

Article

The Duty of Treatment: Human Rights and the HIV/AIDS Pandemic

Noah Novogrodsky[†]

This Article argues that the treatment of HIV and AIDS is spawning a juridical, advocacy, and enforcement revolution. The intersection of AIDS and human rights was once characterized almost exclusively by anti-discrimination and destigmatization efforts. Today, human rights advocates are demanding life-saving treatment and convincing courts and legislatures to make states pay for it. Using a comparative Constitutional law methodology that places domestic courts at the center of the struggle for HIV treatment, this Article shows how the provision of AIDS medications is reframing the right to health and the implementation of socio-economic rights. First, it locates an emerging right to treatment in the global case law and authoritative decisions of treaty bodies. Second, it argues that the right to treatment has transformed rights discourse, strengthened the conceptual interdependence and indivisibility of all human rights and reframed the role of the judiciary. Third, it contends

[†] Senior Scholar, O'Neill Institute for National and Global Health Law, Georgetown University Law Center, and Visiting Professor, University of Connecticut School of Law, nbn2@law.georgetown.edu. I am grateful for the advice and comments of Lawrence Gostin, Harold Koh, Rick Brooks, Isadora Helfgott, Charles Novogrodsky, Meg deGuzman, Tara Melish, Eric Friedman, Susan Benesch, Vicki Jackson, David Luban, Nina Pillard, Jonathan Todres, Julia Fromholz, Gerald Caplan, Stephen Lewis, Megan McLemore, Joe Amon, Nick Robinson, Katharine Young, Eric Naiman, and Asli Bali. I am also indebted to Lindsay Gastrell, Zeynep Darendeliler, Michael Yedinak and Caitlin Sochacki for their excellent research assistance and to the many Seminario en Latinoamérica de Teoría Constitucional y Política (SELA) participants for their help in understanding Latin American legal developments. The work of Tara Melish, Alicia Yamin and Mary Ann Torres was particularly helpful to me for their analysis as well as their translations of the Latin American cases, many of which are only available in Spanish. The title was inspired by Diane Orentlicher's *Settling Accounts: The Duty to Prosecute Human Rights Violations of a Prior Regime*, 100 YALE L. J., 2357 (1991). The early versions of the paper were inspired by the participants in the Spring 2008 Yale Law School HIV/AIDS in Africa Reading Group. The later drafts of this paper profited immensely from the edits of Sarah Cox and Lee Sims of the University of Connecticut School of Law Library and the dedicated team of editors at the YHRDLJ.

that the justiciable quality of the right to treatment holds the potential to clarify which rights claims are likely to result in concrete remedies and, by extension, which cases and causes will elevate the status of social and economic rights more generally.

INTRODUCTION

On the floor of the hut lies a young woman – always young – in her twenties or thirties, so wan and emaciated as to be unable to lift either hand or head. I bend down, painfully inadequate to the circumstance, and touch her brow, uttering some pointless banality which is intended to soothe, and then as I step back, looking around me, I see her children, all her children, standing in the darkened shadows, watching their mother die.¹

Imagine a disease so deadly that it kills a quarter of the population in the prime of their lives. Envision a drug powerful enough to forestall certain death by decades. Further imagine that a small group of companies had priced the drug at a level affordable to only a fraction of the population. Now consider a court with the authority to compel delivery of the drug for desperately ill people, to grant life through a judicial order.

As anyone familiar with the legal struggle over AIDS drugs knows, each of these postulates is all too real. The Human Immunodeficiency Virus (HIV), the retrovirus that leads to Acquired Immunodeficiency Syndrome (AIDS) is devastating much of the developing world, particularly East and Southern Africa. In 2007, UNAIDS (the only United Nations division dedicated to a single disease) counted 33.2 million infected persons worldwide, a staggering 22.5 million of whom live in sub-Saharan Africa.² The same year, 72% of all adult and child deaths due to AIDS occurred in sub-Saharan Africa.³ In South Africa alone, between 800 and 1000 people die every day of AIDS-related complications.⁴

The drugs to treat AIDS exist and have rendered the vast majority of these deaths entirely avoidable. Comprehensive education, prevention, and treatment programs in the global north have greatly reduced the likelihood of transmission.⁵ Infected persons with access to life-sustaining

1. STEPHEN LEWIS, RACE AGAINST TIME 54 (2005).

2. JOINT U.N. PROGRAMME ON HIV/AIDS [UNAIDS], AIDS EPIDEMIC UPDATE: DECEMBER 2007, at 7 (2007), available at http://data.unaids.org/pub/EPISlides/2007/2007_epiupdate_en.pdf. UNAIDS is the colloquial name of the Joint United Nations Programme on HIV/AIDS, the U.N. agency that compiles statistics on the pandemic and coordinates the activities of other branches of the U.N.

3. UNAIDS, REPORT ON THE GLOBAL AIDS EPIDEMIC 2008: EXECUTIVE SUMMARY 5 (2008), available at http://data.unaids.org/pub/GlobalReport/2008/JC1511_GR08_ExecutiveSummary_en.pdf [hereinafter UNAIDS 2008 REPORT].

4. ROB DORRINGTON ET AL., THE DEMOGRAPHIC IMPACT OF HIV/AIDS IN SOUTH AFRICA: NATIONAL AND PROVINCIAL INDICATORS FOR 2006 at 11 (2006), available at <http://www.mrc.ac.za/bod/DemographicImpactHIVIndicators.pdf>.

5. But see Jose Antonio Vargas and Darryl Fears, *HIV/AIDS Rate in DC Hits 3%*, WASH. POST, Mar. 15, 2009 at A1.

highly active anti-retroviral therapy (described variously as HAART, ART or ARVs) have dramatically reduced rates of morbidity and mortality and can expect a vastly improved the quality of life. For People Living with HIV and AIDS (PLWHA), the medicines have converted the disease from a death sentence to a manageable chronic illness.⁶ ART is readily available in developed countries – the drugs are usually covered by public or private health insurance⁷ – and to wealthy individuals the world over.⁸ Since 2001, the cost of first line drugs has dropped precipitously. The price of triple-combination HIV/AIDS therapy purchased from originator companies fell by 95%, and generics became widely available in many developing countries at a discount of 99%.⁹ Drugs that cost \$10,000 to \$15,000 per patient per year in 2001 now cost \$132 in generic form.¹⁰

The life-altering power of ARVs has had profound legal and political consequences. AIDS activists, in alliance with some developing countries, have waged a multi-front campaign to gain access to ART in which they have employed imaginative strategies in domestic debates and legal actions around the globe.¹¹ Spurred in part by legal activism, international, governmental, and nongovernmental agencies have belatedly begun “to channel money, consultants, condoms, and other commodities to AIDS programs all over the world.”¹² Much of the funding is used to purchase ARVs.¹³ Since 2002, the Global Fund to Fight AIDS, Tuberculosis and

6. World Health Org. [WHO], *Scaling Up Antiretroviral Therapy in Resource-Limited Settings: Treatment Guidelines for a Public Health Approach 5* (2004), *available at* http://www.who.int/hiv/pub/prev_care/en/arvrevision2003en.pdf [hereinafter *WHO Treatment Guidelines*].

7. *See, e.g.*, 42 U.S.C. § 1396d(a)(12)(2000); “Medicare Prescription Drug, Improvement, and Modernization Act of 2003” Pub. L. No. 108-173, 117 Stat. 2066 (2003).

8. Justice Edwin Cameron, an HIV-positive judge from South Africa, addressed the International AIDS Society Conference in Durban in 2000 and spoke to the cruel irony that he is alive because he can afford ART. “Amidst the poverty of Africa, I stand before you because I am able to purchase health and vigour. I am here because I can pay for life itself. To me this seems a shocking and monstrous iniquity of very considerable proportions – that, simply because of relative affluence, I should be living when others have died; that I should remain fit and healthy when illness and death beset millions of others.” Edwin Cameron, *The Deafening Silence of AIDS* (July 19, 2000), <http://www.actupny.org/reports/durban-cameron2.html>. *See also* STEPHANIE NOLAN, 28 *STORIES OF AIDS IN AFRICA* 78 (2007) (recounting Ugandan doctor Lydia Mughereera’s position of relative privilege which allows her to purchase ARVs).

9. It was Cipla, the Indian generic pharmaceutical company, that first bundled three-in-one drugs into a single pill, making ART adherence easier for PLWHA. *See* Avert, *AIDS, Drug Prices and Generic Drugs*, <http://www.avert.org/generic.htm> (last visited Mar. 14, 2009).

10. *See* Médecins Sans Frontières, *Untangling the Web of Price Reductions: A Pricing Guide for the Purchase of ARVs for Developing Countries 6* (10th ed. 2007).

11. *See, e.g.*, RAYMOND A. SMITH & PATRICIA D. SIPLON, *DRUGS INTO BODIES: GLOBAL AIDS TREATMENT ACTIVISM* (2006). The backlash against global AIDS activism has been significant, particularly from pharmaceutical patent holders and their political allies in the global North, who seek to enforce intellectual property rules. *See, e.g.*, *Pharm. Mfrs.’ Ass’n.s v President of South Africa, High Court of South Africa, Transvaal Provincial Division, Case No. 4183/98* (2001), <http://www.tac.org.za/Documents/MTCTPrevention/pharmace.txt>.

12. HELEN EPSTEIN, *THE INVISIBLE CURE: AFRICA, THE WEST, AND THE FIGHT AGAINST AIDS*, xiii-xiv (2007).

13. Fully 55% of U.S. bilateral assistance through PEPFAR in the years 2003-2008 was

Malaria ("the Global Fund") has committed \$6.8 billion in 136 countries to scale up prevention, care and treatment.¹⁴ In combination with \$56 billion from the President's Emergency Plan for AIDS Relief (PEPFAR) in the U.S.,¹⁵ and the philanthropic efforts of private donors including the William J. Clinton Foundation¹⁶ and the Bill and Melinda Gates Foundation,¹⁷ the Global Fund has ensured that more money is directed to global AIDS than to any other international health problem,¹⁸ and that a significant percentage of that funding is used to purchase ART. The price of generic ARVs and the funding interests of international donors have emboldened the World Health Organization (WHO), the United Nations and treatment providers to speak publicly of "universal access" to ART by 2010.¹⁹

In early 2007, however, fewer than 1.5 million Africans were receiving ART, out of at least 4.6 million in immediate need.²⁰ In the past five years, more than 10 million Africans have died of AIDS, most of whom would be alive if they had lived elsewhere.

Despite the cataclysmic toll and the alarming inequities in access to life-saving medicines, the disease is frequently described as just one aspect

spent on treatment. Avert, What is PEPFAR?, <http://www.avert.org/pepfar.htm> (last visited Mar. 22, 2009).

14. The Global Fund is a public-private partnership to attract, manage and disburse resources to fight infectious disease.

