chap26.htm

Fonn S et al "Implementation of the New South African Abortion Law: A Six-Month Overview from Hospital Reports" (1998a) 6 *Reproductive Health Matters* 145

Fonn S et al "Reproductive Health Services in South Africa: From Rhetoric to Implementation" (1998b) 6 *Reproductive Health Matters* 22

Goemaere E "South Africa: how access to treatment helps prevent the spread of HIV" available at http://195.114.67.76/msf/accessmed/accessmed.nsf/

*Government Gazette* GN R8 of 22 January 1997 available at http://www.polity.org.za/govdocs/proclamations/1997/proc008.html

Gray G et al "Preliminary efficacy, safety, tolerability, and pharmacokinetics of short course regimens of nucleoside analogs for the prevention of mother-to-child transmission of HIV" (XIII International AIDS Conference, Durban, July 2000) cited in Laurence Peiperl "Antiretroviral Treatments to Reduce Mother-to-child Transmission of HIV" (25 August 2000) available at http://hivinsite.ucsf.edu/topics/pregnancy_and_childbirth/perinatal_transmission/

Joint United Nations Programme on HIV/AIDS (UNAIDS) Technical Update "Mother-to-child transmission of HIV" (September 2000) available at http://www.unaids.org/publications/documents/mtct/MTCT_TU4.doc

Kohm LM and Holmes C "The Rise and Fall of Women's Rights: Have Sexuality and Reproductive Freedom Forfeited Victory?" (2000) 6 *Wm & Mary J Women & L* 381

Mandela N "State of the Nation Address" (Parliament of South Africa, 24 May 1994) available at http://www.polity.org.za/govdocs/speeches/1994/sp0524.html

Marseille E et al "Cost effectiveness of single-dose nevirapine regimen for mothers and babies to decrease vertical HIV-1 transmission in sub-Saharan Africa" *The Lancet* 354:9181 (4 September 1999: 803)

McIntyre J "Caught in the Crossfire: The Ethics of Perinatal Transmission Trials in South Africa" in "AZT Trials to reduce Perinatal HIV Transmission: A Debate about Science, Ethics and Resources" (1998) 6 *Reproductive Health Matters* 129

Mofenson L "Perinatal Exposure to Zidovudine–Benefits and Risks" *New England Journal of Medicine* 343:11 (September 2000) available at http://www.nejm.org/content/2000/0343/0011/0803.asp

Mureinik E "A Bridge to Where? Introducing the Interim Bill of Rights" (1994) 10 *SAJHR* 31

Mureinik E "Beyond a Charter of Luxuries: Economic Rights in the Constitution" (1992) 8 *SAJHR* 464

Mureinik E "Reconsidering Review: Participation and Accountability" (1993) *Acta Juridica* 35.

News Centre "World AIDS Day Report: First supplies in the VIRAMUNE® donation programme for developing countries" (28 November 2000available at http://www.boehringer-ingelheim.com/corporate/asp/news/ndetail.asp?ID=126

Packer C *The Right to Reproductive Choice: A study in International Law* (1996)

Porter B "Beyond *Andrews*: Substantive Equality and Positive Obligations after *Eldridge* and *Vrien*'" (1999) 11 *Constitutional Forum* 71

Roberts DE "The Future of Reproductive Choice for Poor Women and Women of Color" (1992) 14 *Women's Rights L Reporter* 305

Skordis J and Nattrass N, "What is Affordable: The Political Economy of Policy on the Transmission of HIV/AIDS from Mother to Child in South Africa" (AIDS in Context International Conference, University of the Witwatersrand, 5 April 2001) [unpublished].

Söderlund et al "Prevention of vertical transmission of HIV: analysis of cost effectiveness of options available in South Africa" (1999) 318 *British Medical J* 1650 cited in Benatar S "Preventing Vertical HIV Transmission: The Controversy in South Africa" (1999-00) 1 *J Women's Health & L* 213

Söderlund N, Gray G and Zwi K "Breast or bottle? A cost-effectiveness evaluation of formula feeding for the prevention of post-natal transmission of HIV in an urban South African setting" (XII International AIDS Conference, Geneva, 28 June – 3 July 1998) cited in Gray G and McIntyre J "Mother-to-child transmission of HIV: Where to now?" *The AIDS Bulletin* 8:1 (March/April 1999) available at http://www.mrc.ac.za/aids/mar99/mother.htm

Stradiotto R and Boudreau J "Resource Allocation and Accountability in Health Care" (2000) 20 *Health Law in Canada* 40

TAC Press Statement on Mother-to-Child Transmission, "TAC Condemns Further delays in MTCTP Implementation" available at http://www.tac.org.za/ns010508.txt

UNAIDS Press Release "Preventing Mother-to-Child HIV Transmission: Technical Experts recommend Use of Antiretroviral Regimens Beyond Pilot Projects" (25 October 2000) available at http://www.unaids.org/whatsnew/press/eng/geneva251000.html

West RL "Taking Freedom Seriously" (1990) 104 *Harvard LR* 40, 85.