

The Imperative to Treat: The South African State's Constitutional Obligations to Provide Antiretroviral Medicines

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Introduction

South Africa is in the grips of a shattering HIV and AIDS pandemic, with over eleven percent of its population infected. The pandemic's magnitude demands urgent and effective action to limit infection rates and mitigate impact, with the provision of antiretroviral medicines being a critical element of a comprehensive continuum of prevention, treatment, care and support.¹ While these medicines can prolong life and substantially contain the impact and spread of HIV and AIDS, access in South Africa remains negligible, and highly contested terrain.

This note explores this issue in terms of the obligations placed on the state by the domestic and international right to health.² South Africa's Constitution is marked by a pervasive commitment to individual equality, dignity and freedom, and justiciable health rights that require the state to act reasonably in progressively realizing access to health care services within available resources.³ This article assesses what the prevailing social, economic, and constitutional context suggest are reasonable measures to provide access to essential medicines in the HIV/AIDS pandemic.

Part one describes the extent of the national epidemic, and Part two examines the state's obligations to provide access to health care services. Part three explores constitutional and international law for guidance as to what constitutes reasonable measures in relation to antiretroviral medicines.

I. HIV/AIDS in South Africa

In a region where HIV/AIDS pandemics have reached unprecedented dimensions, South Africa has the largest numbers of infected people, with official estimates of almost five million, approximately one in nine South Africans.⁴ Civil society studies put the figure closer to 6.5 million.⁵

While no race, place or age is exempt, levels of infection are highest among black South Africans, amongst women, and in informal urban settlements.⁶ The worst-affected age group is 25 to 29, followed by 30 to 34.⁷ Tremendous stigma and marginalization associated with the illness manifest in pervasive discrimination in employment, health care, education, and violations of privacy rights. While this experience is common globally, stigma is greatest in high prevalence countries, where AIDS is viewed as a death sentence, creating considerable silence and denial about the illness. This social marginalization and discrimination is so great that the South African Constitutional Court has recognized people living with HIV and AIDS as one of the most vulnerable groups in South African society.⁸

This vulnerability is compounded by the progressively fatal nature of the disease. AIDS accounted for twenty-five percent of all deaths in 2000, and has become the dominant cause of death in the country.⁹ More than seven million people will eventually die from AIDS in South Africa, leaving two million children orphaned.¹⁰

The illness and death of the most reproductively and economically active members of society has significant social and economic consequences, shattering families, deepening household poverty, and ultimately limiting economic growth and development. Public health care is being overwhelmed by HIV/AIDS: last year, forty percent of adult medical admissions at a public hospital in Johannesburg had HIV, as did sixty percent of pediatric admissions at a state hospital in Durban.¹¹ This sector is also suffering considerable attrition through AIDS-related morbidity and mortality among health care workers, with a similar pattern experienced in education and labour.

Illness and death on this scale is all the more shocking since antiretroviral therapies can halt the virus' ultimately fatal destruction of the immune system. Comprehensive use in developed countries and Brazil has slashed rates of AIDS related illness and death, changing the disease's definition from progressive and fatal, to chronic and manageable.

a. Antiretroviral Access in South Africa

Access in South Africa is negligible, with only twenty thousand people using the drugs, predominantly through private health care.¹² There are growing numbers of corporate workplace programs offering treatment,¹³ with non-governmental and research pilot programs able to provide treatment for small numbers of people.¹⁴ There are no long-term antiretroviral therapies available in the public sector.

The drug's average cost has plummeted from US\$15,000 per year in 1999 to current generic prices of around US\$200–300.¹⁵ Although this cost is still high for developing countries, with grants from the Global Fund for HIV/AIDS, Tuberculosis and Malaria, and other international funding sources, many developing countries, including Botswana, Ghana, Malawi and Senegal, are moving towards national antiretroviral treatment programs. In addition, the World Health Organization (WHO) has formulated simplified treatment regimes for resource-poor settings, offering partial solutions to infrastructural obstacles. Although significant political obstacles remain, access to antiretrovirals is slowly becoming a reality even in poor countries.

b. National AIDS Policy and Controversy

Despite this changing global picture, and despite being one of the richest countries in the region, access to antiretrovirals in South Africa remains a controversial topic, and a site of ongoing legal and political struggle. For many years, national AIDS policy has been "fraught with an unusual degree of political, ideological and emotional contention."¹⁶

There have been ongoing controversies about national policy and leadership, compounded by President Mbeki's public espousal of AIDS denialist theories, which refute a causal link between HIV and AIDS, and argue that immune failure is rather caused by drug-oriented gay lifestyles and the toxicity of antiretroviral medicines, or in the case of Africa, from malnutrition and illness associated with poverty. An opposition to antiretrovirals is central to this belief.