15. See Unites States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003, 22 U.S.C. §§ 7601-82 (2003). PEPFAR was initially funded for 2003-2008 with \$15 billion, at least \$10 billion of which was new funding. PEPFAR's stated goal for this period was to avert seven million new HIV infections, begin providing two million people with ART and extend care to ten million HIV-positive people. U.S. PRESIDENTS EMERGENCY PLAN FOR AIDS RELIEF, MAKING A DIFFERENCE: SUPPORTING ANTIRETROVIRAL TREATMENT (2006), *available at* <http://www.state.gov/documents/organization/67502.pdf>. In July 2008, Congress authorized an additional \$41 billion for the program for the period 2009-2013. See Press Release, Office of the Press Secretary, President Bush Signs HR 5501, the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis and Malaria Reauthorization Act of 2008, *available at* <http://georgewbush-whitehouse.archives.gov/news/releases/2008/07/20080730-12.html>.

16. Clinton Foundation Programs: HIV/AIDS Initiative, <http://www.clintonfoundation.org/cf-pgm-hs-ai-home.htm>. The Clinton Foundation HIV/AIDS Initiative has been instrumental in negotiating price reductions and bulk procurement opportunities from pharmaceutical companies. See The Clinton Foundation, What We've Accomplished, <http://www.clintonfoundation.org/what-we-do/clinton-global-initiative/what-we-ve-accomplished> (last visited Mar. 22, 2009).

17. The Gates Foundation, which declares that it is driven by the view that "all lives - no matter where they are being led - have equal value" has given or pledged nearly \$8 billion to global health initiatives, including at least \$650 million to the Global Fund. See Bill and Melinda Gates Foundation, <http://www.gatesfoundation.org/>.

18. See generally Laurie Garrett, *The Challenge of Global Health*, 86 FOREIGN AFF. 14, 26 (2007) (recognizing that funding for HIV/AIDS has increased exponentially even as other health services are backsliding in a number of countries).

19. See WHO, Universal Access by 2010, <http://www.who.int/hiv/universalaccess2010/en/>.

20. WHO, UNAIDS & U.N. Children's Fund [UNICEF], *Towards Universal Access: Scaling Up Priority HIV/AIDS Interventions in the Health Sector* 5 (2007). But see UNAIDS 2008 Report, *supra* note 3, at 17 (indicating that by the end of 2007, the number of people receiving ART in Sub-Saharan Africa had risen to more than two million).

of a public health catastrophe, a barrier to development,²¹ a failure of foreign policy priorities,²² and a threat to military and political stability.²³ Legal demands for treatment within the field of HIV/AIDS and human rights are often eclipsed by questions of stigma and discrimination,²⁴ poverty and underdevelopment,²⁵ and a larger critique leveled at the global intellectual property regime.²⁶

Each of these portrayals misses the reality that national courts and administrative tribunals are increasingly finding that individuals have a human right to anti-retroviral treatment to combat HIV/AIDS. Across the globe, most strikingly in low and middle-income states, judicial authorities are holding that claims to treatment articulate a justiciable right that is grounded in domestic law and supported by international human rights commitments. In many jurisdictions, legal recognition of this kind now forms the basis for affirmative demands that state officials provide medicines to infected persons. The treatment jurisprudence thus disproves the overly general assertion that courts are incapable of deciding positive rights cases which require an evaluation of government spending or that doing so violates separation of powers principles. Instead, an increasing number of states, health authorities, or government ministries have followed or preempted legal action by ensuring widespread access to ARVs. The global treatment cases thus provide an instructive lesson in the enforcement of economic and social rights, one that embraces domestic litigation and related legislative processes as a means of enunciating and ultimately implementing contested norms.

Neither courts nor scholars have given sufficient consideration to the theoretical basis for ordering treatment or to the significance of judicial

21. See United Nations Millennium Declaration, G.A. Res. 55/2, ¶ 19, U.N. Doc. A/RES/55/2 (Sept. 18, 2000) (resolving to have “halted, and begun to reverse, the spread of HIV/AIDS, the scourge of malaria and other major diseases that afflict humanity” by 2015 as one of several fundamental development goals); U.N. DEV. PROGRAMME [UNDP], HUMAN DEVELOPMENT REPORT 2005 3 (2005), available at <http://hdr.undp.org/reports/global/2005> (“The HIV/AIDS pandemic has inflicted the single greatest reversal in human development” since the first Human Development Report in 1990).

22. See generally LAURIE GARRETT, *THE COMING PLAGUE* 592-620 (1994); David P. Fidler, *Fighting the Axis of Illness: HIV/AIDS, Human Rights and U.S. Foreign Policy*, 17 HARV. HUM. RTS. J. 99 (2004) (discussing “foreign policy challenges presented by infectious diseases,” governance responses to these diseases, and U.S. foreign policy approaches to HIV/AIDS. *Id.* at 101); J. M. Spectar, *The Olde Order Crumbleth: HIV-Pestilence as a Security Issue & New Thinking About Core Concepts in International Affairs*, 13 IND. INT’L & COMP. L. REV. 481 (2003) (examining “implications of the link between AIDS and security” and “policy responses of key international actors.” *Id.* at 481.).

23. See generally Robert L. Ostergard, Jr., *Politics in the Hot Zone: AIDS and National Security in Africa*, 23 THIRD WORLD Q. 333 (2002); Editorial, *AIDS: Security Implications for Africa*, 10 (4) AFR. SECURITY REV. 3 (2001); U.S. INST. OF PEACE, SPECIAL REPORT: AIDS AND VIOLENT CONFLICT IN AFRICA (2001), available at <http://www.usip.org/pubs/specialreports/sr75.pdf>.

24. See, e.g., LAWRENCE O. GOSTIN, *THE AIDS PANDEMIC, COMPLACENCY, INJUSTICE AND UNFULFILLED EXPECTATIONS* xxv (2004).

25. See, e.g., Jennifer Prah Ruger, *Combating HIV/AIDS in Developing Countries*, 329 BMJ 121 (2004).

26. Alicia E. Yamin, *Not Just a Tragedy: Access to Medications as a Right Under International Law*, 21 B.U. INT’L L.J. 325, 344 (2003); Zita Lazzarini, *Access to HIV Drugs: Are We Changing the Two-World Paradigm?*, 17 CONN. J. INT’L L. 281, 286 (2002).

enforcement of a single manifestation of socio-economic rights. This article speaks to that gap by examining why and how AIDS advocates have succeeded in establishing a human right to treatment of HIV. Part I traces the relationship of human rights law to the virus and explores the limitations of the civil and political rights framework originally used to advance the interests of people living with HIV/AIDS. Part II explores the right to treatment as an increasingly well articulated representation of the right to health within the global case law and interpretive decisions of authoritative bodies. This section recognizes the phenomenon of judicially compelled treatment and identifies domestic courts as the locus of a particular expression of the right to health. Part III develops a three-part model that begins to theorize the potentially transformative nature of the global treatment jurisprudence. This model argues that the struggle for treatment has appropriately synthesized previously disconnected human rights norms, grounded socio-economic rights enforcement in a vision of law governed by national Constitutions but informed by diverse international human rights commitments, and catalyzed claims to treatment in ways that devalue intellectual property rights and upend development orthodoxies. Part III elaborates the components of the treatment success while considering what this body of law portends for the enforcement of other social and economic rights. I conclude by asking whether the treatment revolution will serve as a paradigm-shifting event commensurate with the scale of the global tragedy that is AIDS.

I. THE AIDS PANDEMIC AND HUMAN RIGHTS

Although the burden of AIDS is carried by the global south, the relationship between AIDS and human rights has evolved in response to the nature of the crisis in the developed world. Until recently, the field was predominantly defined by the civil and political rights protections demanded by PLWHA and their allies. For the millions of infected people in the developing world, however, this framework is incomplete. In the eleven Southern and Eastern African countries where 40% of the world's infected people live, AIDS is a generalized epidemic. It is here that treatment has the greatest impact and where the struggle to link infected people with ARVs holds the potential to transform the implementation of economic and social rights.

A. A Disaster Without a Name

1. The Data

Although globally life expectancy has increased by almost twenty years since the 1950s,²⁷ in many high-prevalence states, HIV/AIDS is

27. WHO, WORLD HEALTH REPORT 2003: SHAPING THE FUTURE, at 3 (2003), *available at* http://www.who.int/whr/2003/en/whr03_en.pdf.

generating a protracted reduction in adult life spans. Most heavily AIDS-impacted countries have lost up to fifteen years of life expectancy at birth and have reversed decades of progress.²⁸ Today, the median life expectancy for male citizens of Swaziland is thirty-six years.²⁹ Fifty-six percent of South African fifteen-year-olds will not live to age sixty.³⁰ In response to Botswana's 24% prevalence rate among adults aged fifteen to forty-nine, the country's former president, Festus Mogae, said simply, "We are threatened with extinction."³¹ In the same vein, the Zambian representative to the Security Council has called the pandemic "a threat to our very survival as viable nations."³²

The demographics of death have led some experts to describe AIDS as a Darwinian phenomenon,³³ a force capable of distorting the human metric of societies, and "a disaster [that] has no name and no place in today's social imagination."³⁴ Women everywhere are particularly susceptible to infection. "In sub-Saharan Africa, fifty-seven percent of adults living with the virus are women . . ."³⁵ According to a 2004 study, "in South Africa twice as many women as men [have] the virus . . ."³⁶ Fully two thirds of young HIV-positive people in Sub-Saharan Africa are women and girls.³⁷ In 2006, 43% of young women attending antenatal clinics in Manzini Swaziland were HIV-positive, a pattern that some commentators are calling a crisis of social reproduction.³⁸

28. Alex de Waal, *HIV/AIDS: The Security Issue of a Lifetime*, in GLOBAL HEALTH CHALLENGES FOR HUMAN SECURITY 125, 127 (Lincoln Chen et al. eds., 2003).

29. UNAIDS, Country Reports, *Swaziland*, http://www.unaids.org/en/Regions_Countries/Countries/swaziland.asp.

30. DORRINGTON ET AL., *supra* note 4, at 41.

31. Maggie Farley, At AIDS Disaster's Epicenter, Botswana Is a Model of Action; During U.N. Conference, Leader Speaks of National 'Extinction,' But Country Plans Continent's Most Ambitious Programs, L.A. TIMES, June 27, 2001, available at <http://www.aegis.com/news/lt/2001/LT010621.html>.

32. Press Release, U.N. Info. Serv., Security Council Holds Debate on Impact of AIDS on Peace and Security in Africa, U.N. Doc. UNIS/SC/1173 (Jan. 11, 2000).

33. Alex de Waal & Alan Whiteside, *AIDS: A Darwinian Event?*, in THE HIV/AIDS EPIDEMIC IN SUB-SAHARAN AFRICA IN A HISTORICAL PERSPECTIVE 57-72 (Philippe Denis & Charles Becker, eds., online ed. 2006), available at http://www.refer.sn/rds/IMG/pdf/08WA_ALWHITESIDE.pdf.

34. De Waal, *supra* note 28, 136.

35. Amnesty International, *Women, HIV/AIDS and Human Rights*, 3 (2004), <http://www.amnesty.org/en/library/asset/ACT77/084/2004/en/dom-ACT770842004en.pdf>.

36. *Id.* "[I]n Kenya and Mali the ratio of HIV-positive young women to young men is 4.5 to 1." *Id.* See also Dorrington et al., *HIV/AIDS Profile in the Provinces of South Africa: Indicators for 2002*, at 4 (2002) (recognizing that by 2002 the virus was far more prevalent in female youth than in male youth), available at <http://www.mrc.ac.za/bod/AIDSindicators2002.pdf>.

37. *Id.* The U.N. Secretary-General's Task Force on HIV/AIDS in Southern Africa has detailed the interrelationship among economic dependency, poverty, and HIV/AIDS infection, concluding that "as more and more women and girls take to the streets in search of ways to survive, it will be impossible to ignore the importance of gender transformatory strategies." Report, U.N. Secretary General's Task Force on Women, Girls, and HIV/AIDS in Southern Africa, *Facing the Future Together* 46, <http://womenandaids.unaids.org/regional/default.html>.

38. UNAIDS, *Epidemic Update: Special Report on HIV/AIDS* 13, UNAIDS/06.29E (Dec. 2006). See also Janet Bujra, *AIDS as a Crisis in Social Reproduction*, 31 REV. OF AFR. POL. ECON.

In much of the developing world, women are economically disempowered and forced into transactional sex, intergenerational relationships and other dependency arrangements.³⁹ Unsurprisingly, the trafficking of young girls into prostitution is emerging as an AIDS risk factor because significant numbers of those girls return home HIV-positive.⁴⁰ The power imbalances between husbands and wives are so great in some societies that marriage actually increases the likelihood of infection for women.⁴¹ Few women, much less married women, successfully negotiate condom use.⁴²

The cost for individual households is particularly high. Families routinely mortgage everything to care for those infected with HIV, more often than not a male breadwinner. The burden of caring for a family member with HIV, both in terms of treatment and loss of income, may halve family income, heightening levels of poverty and malnutrition. In severe cases, the caregiving responsibilities represent an existential threat to the household.⁴³ Young adults with HIV return home placing unexpected burdens on elderly parents, not least if they are themselves parents. When breadwinners die, the survivors are left with virtually no safety net. All too often, widows are then subjected to the additional dangers of property-grabbing and disinheritance.⁴⁴ Their children are equally vulnerable. Most HIV-positive children, 90% of whom are infected through vertical transmission,⁴⁵ die before their fifth birthday.⁴⁶ For those

631 (2004).

39. PAUL FARMER, *PATHOLOGIES OF POWER: HEALTH, HUMAN RIGHTS AND THE NEW WAR ON THE POOR* 30 (2005); see also Erika R. George, *Virgin Territory: Virginity-Testing as HIV/Prevention*, 96 CAL. L. REV. 1447, 1449 (2008) (recognizing that in South Africa, the practice of virginity-testing has become common place in some provinces, fueled by the sense that virgins are disease-free).

40. Jay G. Silverman et al., *HIV Prevalence and Predictors of Infection in Sex-Trafficked Nepalese Girls and Women*, J. AM. MED. ASS'N, Aug. 1, 2007, at 536.

41. See, e.g., PHYSICIANS FOR HUMAN RIGHTS, *EPIDEMIC OF INEQUALITY: WOMEN'S RIGHTS AND HIV/AIDS IN BOTSWANA AND SWAZILAND* 100 (2007); Cynthia A. Gomez & Barbara VanOss Marin, *Gender, Culture, and Power: Barriers to HIV-Prevention Strategies for Women*, 33 J. SEX RES. 355, 360 (1996); J. Thomas, *Women's Lack of Control in Relationships May Lead to Inconsistent Condom Use*, 31 INT'L FAM. PLAN. PERSP. 45 (2005).

42. Saidi H. Kapiga et al., *Risk Factors for HIV Infection among Women in Dare-es-Salaam, Tanzania*, 7 J. ACQUIRED IMMUNE DEFICIENCY SYNDROMES 301 (1994).

43. INT'L CRISIS GROUP, *HIV/AIDS AS A SECURITY ISSUE* 6 (2001), http://www.crisisgroup.org/library/documents/report_archive/A400321_19062001.pdf.

44. See Richard S. Strickland, International Center for Research on Women, *To Have and to Hold: Women's Property and Inheritance Rights in the Context of HIV/AIDS in Sub-Saharan Africa*, 20 (June 2004) available at http://www.icrw.org/docs/2004_paper_haveandhold.pdf; Linda Dumba, *Using International Human Rights Instruments to Realize Women's Property and Inheritance Rights in the context of HIV/AIDS in Namibia* 17 (Apr. 30, 2007) (unpublished manuscript, on file with the YHRDLJ).

45. Vertical transmission refers to the infection of children in utero, during the birthing process or via breast feeding. See Jonathan Todres, *Rights Relationships and the Experience of Children Orphaned by AIDS*, 41 U.C. DAVIS L. REV. 417, 454 (2007).

46. See PETER O. WAY, U.S. CENSUS BUREAU, *THE FUTURE OF ADULT MORTALITY UNDER THE AIDS THREAT* 16 (explaining that in 2002, more than half of all deaths of Zimbabwean children under five were caused by AIDS) available at www.un.org/esa/population/publications/adultmort/WAY_Paper11.pdf, at 16 (explaining that in 2002, more than half of all deaths of Zimbabwean children under five were caused by AIDS).

who survive, the prospect of being orphaned is daunting. By 2003, 12.3 million children in Africa had been orphaned by AIDS⁴⁷ and another twenty million are expected in the next decade⁴⁸

2. The Threat to Human Security

The cumulative impact of AIDS on life expectancy, quality of life, women, children, household economics and the fabric of traditional communities is so grave that it now threatens "human security."⁴⁹ The Secretariat of the WHO has begun to use the term "global public health security" to refer to the activities required, both passive and active, "to minimize vulnerability to acute public health events that endanger the collective health of populations living across geographical regions and international boundaries," including avian flu, SARS and HIV/AIDS.⁵⁰ Although commentators disagree about the potential breadth of human security,⁵¹ there is consensus that the concept links the intellectual constructs of development, security and human rights – that is, freedom from fear, freedom from deprivation and the freedom to live in dignity.⁵²

47. UNAIDS, UNICEF & USAID, CHILDREN ON THE BRINK 2004: A JOINT REPORT OF NEW ORPHAN ESTIMATES AND A FRAMEWORK FOR ACTION 3 (July 2004), available at http://www.unicef.org/publications/files/cob_layout6-013.pdf.

48. UNICEF, AFRICA'S ORPHANED AND VULNERABLE GENERATIONS (2006), available at http://www.unicef.org/adolescence/files/Africas_Orphaned_and_Vulnerable_Generations_Children_Affected_by_AIDS.pdf.

49. See *The Global AIDS Crisis Deemed Threat to U.S., Human Security*, 3 GUTTMACHER REP. ON PUB. POL'Y (2000), <http://www.guttacher.org/pubs/tgr/03/3/gr030313b.html>. The term "human security" was first introduced in the mid-1990s in an effort to broaden the concept from 'national security' and the military defense of political boundaries to a 'people-centered' approach of anticipating and coping with the multiple threats faced by ordinary people in an interconnected world. As the 2001 International Commission on Intervention and State Sovereignty reported, "The traditional, narrow perception of security leaves out the most elementary and legitimate concerns of ordinary people regarding security in their daily lives. It also diverts enormous amounts of national wealth and human resources into armaments and armed forces, while countries fail to protect their citizens from chronic insecurities of hunger, disease, inadequate shelter, crime, unemployment, social conflict and environmental hazard." See INT'L COMM'N ON INTERVENTION AND STATE SOVEREIGNTY, THE RESPONSIBILITY TO PROTECT, ¶2.23 (Dec. 2001), available at <http://www.iciss.ca/pdf/commission-report.pdf>.

50. See WHO, 2007 WORLD HEALTH REPORT, A SAFER FUTURE: GLOBAL PUBLIC HEALTH SECURITY IN 21ST CENTURY, available at <http://www.who.int/whr/2007/chapter2/en/index.html>.

51. Most proposed frameworks for understanding human security vary in their relative emphases on freedom from fear and freedom from want. Gary King and Christopher Murray define human security by "the number of years of future life spent outside a state of 'generalized poverty'." Gary King & Christopher Murray, *Rethinking Human Security*, 116 POL. SCI. Q. 585, 585 (2001). Jennifer Leaning and Sam Arie include a psychological dimension in their proposed framework, measuring security in terms of "a sustainable sense of home; constructive social and family networks; and an acceptance of the past and a positive grasp of the future." Jennifer Leaning & Sam Arie, *Human Security in Transition: A Background Document of Definition and Application* (Sept. 2000) (unpublished manuscript, on file with YHRDLJ).

52. See Anne-Marie Slaughter, *Security, Solidarity, and Sovereignty: The Grand Themes of U.N. Reform*, 99 AM. J. INT'L L. 619, 622 (2005).

The collective danger posed by AIDS is underscored by the fact that the United Nations Security Council has convened to discuss the impact of AIDS on peace and security in Africa.⁵³ The extraordinary Security Council meeting on the virus led directly to Security Council Resolution 1308, which declares in its Preamble that HIV/AIDS is "a risk to stability and security."⁵⁴ Resolution 1308 recognizes that "the spread of HIV/AIDS can have a uniquely devastating impact on all levels of society" and reaffirmed "the importance of a coordinated international response to the HIV/AIDS pandemic, given its possible growing impact on social instability and emergency situations."⁵⁵

3. AIDS Exceptionalism

HIV/AIDS is particularly problematic because of who succumbs to the virus. AIDS commonly kills people at a time when they are sexually active, that is, in their middle age, the most economically productive years for the majority of people. Of course, HIV is not the only risk to health, nor is it the largest cause of preventable death. Other infectious diseases, notably tuberculosis and malaria, account for millions of deaths each year.⁵⁶ But those diseases prey on the very young and very old. HIV/AIDS is different. The pandemic has attenuated the class of skilled labor including teachers, doctors, nurses, small business owners, and other members of the urban, managerial and professional elite. The World Bank Group estimates that by 2010, South Africa's GDP will be 17% lower than it would be without the impact of AIDS. Within two generations, South Africa's average household income is predicted to be a quarter of what it would be in the absence of the virus.⁵⁷

AIDS also differs from other diseases because of the stigma and

53. The January 10, 2000, meeting of the Security Council on AIDS marks the first and only time the Security Council has gathered to consider the impact of a pathogenic threat. As Kofi Annan acknowledged, "The impact of AIDS in [Southern Africa] is no less destructive than that of warfare itself. Indeed, by some measures it is far worse. Last year, AIDS killed about ten times more people in Africa than did armed conflict By overwhelming the continent's health services, by creating millions of orphans and by decimating health workers and teachers, AIDS is causing social and economic crises which in turn threaten political stability." Kofi Annan Address, Security Council on the Situation in Africa: The Impact of AIDS on Peace and Security (Jan. 10, 2000).