These ideas appear to have motivated, at least in part, the state's long running refusal and delay of any form of antiretroviral medicines in the public sector, most notably in respect of preventing mother-to-child transmission (MTCT) of HIV. This is at a time when infection rates in newborns are around 80,000 a year, with Nevirapine, the antiretroviral drug in question, holding the potential to prevent infection in 30–40,000 children, and offered free to the state for five years.

In 2000, the government announced it would introduce MTCT pilot sites, but delayed setting up any for a year, while simultaneously blocking public sector availability of Nevirapine. Consequently, in 2001, civil society groups instituted legal action against the state in the Treatment Action Campaign (TAC) case, arguing a breach of the constitutional right to access health care services. The state argued that its cautious approach was reasonable given concerns about the cost, safety and efficacy of the drug. When the high court ruled for the plaintiffs, the government appealed the decision to the Constitutional Court. In July 2002, the Constitutional Court ordered the government to "devise and implement within available resources a comprehensive program on mother-to-child transmission of HIV,"¹⁷ and without delay to remove restrictions on Nevirapine and make it available in public hospitals and clinics outside test sites.¹⁸

This decision reflects the capacity to achieve greater accountability for national AIDS policies through the judicial enforcement of the right to health. It also illustrates civil society's ability to successfully challenge state intransigence to achieve policies more consistent with the state's human rights obligations.

While Cabinet recently announced an investigation into public sector provision of antiretrovirals, it has also refused to sign and accept a national AIDS treatment plan presented by a governmental council. Appropriate action on antiretrovirals seems unlikely to occur anytime soon, and national AIDS policy on treatment seems destined to play itself out in the courts.

II. What are the State's Obligations Under the Constitutional Right to Health?

The South African Constitution entrenches a range of justiciable social and economic rights, including the right to access health care services.¹⁹ These flow from the Constitution's foundational commitment to the creation of a society based on human dignity, equality and freedom, which are the primary goals and values of the South African Constitution, holding a 'meta-interpretive role' in constitutional adjudication,²⁰ and appearing in several constitutional provisions.²¹

Section 27(1) entrenches the right to have access to health care services, including reproductive health care. Section 27(2) limits the state's obligations under this right to taking reasonable legislative and other measures within available resources to achieve its progressive realization.²²

As its text suggests, this is not a guarantee to health care on demand, but a limited right to such health care as can be provided over time, and within resource constraints. Its qualified nature was illustrated in the first Constitutional Court case on s. 27. In the *Soobramoney* case, the court denied an appeal against a lower court decision upholding a provincial hospital's policy of rationing dialysis. It found that this policy did not breach state obligations to provide access to health care services within available resources. The court held that the policy was a reasonable response to resource constraints, and a good faith effort to maximize the health benefits of dialysis accordingly.²³

In the context of limited state resources and high levels of poverty, the court recognized that not all health care needs could be met, particularly claims for expensive medical treatments or drugs that threatened the state's ability to provide other health care, and indeed to meet all other social and economic needs.²⁴ Difficult decisions about resource allocation and prioritization had to be made, and the court indicated that it would be "slow to interfere with rational decisions taken in good faith by the political organs and medical authorities whose responsibility it is to deal with such matters."²⁵

By limiting the ambit of the state's obligation to allow rationed access to an expensive treatment, the court intimated that the government's primary obligation under s. 27 was to meet the basic health care needs of the majority of its population living in great poverty.²⁶ This implicit aspect of the decision was elaborated in the *Grootboom* case on hous-

ing, which established the jurisprudential test of reasonableness to measure state compliance with social and economic obligations.²⁷ This test was confirmed and applied to the right to health in the *TAC* case.

a. The Test of Reasonableness

In a unanimous judgment delivered by Justice Yacoob, the court in *Grootboom* established that the state's compliance with social and economic rights would be judged by the reasonableness of measures taken to progressively realize rights within available resources. In determining reasonableness, courts will consider the social and historical context of problems, and the textual context of relevant rights within the Bill of Rights as a whole.²⁸ This is consistent with the purposive and generous interpretation of rights favored by the court, as well as the explicitly transformative intent of the Constitution.²⁹

The framework for analysis is provided by the limitations clause common to the primary social and economic rights, namely: a) the obligation to take reasonable legislative and other measures, b) to achieve progressive realization, c) within available resources.³⁰ These three elements determine the extent of the state's obligations.