54. S.C. Res. 1308, Preamble, U.N. Doc S/RES/1308 (July 17, 2000).

55. *Id.* ¶ 4. In the specifics, Resolution 1308 addressed the impact of HIV/AIDS on international peacekeeping operations; it calls on the U.N. to work toward preventing the spread of HIV/AIDS by providing education for peacekeeping personnel and urges member states to develop effective long-term strategies for HIV/AIDS education, prevention, testing, and treatment of their personnel.

56. See WHO, *Global Tuberculosis Control — Surveillance, Planning, Financing*, WHO/HTM/TB/2004.331 (2004), available at www.who.int/tb/publications/global_report/2004/en; WHO, *Guidelines for Malaria Control* (Jan. 2004), available at www.rbm.who.int/cmc_upload/0/000/017/113/who_recommended.htm.

57. Debrewerk Zewdie, Director, World Bank Group, Presentation at the Georgetown University Law Center: HIV/AIDS - A Challenge to Development (Nov. 2006) (Power Point on file with author).

discrimination which still attach to infected persons.⁵⁸ Unlike malaria, HIV/AIDS continues to be associated with a wide range of human rights abuses, both those that facilitate HIV transmission, including intergenerational sex,⁵⁹ and those that target persons already infected, such as discrimination in employment and in access to services of the state.⁶⁰

AIDS has also generated encouraging trends; in the pantheon of modern diseases, HIV is exceptional because of the mass movement that has organized to advocate for research, prevention, care and treatment of the virus.⁶¹ Globally, the mobilization around HIV and AIDS has domestic and international dimensions. Today, South Africa's Treatment Action Campaign is reflective of grassroots organizations that have been so successful that they are forced to consider whether to join government or multilateral entities in the fight against AIDS or maintain their outsider status as unadulterated critics.⁶² No other health movement can claim this degree of achievement or organizing potential.

The accomplishments of AIDS campaigners have translated into defined structures, modalities and unprecedented levels of attention as measured by funding dollars. Although many commentators decry the disproportionate share of global health spending directed to HIV and AIDS,⁶³ proponents of sustained funding counter that combating HIV is not an either/or proposition and that the virus has served as an important catalyst for increased health systems support.⁶⁴ Significantly, the contours of this debate take place within a shared understanding of AIDS exceptionalism and the reality that both the public health consequences and the social meaning of HIV differs from those of other diseases.

58. JONNY STEINBERG, *SIZWE'S TEST: A YOUNG MAN'S JOURNEY THROUGH AFRICA'S AIDS EPIDEMIC* (2008). See also Jonathan Todres, *supra* note 45, at 426 citing General Comment No. 3: HIV/AIDS and the Rights of the Child, CRC/GC.2003/1, ¶ 7 (2003) (observing that children of HIV-positive parents carry additional burdens and "may suffer discrimination directly or be stigmatized when others in their communities assume they, like their parents, have AIDS").

59. PHYSICIANS FOR HUMAN RIGHTS, *supra* note 41, at 70. See also Human Rights Watch, *A Question of Life or Death: Treatment Access for Children Living with HIV in Kenya* (Dec. 16, 2008); Human Rights Watch, *Hidden in the Mealie Meal: Gender-Based Abuses and Women's HIV Treatment in Zambia* (Dec. 18, 2007).

60. See HUMAN RIGHTS WATCH, *LETTING THEM FAIL: GOVERNMENT NEGLECT AND THE RIGHT TO EDUCATION FOR CHILDREN AFFECTED BY AIDS* (2005), available at <http://www.hrw.org/en/reports/2005/10/10/letting-them-fail>.

61. See Amy Kapczynski, *The Access to Knowledge Mobilization and the New Politics of Intellectual Property*, 117 YALE L. J. 804, 828 (2008).

62. See William J. Forbath, *Realizing a Constitutional Social Right – Cultural Transformation, Deep Institutional Reform, and the Roles of Advocacy and Adjudication* (Oct. 8, 2008), available at, <http://ssrn.com/abstract=1292879>.

63. See David J. Casarett & John D. Lantos, *Have We Treated AIDS Too Well? Rationing and the Future of AIDS Exceptionalism*, 128 ANNALS OF INTERNAL MED. 756-59 (1998); Roger England, *The Writing Is On The Wall for UNAIDS*, 336 BMJ 1072 (2008).

64. See Stephen Lewis, *Dead Wrong*, Address before the Third Annual Student AIDS Conference at Harvard Medical School, (Jan. 25, 2008), available at <http://www.aids-freeworld.org/content/view/107/153/>.

B. The First Generation of AIDS and Human Rights Discourse

Notwithstanding the scale of the pandemic and the urgent need for treatment, the field of HIV and the law has traditionally been dominated by antidiscrimination, destigmatization, and privacy principles. The reasons that these principles dominate are manifold and rooted in the history of the pandemic.

AIDS was initially understood by both epidemiologists and the general public as a disease of gay men, injecting drug users, prostitutes and their sexual partners.⁶⁵ Outside of public health circles – and sometimes within the health sector – the disease was met with antipathy; PLWHA faced abject homophobia and discrimination. In the states of Indiana and Florida, HIV-positive children were expelled from public schools.⁶⁶ So great was the fear, ignorance and loathing of PLWHA that HIV-positive employees were fired although they posed no infection risk to their co-workers.⁶⁷ In some countries, marriage licenses were withheld from couples where one partner tested positive for the virus.⁶⁸

Although scientists recognized the composition of the virus in 1984, there was no effective treatment available to people living with HIV/AIDS until 1996. To contain a disease for which there was neither a cure nor comprehensive treatment, most public health programs focused on prevention, care and the amelioration of opportunistic infections. For their part, UNAIDS, the WHO and the NGOs working to combat HIV/AIDS directed their attention to the abuse and opprobrium directed at HIV-infected people.⁶⁹ In this respect, North American and European activist groups including ACT-UP and the Gay Men's Health Crisis, sought to break the silence around AIDS by loudly and effectively championing the needs of infected people.⁷⁰ By staging die-ins and appearing in public bound and gagged, activists in the developed world created performances that generated a deep reservoir of sympathy for PLWHA.⁷¹

65. See, e.g., RANDY SHILTS, *AND THE BAND PLAYED ON: POLITICS, PEOPLE, AND THE AIDS EPIDEMIC* 83 (1987).

66. GOSTIN, *supra* note 24, at xxv.

67. See Sofia Gruskin, *Negotiating the Relationship of HIV/AIDS to Reproductive Health and Reproductive Rights*, 44 AM. U. L. REV. 1191, 1195-96 (1995).

68. See MELISSA LATIGO, MARRIAGE LAWS, LAW DEVELOPMENT COMMISSION OF ZAMBIA (2005), available at http://ocw.mit.edu/NR/rdonlyres/Special-Programs/SP-253Spring-2005/B7165652-1EE7-4128-98C8475C29BC728E/0/melissa_latigo.pdf.

69. The AIDS law community's focus on combating stigma and discrimination is not unique to this field. See RISA L. GOLUBOFF, *THE LOST PROMISE OF CIVIL RIGHTS* (2007) (arguing that in the period before and after *Brown v. Board of Education*, 347 U.S. 483, 494 (1954), U.S. civil rights lawyers focused attention on the stigma associated with segregated education rather than the material deprivations associated with the labor of African American workers).

70. See John G. Twomey, Jr., *AIDS Activism*, HASTINGS CTR. REP., July/Aug. 1990, at 39. Recall that the President of the United States did not publicly mention the disease until the WHO had counted more than 38,000 cases in the U.S. See GOSTIN, *supra* note 24, at xxv.

71. ACT-UP and other groups also offered a blueprint for performative activism that has been appropriated and rearticulated by the Treatment Action Campaign and other groups advocating for economic, social and cultural rights today. See Lucie E. White, *African Lawyers Harness Human Rights to Face Down Global Poverty*, 60 ME. L. REV. 165 (2008).

By 1997, the United States was spending \$8.5 billion per year on 44,000 domestic infections.⁷² In Uganda, where the prevalence rate peaked at 18% of the adult population, President Museveni destigmatized the disease by drawing attention to infections among respected military personnel. Museveni also urged men to limit their number of sexual partners.⁷³ And even as AIDS became a generalized epidemic in East and Southern African states in the mid 1990s, Senegal helped to contain the impact of the virus by investing significant resources to increase AIDS awareness and prevention.⁷⁴

Still the disease progressed. Public health officials quickly recognized that the principles and practices used to guide the control of other communicable diseases such as tuberculosis, typhoid, or most sexually transmitted infections were maddeningly inapplicable to HIV/AIDS. At the outset of the epidemic, the use of surveillance, prevention and the threat of quarantine failed to stop the spread of the disease.⁷⁵ Too often, individuals who suspected that they were HIV-positive were driven underground, where it was difficult to track the progression of the disease.

The legal developments in this era reflect the challenges faced by lawyers and AIDS activists confronting demonstrable bigotry and discrimination. In Canada, Simon Thwaites, a seaman in the Armed Forces, won a landmark antidiscrimination suit after his employment was terminated based on his HIV-positive status.⁷⁶ In Botswana, an Industrial Court confirmed that an employee could not be dismissed for refusing to submit to an HIV antibody test.⁷⁷ In *Bragdon v. Abbott*, the United States Supreme Court held that asymptomatic HIV constitutes a disability within the meaning of the American with Disabilities Act, thus serving to prevent discrimination against seropositive individuals.⁷⁸

The fear, hatred, and maltreatment that gave rise to these cases informed three critical understandings of AIDS scholars. First, as Jonathan Mann, the first WHO Global AIDS Director, observed, AIDS is contained

72. See Greg Behrman, *The Invisible People: How the U.S. Has Slept Through the Global AIDS Pandemic, the Greatest Humanitarian Catastrophe of Our Time* 78 (2004). By contrast, African states confronting tens of millions of infected people spent a total of \$160 million on AIDS in 1997.

73. Helen Epstein, *AIDS: The Lesson of Uganda*, N.Y. REV. BOOKS, July 5, 2001, at 18.

74. Lawrence O. Gostin, *The Global Reach of HIV/AIDS: Science, Politics, Economics, and Research*, 17 EMORY INT'L L. REV. 1, 21 (2003).

75. *Id.* at 7.

76. *Canada (Attorney General) v. Thwaites*, [1994] 3 F.C. 38 (Can.). See also *Hoffman v. South African Airways*, 2000 (11) BCLR 1235 (CC) (S. Afr.) (finding South African Airways' refusal to hire HIV-positive people to violate South Africa's constitutional guarantee of equality and ordering the airline to offer to employ Hoffmann as a cabin attendant); *MX v. ZY*, A.I.R. 1997 BOM (High Court of Judicature, India 1997) (ruling against ZY, a public sector corporation that refused to employ PLWHA, including MX), quoted at <http://www.cehat.org/rthc/paper3.htm>.

77. *Diau v. Botswana Building Society (BBS)*, Case No. IC 50/2003, Indus. Ct. of Botswana (2003).

78. 524 U.S. 624 (1998); see also *Doe v. Dolton Elementary School District*, 694 F.Supp. 440, 447 (N.D. Ill. 1988) (repudiating school district's attempt to separate HIV-positive students and stating that "if AIDS-infected children are segregated, they will suffer the same feelings of inferiority the Supreme Court sought to eradicate in *Brown v. Board of Education* . . .").

only by assiduously protecting the civil and political rights of HIV-positive people.⁷⁹ Without protection, individuals refuse to be tested for HIV and the resulting decline in accurate information undermines public health efforts to halt the spread of the disease. Conversely, where individuals can reveal their status without fear of reprisal, information flourishes, educational efforts take root, and the prevention of new cases is a realistic possibility. "[T]he evolving HIV/AIDS pandemic," Mann wrote, "[shows] a consistent pattern through which discrimination, marginalization, stigmatization, and more generally, a lack of respect for the human rights and dignity of individuals and groups heighten their vulnerability to becoming exposed to HIV."⁸⁰ In turn, an HIV-positive status begets human rights violations, including discrimination and violence.

Second, Mann, Lawrence Gostin, and others linked the promotion and protection of human rights with the promotion and protection of public health, two fields that had not previously been connected.⁸¹ Where international human rights are defined narrowly by reference to civil and political rights, individuals may enjoy privacy and protection against abuses of power by government authorities but have little recourse to affirmative goods.⁸² In contrast, public health has historically been defined by state efforts to ensure the conditions under which whole communities may be healthy but the discipline has traditionally diminished the significance of individual claims. While the dichotomy is obvious, one signal achievement of the WHO and UNAIDS was the reconceptualization of human rights and public health as complementary, not competing values.⁸³ This understanding emphasized the way that public health can respect the needs of individuals, promote trust between public health personnel and the community, foster conditions of nondiscrimination, and support access to health care and education.⁸⁴

Third, social scientists began to acknowledge the social determinants of health in the spread of the disease. Experts concluded that the HIV/AIDS pandemic thrives when economic conditions force workers to migrate in search of employment, bringing forms of social fragmentation that loosen family ties and encourage abandonment of traditional sexual mores and taboos.⁸⁵ Under Mann's leadership, the WHO publicly identified AIDS as a disease of global poverty because the vast majority of infections are in developing countries. Writing in 1997, Mann also noted that "it [had become] clear that those populations who, before AIDS arrived, were

79. Jonathan M. Mann, *Afterword* to LAWRENCE O. GOSTIN & ZITA LAZZARINI, *HUMAN RIGHTS AND PUBLIC HEALTH IN THE AIDS PANDEMIC* 167 (1997).

80. Jonathan M. Mann et al., *Health and Human Rights*, in *HEALTH AND HUMAN RIGHTS* 17 (Jonathan M. Mann et al. eds., 1999).

81. Leonard S. Rubenstein, *Foreword* to *PUBLIC HEALTH & HUMAN RIGHTS: EVIDENCE-BASED APPROACHES* xi-xiii (Chris Beyrer & H.F. Pizer eds., 2007).

82. Gerhard Erasmus, *Socio-Economic Rights and Their Implementation: The Impact of Domestic and International Instruments*, 32 INT'L J. LEGAL INFO. 243 (2004).

83. GOSTIN, *supra* note 24, at 64-5.

84. *See id.* at 43.

85. EPSTEIN, *supra* note 12. *See also* Nanu Poku & Fantu Cheru, *The Politics of Poverty and Debt in Africa's AIDS crisis*, 15 INT'L REL. 37, 89-96 (2001).

already societally marginalized or stigmatized, became at greatest risk of HIV infection.”⁸⁶ Mann’s conclusions have only been reinforced in subsequent years.⁸⁷

The International Guidelines on HIV/AIDS and Human Rights (“the Guidelines”), a joint publication of the Office of the United Nations High Commissioner for Human Rights and of UNAIDS, reflect each of these insights. The Guidelines aim to assist states in translating international human rights norms into practical observance in the context of HIV. To this end, the Guidelines emphasize a host of civil and political rights obligations of states including non-discrimination and equality before the law; the rights of women and children as particularly vulnerable groups; the right to marry and to found a family; and the right to privacy, liberty of movement and to security of the person.⁸⁸

But the first generation of thinking about HIV/AIDS and human rights was largely silent on the subject of treatment. Writing in 1998 – only two years after the efficacy of ART was discovered and three years before the price of drugs began to drop precipitously – Mann downplayed the importance of medicine per se to global public health. “The contribution of medicine to health,” Mann offered, “while undeniably important (and vital in certain situations), is actually quite limited.”⁸⁹

C. The Impact of Treatment

Science has challenged Mann’s assertion that treatment bears limited value. The fulcrum of the case for treatment is that it is the most effective insurance against premature morbidity, opportunistic infections, and death for HIV-positive people.⁹⁰ Many observers describe the “Lazarus” effect of ART.⁹¹ Sustained treatment drastically improves the quality of life for HIV-infected people; it renders symptoms largely invisible – an important check against some forms of abject discrimination – and allows HIV-positive individuals to work, parent, and live as full a life as possible.⁹²

86. Jonathan Mann, *Afterword* to LAWRENCE O. GOSTIN & ZITA LAZZARINI, *HUMAN RIGHTS AND PUBLIC HEALTH IN THE AIDS PANDEMIC* (1997). See also Peter Piot, Executive Director of UNAIDS, “Message from Peter Piot on International Women’s Day, Mar. 8, 2003,” available at http://data.unaids.org/Media/Speeches01/sp_piot_womensday_080303_en.doc

(recognizing that inequality between the sexes and women’s lack of power to challenge these inequalities lie at the heart of women’s vulnerabilities to HIV).

87. See WHO, COMMISSION ON SOCIAL DETERMINANTS OF HEALTH FINAL REPORT (2008), available at http://www.who.int/social_determinants/en/.

88. UNAIDS, *INTERNATIONAL GUIDELINES ON HIV/AIDS AND HUMAN RIGHTS*, U.N. Sales No. E.06XIV.4 (2006).

89. Jonathan M. Mann, *Medicine and Public Health, Ethics and Human Rights*, in *HEALTH AND HUMAN RIGHTS*, *supra* note 80, at 441.

90. For the HIV Outpatient Study Investigations, see F.J. Palella et al., *Declining Morbidity and Mortality among Patients with Advanced Human Immunodeficiency Virus Infection*, 338 *NEW ENG. J. MED.* 853 (1998).

91. Laura Bush, Speech at the National Press Club (July 25, 2007), <http://georgewbush-whitehouse.archives.gov/news/releases/2007/07/20070725-5.html>.

92. Joanne Csete, *Several for the Price of One: Right to AIDS Treatment as Link to Other Human Rights*, 17 *CONN. J. INT’L L.* 263, 269 (2002).

Treatment of HIV is therefore biomedically and conceptually different than interventions for many other diseases. There is no single cure for AIDS and scientists have not yet developed a vaccine to guard against infection. Although children cannot be inoculated against AIDS as they are for meningitis, diphtheria, and yellow fever, treatment for HIV is highly effective and can lower viral loads to almost undetectable levels.⁹³

In the past decade, the problems associated with ART, principally the toxicity of the medicines and the large burden of pill taking, have been addressed by therapeutic regimens that have become simpler, better tolerated, and more effective.⁹⁴ Treatment may also act as a form of prevention, beginning with the drugs used to inhibit mother to child transmission.⁹⁵ Substantial medical evidence demonstrates that treatment leads to reduced rates of transmission by infected persons as viral loads decline with ART.⁹⁶ Médecins Sans Frontières (MSF) has also shown that the general population makes dramatically greater use of prevention services when HIV-positive individuals have access to ART as well as treatment for opportunistic infections associated with AIDS.⁹⁷ Many public health officials believe that "prevention makes treatment affordable, and treatment can make prevention more effective."⁹⁸

Even in resource-constrained settings, treatment works.⁹⁹ Global efforts to combat HIV have succeeded in placing millions of people on treatment in the developing world, despite chronic shortages of health care workers.¹⁰⁰ There is growing evidence from a number of sites in Africa that

93. The efficacy of ART is mirrored by the cancer drug Gleevec (Imatinib Mesylate) produced by Novartis to treat Chronic Myeloid Leukemia. In India, treatment advocates led by the Lawyers Collective for Human Rights, successfully challenged Novartis' patent on Gleevec in an effort to make the drug more available. See *infra*, Section C.1.

94. See Julio S. G. Montaner et al., *The Case for Expanding Access to Highly Active Antiretroviral Therapy to Curb the Growth of the HIV Epidemic*, 368 LANCET 531 (2006), available at [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(06\)69162-9/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(06)69162-9/fulltext).

95. See Viviane D. Lima et al., *Expanded Access to Highly Active Antiretroviral Therapy: A Potentially Powerful Strategy to Curb the Growth of the HIV Epidemic*, 198 J. OF INFECTIOUS DISEASE 59 (2008) (reporting on a study that demonstrated the dramatic impact that increased HIV coverage has in reducing HIV transmission). But see EPSTEIN, *supra* note 12, at xiii (2007) (arguing, based on the epidemic in Africa, that prevention is distinct from and more important than treatment).

96. See Mariah J. Wawer, et al., *Rates of HIV-1 Transmission per Coital Act, by Stage of HIV-1 Infection*, in Rakai, Uganda, 191 J. OF INFECTIOUS DISEASES 1403-09 (2005). See also Berkeley Law Clinical Program, Memorandum Addressing the Need for a Treatment Agenda to be Included in the Proposed World Bank-Financed Sri Lanka National AIDS Prevention Project, http://www.law.berkeley.edu/clinics/ihrcl/pdf/access_to_hiv_medicines.pdf (2002).

97. Csete, *supra* note 92, at 264.

98. See J. A. Saloman et al., *Integrating HIV-Prevention and Treatment: From Slogans to Impact*, 2 PUB. LIBR. OF SCI. (PLOS) MED. 50, 55 (2005), available at <http://medicine.plosjournals.org/perlserv/?request=get-document&doi=10.1371/journal.pmed.0020016>.

99. Serena P. Koenig et al., *Scaling-up HIV Treatment Programmes in Resource-limited Settings: the Rural Haiti Experience*, 18 AIDS 21, 25 (2004); TRACY KIDDER, MOUNTAINS BEYOND MOUNTAINS (2003) (providing an account of the work of Paul Farmer, Jim Kim, and Partners in Health in Haiti and other impoverished states).

100. AIDS is accelerating the mass migration of sub-Saharan health workers; Malawi has seventeen nurses per 100,000 people, while many Northern countries boast more than 1,000 per 100,000. See Editorial, *Africa's Health-Care Brain Drain*, N.Y. TIMES, Aug. 13, 2004. See also PHYSICIANS FOR HUMAN RIGHTS, BOLD SOLUTIONS TO AFRICA'S HEALTH WORKER SHORTAGE 3

ARV treatment also promotes food security and improves the state of medical services generally.¹⁰¹ Should scientists ever develop a vaccine, the health care infrastructure necessary to implement ART may facilitate administration of a cure.¹⁰²

II. THE RIGHT TO TREATMENT

If the first generation of AIDS and human rights law addressed discrimination, the second generation is focused on treatment. In courts and legislatures around the world, authorities are confronting demands for ART. Significantly, the treatment cases are generally not rooted in an anti-discrimination framework or the claim that certain patients deserve treatment because others have it. Rather, these cases are a plea for medication, most frequently premised on the human dignity of HIV-positive people and the responsibility of states to safeguard a minimal quality of life for all citizens. In the consistent and unyielding demand for ART, treatment campaigners have built on the networks and language developed by AIDS activists in the early years of the disease and applied those strategies and organizing possibilities to the realm of expensive medicines.