1. Reasonable Legislative and Other Measures

At a minimum, reasonable measures require a comprehensive program, which provides for crises and for short, medium and long term needs.³¹ Thus, a program that excludes "a significant segment of society" will be unreasonable. So too is a failure to attend to the most urgent and desperate needs.³² This was a critical aspect of the court's decision in *Grootboom*, which found the government's otherwise laudable efforts to provide subsidized housing unreasonable precisely for failing to provide for people in desperate need. Comprehensiveness is therefore not a utilitarian notion: a program that meets the majority of needs but not the most urgent and desperate will be unreasonable. This Kantian emphasis on individual humanity and worth permeates considerations of reasonableness, giving great determinative weight to the depth and extent of individual suffering in question.

The court stressed that socioeconomic rights were entrenched to afford people their basic human needs and this flowed from the constitutional commitment to creating a society based on dignity, equality and freedom.³³ While the court has acknowledged that government could not conceivably meet even all basic needs, its obligation is to *seek to*

meet these needs, acting reasonably to provide access to socio-economic rights on a progressive basis.³⁴

2. Progressive Realization

Given the goal of meeting basic needs, the state's obligation to progressively realize rights was "to take steps to achieve this goal."³⁵ This requires the state to move as expeditiously and effectively as possible towards the goal of the full realization of the right in question.³⁶ Accessibility should be progressively facilitated, with legal, administrative, operational and financial hurdles examined and where possible lowered over time.³⁷

3. Resources

Resources are a primary feature of reasonableness, and the state is not required to do more than its available resources permit.³⁸ Resources would therefore govern "the content of the obligation in relation to the rate at which it is achieved as well as the reasonableness of the measures employed to achieve the result."³⁹

III. The State's Reasonable Obligations in Respect of Antiretroviral Therapies

Thus, the reasonableness test appears to endorse a national HIV/AIDS policy that seeks to meet basic HIV/AIDS related health care needs, without ignoring their urgency nor the desperate need for them. This suggests that the absence of a national HIV/AIDS treatment strategy is prima facie unreasonable, and in violation of the right to health's fundamental requirement of a comprehensive strategy and plan.

While a national treatment plan is indisputably required, the question remains whether this plan should progressively realize comprehensive access to antiretrovirals as a basic health care need, or whether like dialysis, it should be excluded or severely rationed?

It is difficult to sustain the argument that providing essential medicines in a raging pandemic is neither a basic health care need nor obligation. These are the only effective medical treatments for a pandemic illness affecting a significant por-

tion of the country, with devastating individual, social and economic consequences. That they meet basic health care needs is supported by the WHO's inclusion of antiretrovirals as essential medicines on its essential drugs list, and their subsequent inclusion within the minimum core of the right to health in international law.⁴⁰ The core is the

minimum essential level of health that states have priority obligations to provide. International law places comparable importance on treating and controlling epidemic disease.⁴¹ Although the Constitutional Court has refused to transplant the minimum core in its totality into domestic socioeconomic rights,⁴² it also recognizes its interpretive relevance to determining reasonableness.⁴³ This

relevance is compounded by a natural overlap between the minimum core of health and basic health care needs. This suggests that a failure to take reasonable steps to provide these medicines is a dire breach of the minimal requirements of the right to health.

That these drugs constitute basic needs and obligations is therefore not altered by their expense. The state is obliged to take all possible steps towards comprehensive access to antiretrovirals, with hurdles examined and where possible lowered over time.