A. The Source of the Right

Demands for AIDS medicines draw upon an international human rights framework that encompasses positive claims to certain goods. A right to treatment of HIV and AIDS is a right to life, a right to live in dignity, and a right to health. As Alicia Yamin observed in her seminal article, because treatment forestalls death and grave morbidity, domestic courts and international bodies are increasingly finding that the deprivation of treatment violates the right to life.¹⁰³ Rights to life embody non-derogable *jus cogens* norms of international law and may therefore be invoked to underscore the urgency of assuring treatment for HIV/AIDS.

(2006).

101. See ALISON GARDNER, THE WORLD BANK, HIV/AIDS, NUTRITION, AND FOOD SECURITY: WHAT CAN WE DO (A SYNTHESIS OF INTERNATIONAL GUIDANCE) (2008); see also Food and Agricultural Org. of the U.N., HIV/AIDS and Food Security, <http://www.fao.org/hivaids/> (last visited Mar. 2, 2009).

102. Alan Berkman, *Confronting Global AIDS: Prevention and Treatment*, 91 AM. J. PUB. HEALTH 1348, 1349 (2001).

103. Yamin, *supra* note 26. See generally Office of the High Commissioner for Refugees, *Revised Guideline 6 on Access to Prevention, Treatment, Care and Support* (July 2002) (suggesting that states should enact legislation to provide for the regulation of HIV-related goods, services, and information, so as to ensure widespread availability of medication, prevention measures and other services); U.N. Comm. on the Rts. of the Child, *General Comment No. 3: HIV/AIDS and the Rights of the Child*, U.N. Doc. CRC/GC/2003/3 (Mar. 2003) (asserting that the rights in the general principles of the Convention – non-discrimination (art. 2); the child's interest as a primary consideration (art. 3), life, survival, and development (art. 6); and the rights to have her/his views respected (art. 12) – should be the guiding themes in the consideration of all levels of HIV/AIDS prevention, treatment, care, and support).

Further, international human rights law provides that the exercise of the right to treatment must be realized on a non-discriminatory basis, without distinction of any kind based on race, ethnic group, color, sex, language, religion, political or any other opinion, national or social origin, property, birth, or other status. Discrimination based on any ground that could frustrate the enjoyment or exercise of people's rights to life and to health constitutes a violation of international law.¹⁰⁴ Indeed, the right to health for vulnerable populations is addressed in the Convention on the Elimination of All Forms of Racial Discrimination,¹⁰⁵ the Convention on the Elimination of All Forms of Discrimination Against Women,¹⁰⁶ the Convention on the Rights of the Child,¹⁰⁷ and the 1978 Alma-Ata Declaration, which expressed the importance of primary health care.¹⁰⁸

In the context of the AIDS pandemic, the right to treatment also implicates a right to education, information, and the benefit of scientific progress. The right to the benefit of scientific progress, contained in Article 15 of the International Covenant on Economic, Social, and Cultural Rights (ICESCR), is particularly salient for treatment purposes because ART has evolved to include second and third-line therapies directed at patients who have developed resistance or who require alternative formulations when the first-line regimen is ineffective.¹⁰⁹

Notwithstanding the importance of rights to life, to live free of discrimination, to the benefits of scientific progress, and the overlapping rights promotion structure suggested by the history of AIDS, most observers situate demands for treatment primarily as rights to health guaranteed by both domestic and international law — the proposition that all human beings are entitled to “healthcare” or to “medical care.”¹¹⁰

The right to health is a foundational element of the global human rights matrix and has been a central piece of the international human rights regime since its inception. The WHO Constitution expresses the right as: “The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race,

104. U.N. Comm. on Econ., Soc., and Cultural Rights [CESCR], *General Comment No. 14: The Right to the Highest Attainable Standard of Health*, ¶12, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000) [hereinafter General Comment No. 14].

105. International Convention on the Elimination of All Forms of Racial Discrimination art. 5, *opened for signature* Mar. 7, 1966, 660 U.N.T.S. 212.

106. Convention on the Elimination of All Forms of Discrimination Against Women arts. 12 and 14, *adopted* Dec. 18, 1979, 1249 U.N.T.S. 13, 19 I.L.M. 33 (eliminating gender-based discrimination in health services).

107. Convention on the Rights of the Child art. 24, *adopted* Nov. 20, 1989, 1577 U.N.T.S. 3, 28 I.L.M. 1456.

108. WHO, *The Alma-Ata Declaration* (Sept. 12, 1978).

109. Many of the same pharmaceutical companies that developed the first generation of ARVs have produced second-generation drugs as well. In general, second-line drugs are far more costly. See Colleen V. Chien, *HIV/AIDS Drugs for Sub-Saharan Africa: How Do Brand and Generic Supply Compare*, 2 PLOS ONE e278 (2007). Some of these same firms are also at work on a vaccine.

110. See Steven D. Jamar, *The International Human Rights to Health*, 22 S. U. L. REV. 1 (1994); Virginia A. Leary, *The Right to Health in International Human Rights Law*, 1 HEALTH & HUM. RTS. 24 (1994); Jennifer Prah Ruger, *Toward a Theory of a Right to Health: Capability and Incompletely Theorized Agreements*, 18 YALE J. OF L. & HUMAN. 273 (2006).

religion, political belief, economic or social conditions.”¹¹¹ Health is also a fundamental human right, indispensable for the exercise of other human rights.¹¹²

Article 25 of the Universal Declaration of Human Rights presages the right to health: “Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services”¹¹³ The right was subsequently codified in Article 12 of the ICESCR, which affirms that states parties “recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health” and agree to take steps necessary for, among other goals, “the prevention, treatment and control of epidemic, endemic, occupational and other diseases.”¹¹⁴

Health rights also appear in several regional human rights agreements. Article 16 of the African Charter on Human and Peoples’ Rights (“the Banjul Charter”) establishes the right of every individual to enjoy the “best attainable state of physical and mental health” and declares that states parties shall take “the necessary measures to protect the health of their people.”¹¹⁵ Similarly, the Protocol of San Salvador, a 1988 addition to the American Convention on Human Rights, commits states parties to broad duties to implement a right to health, including universal extension of treatment for endemic and other diseases.¹¹⁶

Rights to health are frequently described as second generation rights, a bundle of claims requiring positive government action to ensure that they are realized. That government officials accord such claims subordinate status is partly a function of the diluted nature of state obligations under the ICESCR. The Covenant allows for the progressive realization of such rights by states and subjects implementation to an available resources limitation.¹¹⁷ Moreover, enforcement of the ICESCR is governed by a diluted reporting mechanism that permits no meaningful sanctions. Although the intention of the Covenant’s drafters was to promote enforcement of the right to health using a State’s ‘maximum available resources,’ recalcitrant states parties have exploited the lack of definition (including the undefined meaning of health) and flexibilities inherent in the treaty’s language to avoid fixed obligations.¹¹⁸

In the absence of a single treaty-provided forum in which to assert

111. WHO Constitution, 1 (45th ed. 2006), available at http://www.who.int/governance/eb/who_constitution_en.pdf.

112. General Comment No. 14, *supra* note 104, para. 1.

113. Universal Declaration of Human Rights art. 25, ¶ 1, G.A. Res. 217A, U.N. GAOR, 3d Sess., 183rd plen. mtg., U.N. Doc. A/810 (Dec. 10, 1948).

114. International Covenant on Economic, Social and Cultural Rights [hereinafter ICESCR] art. 12, G.A. Res. 2200 (XXI), U.N. GAOR, Supp. No. 16, U.N. Doc. A/6316 (Dec. 16, 1966).

115. African Charter on Human and Peoples’ Rights Art. 16, *adopted* June 27, 1981, OAU Doc. CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (*entered into force* Oct. 21, 1986).

116. Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights art. 10, *opened for signature* Nov. 17, 1988, 28 I.L.M. 161.

117. See ICESCR, *supra* note 114; General Comment No. 14, *supra* note 104, para. 2.

118. MATTHEW CRAVEN, THE INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS 16-22, 25-27, 113-114 (1995).

economic, social, and cultural rights claims, the right to health means different things in different places. The enduring debate surrounding the operative conception of specific health demands, the interpretation of specific language,¹¹⁹ and standards for monitoring progress has allowed many actors in the international community to treat socio-economic rights commitments as “hortatory goals, programmatic objectives [and] utopian ideals.”¹²⁰ Indeed, as recently as 1994, Robert E. Robertson wrote that unlike civil and political rights, “[economic, social, and cultural rights] have yet to be translated in a meaningful way into national laws, and they have not been taken to heart by the people.”¹²¹

In this view, claims to health occupy the status of soft law – guiding principles perhaps, but subject to fiscal and political realities and squarely within the province of legislatures, not courts.¹²² Proponents of this perspective argue that courts are incapable of adjudicating economic, social, and cultural rights because they lack the capacity to make informed decisions about the methods of implementing such rights and are ill-equipped to ensure or supervise the enforcement of judgments.¹²³

Additionally, “these rights are often [presented as] non-justiciable because constitution-makers have, for other policy reasons, chosen to exclude courts from this area (as for example, in India, Ireland, Pakistan, Ghana and Nigeria), by casting [economic, social and cultural rights] as Directive Principles of State Policies . . . rather than entitlements of individuals.”¹²⁴ Accordingly, some judges, most notably in the U.S., have refused to entertain alleged violations of the ICESCR, reasoning that its “boundless and indeterminate” principles cannot be applied juridically.¹²⁵ The sheer cost of ARVs, especially for developing countries, poses a final obstacle. And yet the trend in domestic courts, particularly in the context of demands for expensive ART, is that the right to health is not unduly

119. The Covenant is drafted at a level of generality that resists imposing an obligation on states parties to make specific medicines available to individuals in need. In fact, the historic role of medicines in promoting public health is limited. See Jonathan M. Mann, *supra* note 89.

120. See Michael J. Dennis & David P. Stewart, *Justiciability of Economic, Social and Cultural Rights*, 98 AM. J. INT’L L. 462, 464 (2004). But see Yuval Shany, *Stuck in a Moment in Time: The International Justiciability Economic, Social and Cultural Rights* 77-106, in EXPLORING SOCIAL RIGHTS 77, 78 (Daphne Barak-Erez & Aeyal M. Gross eds., 2007) (arguing that economic, social, and cultural rights are internationally justiciable and can be meaningfully enforced by international courts and tribunals).

121. Robert E. Robertson, *Measuring State Compliance with the Obligation to Devote the “Maximum Available Resources” to Realizing Economic, Social, and Cultural Rights*, 16 HUM. RTS. Q. 693, 694 (1994).

122. For a conceptual discussion of soft law generally, see Andrew T. Guzman & Timothy L. Meyer, *International Common Law: the Soft Law of International Tribunals*, 9 CHI. J. INT’L L. 515, 516 (2009); and DINAH L. SHELTON, *SOFT LAW: HANDBOOK OF INTERNATIONAL LAW* (2008), available at <http://ssrn.com/abstract=1003387>.

123. Yash Ghai, *Introduction to YASH GHAI & JILL COTTRELL, ECONOMIC, SOCIAL & CULTURAL RIGHTS IN PRACTICE* (2003).

124. *Id.* at 1.

125. *Flores v. S. Peru Copper Corp.*, 414 F.3d 233, 255 (2d Cir. 2003). The United States has not ratified the ICESCR. Cf. *San Antonio Indep. Sch. Dist. v. Rodriguez*, 411 U.S. 1 (1973) (holding that because education is not a fundamental right under the Federal Constitution, the Texas school financing plan in question did not violate rational basis review).

vague and that the nature of the claim to treatment is wholly justiciable.

B. Defining the Right to Treatment

The right to treatment of HIV and AIDS is not a guarantee of health, nor is it a right to every conceivable medical innovation used to combat the virus. It is rather an increasingly significant part of what a compassionate society does to ensure the health of its people.¹²⁶ The provision of ART satisfies a critical component of the right to health care in constitutional and administrative laws governing state obligations.

At the international level, the Committee on Economic, Social and Cultural Rights (the "Committee" or "CESCR"), which interprets the ICESCR, addressed the meaning of the broadly-recognized right to health in its 2000 General Comment No. 14 on the right to the highest attainable standard of health.¹²⁷ The Comment confirms the emerging understanding of the right to health as a right to access the specific goods and services needed to maintain the highest possible standard of health.¹²⁸ As the Committee explains, "The right to health, like all human rights, imposes three types or levels of obligations on States parties: the obligations to respect, protect and fulfil[.]"¹²⁹

1. The Obligation to Respect

The obligation to respect requires states parties to refrain from interfering directly or indirectly with the enjoyment of the right to health.¹³⁰ The negative commitments associated with the right to treatment suggest that states may not interfere with existing treatment¹³¹ or create conditions of scarcity under which patients in need of treatment are deprived of ART. Respect, in this context, demands that states refrain from discriminating against people within the state's boundaries who require treatment. States could not, for example, direct ART programs to a single ethnic group or geographic region of the country to the exclusion of others.¹³²

126. See generally, Tony Evans, *A Human Right to Health?*, 23 THIRD WORLD Q. 197 (2002) (arguing that socio-economic rights represent the preconditions for civil and political rights to be valued equally).

127. General Comment No. 14, *supra* note 104.

128. *Id.* ¶ 9.

129. *Id.* ¶ 33 (emphasis omitted).

130. *Id.* ¶ 33; see also, Pierre de Vos, *Pious Wishes or Directly Enforceable Human Rights?: Social and Economic Rights in South Africa's 1996 Constitution*, 13 S. AFR. J. HUM. RTS. 67, 82 (1997); Ida Elisabeth Koch, *Dichotomies, Trichotomies or Waves of Duties*, 5 HUM. RTS. L. REV. 81, 82 (2005); PAUL HUNT, *RECLAIMING SOCIAL RIGHTS* 131 (1996) (elaborating on the duty to respect under the ICESCR).

131. This is a non-trivial commitment since patients are generally on ART for life.

132. Even in the absence of *de jure* discrimination, a state's ART programs may nonetheless miss the mark. "In Ukraine, for example, injecting drug users represent more than 80 percent of those currently in need of treatment, but less than 5 percent of those receiving it." Jonathan Cohen, Nancy Kass & Chris Beyrer, *Human Rights and Public Health*

Domestic courts have no difficulty understanding the responsibility to respect. In the Canadian case of *Eldridge v. British Columbia*,¹³³ for example, appellants, who were deaf, successfully challenged the failure of British Columbia's government to provide sign-language interpreters as part of its publicly funded health care system. The Supreme Court of Canada held that the province's failure to respect the needs of hearing impaired individuals constituted a violation of substantive equality.

The justiciability of the obligation to respect is reflected in the decisions of supranational tribunals too, including the Human Rights Committee, which addresses individual complaints under the Optional Protocol to the International Covenant on Civil and Political Rights (ICCPR). The Human Rights Committee has found economic and social rights violations in cases relating to the discriminatory refusal to provide social welfare benefits¹³⁴ and the right of indigenous peoples to their own culture.¹³⁵ Likewise, the European Court of Human Rights has found violations of the right to respect in cases involving unequal access to social welfare benefits¹³⁶ and the provision of adequate medical care in prison where the state has prevented detainees from providing for their own health.¹³⁷

2. The Obligation to Protect

The obligation to protect requires states parties to assist vulnerable populations and to safeguard the availability of medications. General Comment No. 14 clarifies that states parties are required to "ensure that privatization of the health sector does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services; to control the marketing of medical equipment and medicines by third parties; and . . . ensure that third parties do not limit people's access to health-related information and services."¹³⁸ Accordingly, the duty to protect may demand that states regulate the market for essential medicines and exercise state control over information (for example to prevent quackery¹³⁹ and counterfeit medications).¹⁴⁰ In

Ethics: Responding to the Global HIV/AIDS Pandemic, in PUBLIC HEALTH AND HUMAN RIGHTS: EVIDENCE-BASED APPROACHES 362, 382 (Chris Beyer & H.F. Pizer eds., 2007).

133. *Eldridge v. British Columbia* (Attorney General) [1997] 3 S.C.R. 624 (Can.).

134. *Zwaan-de Vries v. the Netherlands*, Commc'n No. 182/1984, U.N. Doc. CCPR/C/OP/2 at 209 (Human Rights Comm. Apr. 9, 1987). See also David Marcus, *The Normative Development of Socioeconomic Rights Through Supranational Adjudication*, 42 STAN. J. INT'L L. 53, 69 (2006) (evaluating socioeconomic rights adjudication in regional and international fora).

135. See *Ominayak v. Canada*, Commc'n No. 167/1984, U.N. Doc. A/45/40 at 1 (Human Rights Comm. Mar. 26, 1990).

136. *Wessels-Bergervort v. Netherlands*, App. 34462/97, Eur. Ct. H.R., Judgment, para. 54 (2002).

137. *McGlinchey v. United Kingdom*, App. No. 50390/99, Eur. Ct. H.R. 57 (2003).

138. General Comment No. 14, *supra* note 104, para. 35.

139. EPSTEIN, *supra* note 12, at 125.

140. AIDS activists argue that medicines are categorically different from cultural goods like Barbie dolls or software. See Médecins Sans Frontières, *A Matter of Life and Death: The Role of Patents in Access to Essential Medicines*, <http://www.msf.org/source/pdf/2001/>

2001, in a poignant illustration of the protective principle, prominent voices in the U.S. Congress called for compulsory licensing to increase the availability of ciprofloxacin to treat anthrax, under the authority of 28 U.S.C. § 1498.¹⁴¹

There is a significant body of national and international case law concerning the duty to protect health rights, including cases addressing access to ARVs.¹⁴² In *Hazel Tau v GlaxoSmith Kline, Boehringer Ingelheim*,¹⁴³ complainants sought to regulate the pricing of ART using South Africa's National Competition Commission in a suit against two large pharmaceutical companies. The complainants alleged that the firms had breached Article 8(a) of South Africa's Competition Act 89 of 1998 by charging excessive prices for antiretroviral medicines to the detriment of consumers. "The excessive pricing of ARVs is directly responsible for premature, predictable and avoidable deaths of people living with HIV/AIDS, including both children and adults," the complainants charged.¹⁴⁴ The Competition Commission found for the complainants, although it allowed the defendants to amortize development costs. The Commission's decision promoted a settlement between the parties under which GlaxoSmithKline and Boehringer Ingelheim agreed to grant voluntary licenses on their patented medicines to generic firms in exchange for a royalty.

3. The Obligation to Fulfill

As important as the responsibilities to respect and protect are, the litmus test for the right to treatment occurs within the obligation to fulfill. In the Committee's view, the obligation to "fulfill" can involve either an affirmative duty to provide or the less immediate responsibility to "facilitate" realization of the right in question. In a series of General Comments, the Committee has declared that states parties are obligated to "fulfil[sic]" the rights to food, water, and health when individuals or

dohacol.pdf (2001).

141. Press Release, Sen. Chuck Schumer, *New Cipro Source Could Dramatically Increase Supply* (Oct. 16, 2001), available at http://www.senate.gov/~schumer/SchumerWebsite/pressroom/press_releases/PR00728.html.

142. The African Commission on Human and People's Rights in its *Decision Regarding Communication 155/96* activated the obligation to protect in a suit brought by two NGOs against the Nigerian Petroleum Development Company and Shell Petroleum Development Corporation for conducting operations that produced widespread environmental degradation and grave health problems in Ogoniland. The Commission concluded that the Nigerian Government had a duty to monitor and control the activities of multinational corporations. See *Decision Regarding Communication 155/96 (Social and Economic Rights Action Center/Center for Economic and Social Rights v. Nigeria)*, Case No. ACHPR/COMM.AO44/1 (May 27, 2002); Dinah Shelton, *Decision Regarding Communication 155/96*, 96 AM. J. INT'L L. 937 (2002).

143. Statement of Complaint, *Hazel Tau & Others v GlaxoSmith Kline and Boehringer Ingelheim*, Competition Commission of South Africa (Sept. 2002), <http://www.tac.org.za/Documents/DrugCompaniesCC/HazelTauAndOthersVGlaxoSmithKlineAndOthersStatementOfComplaint.doc>

144. *Id.*

groups are unable to realize the right "by the means at their disposal."¹⁴⁵

In practice, fulfillment of the right to health has long required states to demonstrate policy and budgetary commitments to achieving the progressive realization of health care.¹⁴⁶ Historically, states parties to the ICESCR have pointed to the allocation of substantial resources in their national budgets for vaccination programs and the measures they take to prevent the spread of infectious disease as illustrations of compliance with ICESCR commitments.¹⁴⁷

General Comment No. 14 goes further and instructs states parties to provide access to "essential drugs, as defined by the WHO Action Programme on Essential Drugs" as part of the state's "minimum core obligations" under the ICESCR. According to the latest WHO definition, essential medicines are "those that satisfy the priority health care needs of the population."¹⁴⁸ They are selected with due regard to disease prevalence, evidence on efficacy and safety, and comparative cost-effectiveness. In 2002, a full complement of antiretroviral drugs was added to the WHO's essential drugs list.¹⁴⁹

The Committee's interpretation is a departure from its historic reticence to declare that states parties are obligated to provide specific health-related goods,¹⁵⁰ but it is hardly alone.¹⁵¹ While many states, particularly affluent ones, now make ARVs available as a standard pharmaceutical component of comprehensive health coverage,¹⁵² the

145. General Comment No. 14, *supra* note 104, at para. 37; CESCR, *The Right to Water* (Arts. 11 and 12 of the ICESCR) General Comment 15, ¶ 25, U.N. Doc. E/C.12/2002/11 (Jan. 20, 2003); CESCR, *The Right to Adequate Food* (Art. 11) General Comment 12, ¶ 15, U.N. Doc. E/C.12/1999/5 (May 12, 1999).