However, as the *TAC* case illustrates, a failure to act with urgency commensurate with the exigencies of the epidemic will itself be unreasonable. As the court in *TAC* indicates:

the nature of the problem is such that it demands urgent attention . . . there is a need to assess operational challenges . . . [and to] monitor issues relevant to the safety and efficacy of and resistance to the use of Nevirapine for this purpose. There is, however, also a pressing need to ensure that where possible, loss of life is prevented in the meantime.⁴⁴

Without treatment, HIV infection will translate into exceedingly painful and brief lives for vast numbers of South Africans. While this itself demands urgent action, the need to act with heightened diligence is intensified even further by the social context of the HIV/AIDS pandemic. The illness's demographics suggest that for many, AIDS-related illness and death amplify a vicious cycle of poverty, discrimination and gender inequality, that effectively negate the constitu-

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tional promise of equal freedom, dignity and equality for many people with HIV and AIDS.

These factors suggest that a failure to work towards the goal of comprehensive treatment violates the human rights of people with HIV/AIDS in an unreasonable manner. This is reflected in the Constitutional Court's judgment in *Hoffman*, where the Court found prevailing social prejudice against people with HIV/AIDS to "render any discrimination against them as a fresh instance of stigmatization; and an assault on their dignity."⁴⁵ This suggests a heightened obligation to plan and implement a national HIV/AIDS treatment plan, with an urgency commensurate with the millions of lives at stake, and the intense vulnerability and desperation in which many people with AIDS live and die.

All that remains are the limitations imposed by the availability of resources. Comprehensive access will require enormous expenditure, peaking at an estimated US \$ 2.28 billion by 2015.⁴⁶ Yet rejecting treatment as a possibility on the basis of this cost assumes that AIDS will not in any event exact a massive financial cost equal to or exceeding the cost of treatment. Without effective treatment, the state must bear the massive health care costs of the AIDS ill and dying, and of caring for two million orphans. The Brazilian experience confirms this, with the national antiretroviral program literally paying for itself in averted hospitalization costs alone.⁴⁷

The direct and indirect cost benefits are potentially so great that WHO's Commission on Macroeconomics and Health indicates that "[HIV and AIDS] treatment isn't just a moral necessity, but a necessary component of economic stabilization and an ultimate return to economic development in high prevalence parts of the world."⁴⁸ This implies that a failure to provide treatment could affect the state's ability to meet all social and economic needs by virtue of the epidemic's inhibition of macroeconomic growth and development.

Yet, if cost is the linchpin to comprehensive access, there are various mechanisms to significantly reduce it, including negotiated discounts, generic manufacture, bulk procurement, and parallel importation. For the South African government, there are no legal obstacles to taking such action, and it has recently promulgated the legislation that will allow it to manufacture generic medicines.⁴⁹

All that stands in the way of doing so now is the requisite political will. If this leadership is not forthcoming from the national government, South African civil society holds a powerful weapon in the right to health to ensure that state

policy follow the dictates of rationality and humanity on which the new South African state is founded.

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1. UNAIDS & UN Office of the High Commissioner for Human Rights, "HIV/AIDS and Human Rights International Guidelines: Revised Guideline 6 Access to Prevention, Treatment, Care and Support," UNAIDS/02.49E (2002), at 14.
2. This note uses the term "right to health" as interchangeable with "the right to access health care services."
3. *Constitution of the Republic of South Africa 1996 Act No. 108 of 1996* ["The Constitution"].
4. In an antenatal survey conducted in 2001, it was estimated that 24.8 percent of pregnant women were infected with HIV by the end of 2001. There was some good news in the survey — the national prevalence rate has slowed in its increase since 1998. However, there was a significant increase in HIV prevalence amongst women aged 30-39. The majority of infections remained in the 20-29 age group, with almost 30 percent of women infected. See South African Department of Health, National HIV and Syphilis Sero-Prevalence Survey of Women Attending Public Antenatal Clinics in South Africa 2001, online: South African Department of Health <<http://www.doh.gov.za>>.
5. Rob E. Dorrington, Debbie Bradshaw & Debbie Budlender, *HIV/AIDS Profile in the Provinces of South Africa: Indicators for 2002*, Center for Actuarial Research, Medical Research Council and the Actuarial Society of South Africa 2002, at 2, online: Medical Research Council <<http://www.mrc.ac.za/bod/AIDSindicators2002.pdf>>.
6. Human Sciences Research Council, *Nelson Mandela/HSRC Study of HIV/AIDS South African National HIV Prevalence, Behavioural Risks and Mass Media Household Survey 2002*, (Cape Town: Human Sciences Research Council Publishers, 2002), online: Human Sciences Research Council Publishers <<http://www.hsrepublishers.co.za/index.html?hiv.html~content>>. The study found that 28.4 percent of infections are found in urban informal settlements versus 15 percent in urban formal settlements. The study also revealed that HIV disproportionately affects women in South Africa, with 17.7 percent infected to 12.8 percent men.
7. *Ibid.*

8. *Hoffman v. South African Airways* [2001] 1 S.Afr.L.R. 1 (S.Afr.Const.Ct), at para. 28.
9. Rob E. Dorrington, *et al*, The Impact of HIV/AIDS on Adult Mortality in South Africa, Technical Report, Burden of Disease Research Unit, Medical Research Council, 2001, online: Medical Research Council <<http://www.mrc.org.za>>.
10. Alan Whiteside & Clem Sunter, *AIDS: The Challenge for South Africa* (Cape Town: Human & Rousseau (Pty) Ltd, 2000), at 69.
11. P.M Jeena *et al.*, “Impact of HIV-1 Co-infection on presentation and hospital-related mortality in children with culture proven pulmonary tuberculosis in Durban, South Africa,” (2002) 6:8 Int. J. Tuberculosis & Lung Disease, at 672-8.
12. Private health care services only twenty percent of the population. In recent years, legislation has been passed prescribing a basic package of minimum benefits for private medical insurance, but antiretroviral therapies are not part of it. Despite this, an increasing number of medical schemes are covering antiretroviral medicines within their benefits.
13. Several companies have linked broader HIV/AIDS prevention and care workplace programs to the provision of antiretrovirals, including Daimler-Chrysler South Africa, Coca-Cola, McCord’s Hospital, Old Mutual, and Anglo-American. See Neil Martinson *et al*, “Antiretrovirals,” in Health Systems Trust, *South African Health Review 2002*, at 241, online: South African Health Systems Trust <<http://www.hst.org.za>>.
14. *Ibid.* For example, the Perinatal HIV Research Unit at Baragwanath Public Hospital is providing treatment to twenty-five children and seventy adults. A Médecins sans Frontières program runs in three clinics in Khayelitsha in Cape Town is serving over 360 patients.
15. Médecins sans Frontières, “Untangling the Web of Price Reductions: a pricing guide for the purchase of ARVs for developing countries,” (15 May 2003, 4th edition), at 7, online: Médecins sans Frontières <<http://www.accessmed-msf.info/documents>>.
16. *Minister of Health and others v. Treatment Action Campaign and others* [2002] 5 S.Afr.L.R. 721 (S.Afr.Const.Ct), at para.20 [TAC].
17. TAC, at para.135.
18. *Ibid.*
19. Sections 26, 27 and 29 respectively provide for housing, water, food, social security and education. Section 28 provides for children’s rights including basic nutrition, shelter, basic health care services and social services.
20. Craig Scott & Phillip Alston, “Adjudicating Constitutional Priorities in a Transnational Context: A Comment on Soobramoney’s Legacy and *Grootboom*’s Promise” (2000) 16 S. Afr. J. Hum. R. 206.
21. Section 1(a), which entrenches the founding provisions of the country, states that the Republic of South Africa is one, sovereign, democratic state founded on the values of human dignity, the achievement of equality and the advancement of human rights and freedoms. Section 7(1) states *inter alia* that the Bill of Rights affirms the democratic values of human dignity, equality and freedom. The limitation of rights in s. 36 is premised upon their being reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom. Section 39(1)(a) on the interpretation of rights, states that when interpreting the Bill of Rights, a court, tribunal or forum must promote the values that underlie an open and democratic society based on human dignity, equality and freedom.
22. The full text of s. 27 states: “(1) Everyone has the right to have access to a) health care services, including reproductive health care; b) sufficient food and water; and c) social security, including, if they are unable to support themselves and their dependants, appropriate social assistance. (2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of these rights. (3) No one may be refused emergency medical treatment.”
23. *Soobramoney v. Minister of Health (Kwa-Zulu Natal)* [1998] 1 S.Afr.L.R. 765 (S.Afr.Const.Ct) [*Soobramoney*].
24. *Soobramoney*, at paras. 8, 28 and 31.
25. *Ibid.* at para. 29.
26. *Ibid.* at para.8: “We live in a society in which there are great disparities in wealth. Millions of people are living in deplorable conditions and in great poverty. There is a high level of unemployment, inadequate social security, and many do not have access to clean water or to adequate health services. These conditions already existed when the Constitution was adopted and a commitment to address them, and to transform our society into one in which there will be human dignity, freedom and equality, lies at the heart of our new constitutional order. For as long as these conditions continue to exist that aspiration will have a hollow ring.”
27. *Government of Republic of South Africa and others v. Grootboom and others* [2001] 1 S.Afr.L.R. 46 (S.Afr.Const.Ct) [*Grootboom*].

28. *Grootboom*, at paras. 22, 24, 25, 43 and 44.
29. See Preamble to the Constitution: “We ... adopt this Constitution as the supreme law of the Republic so as to heal the divisions of the past and establish a society based on democratic values, social justice and fundamental human rights; lay the foundations for a democratic and open society in which government is based on the will of the people and every citizen is equally protected by law; [and] improve the quality of life of all citizens and free the potential of each person.” See also Chief Justice Chaskalson in *Soobramoney*, at para.8.
30. *Grootboom*, at para. 38.
31. *Ibid.* at paras.38, 40, 42 and 43.
32. *Ibid.* at para. 43.
33. *Ibid.* at para. 44.
34. *TAC*, at paras.35 and 36: “It is impossible to give everyone access even to a ‘core’ service immediately. All that is possible, and that can be expected of the state, is that it act reasonably to provide access to the socio-economic rights identified in sections 26 and 27 on a progressive basis.” *Grootboom*, at para.44: “A society must seek to ensure that the basic necessities of life are provided to all if it is to be a society based on human dignity, freedom and equality.”
35. *Grootboom*, at para. 45.
36. UN Committee on Economic, Social and Cultural Rights, *General Comment 3: The Nature of State Party Obligations*, U.N. Doc. HRI/GEN/1/Rev.1 at 45 (1994), at para. 9, cited in *Grootboom*.
37. *Ibid.*
38. *TAC*, at para. 32.
39. *Grootboom*, at para. 46.
40. UN Committee on Economic, Social and Cultural Rights, *General Comment 14: The Right to the Highest Attainable Standard of Health*, UN Doc. E/C.12/2000/4 (2000), at paras. 43 and 44 [*General Comment 14*]. *General Comment 14* indicates that the minimum core of the right to health includes at least the following obligations: “(a) To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups; ... (d) To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs; ... (f) To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include methods, such as right to health indicators and benchmarks, by which progress can be closely monitored; the process by which the strategy and plan of action are devised, as well as their content, shall give particular attention to all vulnerable or marginalized groups.”
41. *Ibid.* at para. 44. *General Comment 14* indicates that obligations of comparable priority include “(a) To ensure reproductive, maternal (pre-natal as well as post-natal) and child health care; (b) To provide immunization against the major infectious diseases occurring in the community; (c) To take measures to prevent, treat and control epidemic and endemic diseases...”
42. *Grootboom*, at paras. 32 and 33; *TAC*, at para.35.
43. *Grootboom*, at para.33; *TAC*, at para.34.
44. *TAC*, at para. 131.
45. *Hoffman*, at para. 28.
46. Nathan Geffen, Nicoli Natrass & Chris Raubenheimer, “The Cost of HIV Prevention and Treatment Interventions in South Africa,” Working Paper No. 28, Center For Social Science Research, University of Cape Town, 2003.
47. Paulo R. Teixeira, “Universal Access To Antiretroviral Therapy: The Brazilian Experience,” (paper presented to the Second Meeting Of The UNAIDS Contact Group On Accelerating Access To HIV/AIDS — Related Care, Rio De Janeiro, 13 December 2000), online: UNAIDS <http://www.unaids.org/acc_access/acc_care_support/DiscursoDrPauloARVContactGroup.doc>.
48. World Health Organization, *Macroeconomics and Health: Investing in Health for Economic Development: Report of the Commission on Macroeconomics and Health*, (Geneva: World Health Organization, 2001), at 51.
49. *Medicines and Related Substances Control Act* No.90 of 1997.