146. See Craven, *supra* note 118, at 125.

147. See generally Audrey R. Chapman, *Conceptualizing the Right to Health: A Violations Approach*, 65 TENN. L. REV. 389, 412 (1998).

148. WHO, Essential Medicines, http://www.who.int/medicines/services/essmedicines_def/en/.

149. WHO, *World Health Organization Model List of Essential Medicines*, 6.4 (12th ed. 2002), <http://whqlibdoc.who.int/hq/2002/a76618.pdf>.

150. The Committee comment has been criticized as unworkable and overly specific. See, e.g., Dennis & Stewart, *supra* note 120, at 494 ("The Committee's position that the right to health contains a core obligation to provide essential drugs as defined by the WHO is at odds with the text of Article 12 (which does not even mention the subject of drugs), as well as the negotiating history of the Covenant itself which makes clear that the right was to be closely tied to the idea of progressive realization of rights under Article 2.").

151. See Hans V. Hogerzeil et. al., Is Access to Essential Medicines as Part of the Fulfillment of the Right to Health Enforceable through the Courts? 368 LANCET 305, 310-11 (2006), available at http://www.who.int/entity/medicines/news/Lancet_EssMedHumanRight.pdf. Hogerzeil acknowledges that some cases involving a demand for ART have not succeeded, although the exceptions tend to prove the rule. For one egregious example, see *Ahamefulu v. Imperial Medical Centre & Another*, [2001] App. No. CA/L/514/2001 (C.A. Nigeria) (refusing to hear the plaintiff, who was HIV-positive, fearing her presence in the courtroom would infect others).

152. See, e.g., 42. U.S.C. § 1396d(a)(12)(2000); Lei No. 9.313, de 13 de Novembro de 1996, D.O.U. de 14.11.1996 (Brazil); Germany, Fourteenth Law of 29 August 2005 amending the Medicaments Law (*Bundesgesetzblatt, Part I, 5 September 2005, No. 54, pp. 2570-2601*); Australia (South Australia), An Act (No. 968 of 1908) to consolidate and amend the law relating to drugs, and for other purposes. Date of assent: 23 December 1908. (The Drugs Act 1908). As last amended by Act No. 34 of 2000, <http://www.parliament.sa.gov.au/Catalog/legislation/>

provision of ART has frequently followed national and regional right-to-treatment cases, virtually all of which have occurred in the context of HIV and AIDS. This phenomenon may be explained by the global mobilization of AIDS activists pressing for ARVs¹⁵³ or the fact that AIDS drugs work so effectively, but it is striking that almost every treatment case has centered on first-line therapies for AIDS, not heart disease, cancer, or any of the other infectious diseases that plague the developing world. Equally telling, treatment cases have mushroomed in domestic and regional courts concerning the policies of low and middle-income countries creating an interstitial jurisprudence that thrives in the absence of a single international forum in which to adjudicate these claims. In cases that reflect and reinforce broad popular mobilization around access to AIDS medicines, judiciaries and interpretive bodies in diverse contexts are ordering state officials to provide PLWHA with life-sustaining treatment. And while many of these cases are informed by international human rights commitments, the treatment case law is characterized principally by its reference to domestic health assurances, not treaty international obligations.

C. National Case Law

Globally, the high-water mark of the right to treatment is the South African Constitutional Court's decision in *Minister of Health v Treatment Action Campaign* (TAC).¹⁵⁴ In TAC, AIDS activists challenged the government of South Africa to make the drug nevirapine widely available in the public health sector and to establish a firm timetable for the rollout of a national program for prevention of mother-to-child transmission (PMTCT) of HIV.¹⁵⁵

Nevirapine is an antiretroviral drug approved for PMTCT by the WHO and (at the time of the case) by the South African Medicines Control Council.¹⁵⁶ Boehringer Ingelheim, the drug's manufacturer, offered to provide it free to the South African government until 2005. South Africa's Ministry of Health had confined the use of nevirapine to two research sites

Acts/d/1908.968.htm. The WHO maintains an international digest of health legislation at <http://www.who.int/idhl-rils/frame.cfm?language=english>.

153. See generally ANNE-CHRISTINE D'ADESKY, *MOVING MOUNTAINS: THE RACE TO TREAT GLOBAL AIDS* (2004) (tracking the worldwide social movement that has galvanized around AIDS treatment).

154. *Minister of Health v Treatment Action Campaign*, 2002 (10) BCLR 1033 (CC) (S. Afr.).

155. Although nevirapine is a common ingredient in the frequently prescribed triple combination therapies (it is one form of non-nucleoside reverse transcriptase inhibitor used alongside nucleoside reverse transcriptase inhibitors and protease inhibitors), in the TAC case it was used solely as a drug given during pregnancy to decrease the likelihood of the child contracting the virus in utero.

156. See generally Mark Heywood, *Current Developments: Preventing Mother-to-Child Transmission in South Africa: Background, Strategies and Outcomes of the Treatment Action Campaign Case Against the Minister of Health*, 19 S. AFR. J. HUM. RTS. 278, 285-86 (2003). In the absence of PMTCT treatment, approximately 30% of children born to seropositive women are themselves infected. When properly administered, nevirapine reduces the risk of mother-to-child transmission by 99%.

per province (for a total of eighteen sites) and public physicians outside the pilot sites could not prescribe it because of governmental concerns regarding its safety and efficacy. The plaintiffs asserted that the limited South African government policy to reduce mother-to-child transmission of HIV (including the limited rollout of nevirapine in public settings) violated the right to health guaranteed by Section 27 of the South African Constitution. Section 27(1)(a) provides that everyone has a right to health care,¹⁵⁷ including reproductive care. Section 27(2) tracks the ICESCR¹⁵⁸ and states that the government must take reasonable measures to achieve the progressive realization of these rights.

In response to the demand for nevirapine in public clinics, the government claimed that separation of powers principles precluded the Court from reviewing socio-economic policies and that the public health system lacked the capacity to deliver the drug nationally.¹⁵⁹ The government also contended that nevirapine was clinically unproven and that the real cost of delivering the drug is not the price of the medicine but the cost of the medical infrastructure, including HIV testing, counseling, follow-up, and the provision of formula for breastfeeding mothers (another transmission route) who cannot afford it.

The Constitutional Court rejected the government's argument that it was incompetent to adjudicate socio-economic rights claims. The right to health, the Court found, is fully justiciable and gives rise to positive obligations to protect and to fulfill as well as negative obligations to respect.¹⁶⁰ In reviewing the government's policy, however, the Court declined to find a "minimum core obligation" binding on the state and instead employed a reasonableness analysis to ask whether confining the rollout of nevirapine to the limited number of sites was reasonable in the circumstances.¹⁶¹ Factually, the Court determined that "the wealth of

157. S. AFR. CONST. 1996 Art. 27(1)(a). Lisa Forman has observed that "[t]his focus on the provision of health care is a markedly narrower formulation than the international human rights to the highest attainable standard of health." Lisa Forman, *Ensuring Reasonable Health: Health Rights, the Judiciary, and South African HIV/AIDS Policy*, 33 J.L. MED. & ETHICS 711, 713 (2005).

158. Under the South African Constitution, the Constitutional Court is required to consider international law in its construction of Bill of Rights provisions. S. AFR. CONST. 1996 Art. 39(1) ("When interpreting the Bill of Rights, a court, tribunal or forum . . . must consider international law.").

159. TAC, 2002 (10) BCLR 1033 (CC) at ¶ 14-16, 22, citing Nat'l Dept. of Health Protocol for providing a comprehensive package of care for PMTCT.

160. Forman, *supra* note 157, at 713 ("Drawn from international human rights law this typology [in section 27 of the South African Constitution] implies both positive and negative duties with respect to each right"), 711 ("Arguments that treaty rights [such as the right to health in article 12 of the ICESCR] are indeterminate and vague have been put to rest by authoritative international interpretations of the entitlements and duties that such rights impose.").

161. TAC, 2002 (10) BCLR 1033 (CC) at ¶ 26-39. The South African Constitutional Court's "reasonableness" standard was developed in *Soobramoney v Minister of Health, KwaZulu-Natal* 1998 (1) SA 765 (CC) and *Government of the Republic of South Africa v Grootboom* 2001 (1) SA 46 (CC). See David Bilchitz, *Towards a Reasonable Approach to the Minimum Core: Laying the Foundations for Future Socio-Economic Rights Jurisprudence*, 19 S. AFR. J. HUM. RTS. 1 (2003) (arguing that the Court should have adopted the CESCR's "minimum core obligations" standard).

scientific material produced by both sides makes plain that . . . nevirapine . . . remains to some extent efficacious in combating mother-to-child transmission even if the mother breastfeeds her baby.”¹⁶² The Court then weighed the dangers involved, and found that “the risk of some resistance manifesting at some time in the future is well worth running,” because the chances of a child dying if infected are very high.¹⁶³

The Court next decided that the government’s objection based on safety was unreasonable since the WHO had recommended the use of nevirapine for PMTCT without qualification.¹⁶⁴ Finally, the Court dismissed the government’s cost concerns and found that the state’s failure to distribute nevirapine to HIV-positive expectant mothers violated women’s constitutional right of access to health care. Accordingly, the Court ordered state health authorities to make the drug available to pregnant women and newborn babies.¹⁶⁵ Recognizing the devastation wrought by AIDS on women and children alike, the Court further ordered the government to develop a policy to provide nevirapine at public hospitals and clinics.¹⁶⁶

TAC is part of a global trend. The demand for treatment has resulted in a series of Latin American cases requiring states to provide comprehensive medical attention to PLWHA.

Beginning in the mid-1990s, the Constitutional Court of Colombia confirmed that the state is required to provide AIDS treatment regardless of cost. Active lobbying in Colombia led to the subsequent addition of ART to the official medicines list.¹⁶⁷ The Constitutional Chamber of the Costa Rican Supreme Court of Justice reached the same conclusion in two cases, *Luis Guillermo Murillo Rodríguez v. Caja Costarricense de Seguro Social* and *William García Álvarez v. Caja Costarricense de Seguro Social*,¹⁶⁸ through which the Costa Rican Social Security Fund was ordered to supply the applicants with ART.

In *Cruz Bermudez v. Ministerio de Sanidad y Asistencia Social*, the Venezuelan Supreme Court found that the Ministry of Health and Social Action had infringed health rights belonging to HIV-positive persons by failing to supply prescribed ART. *Cruz Bermudez* also established a number of specific steps required of the government and ordered the Ministry to seek necessary budget allocations.¹⁶⁹ The Court’s decision relied on the

162. TAC, 2002 (10) BCLR 1033 (CC) at ¶ 58.

163. *Id.* ¶ 59.

164. *Id.* ¶ 60.

165. *Id.* ¶ 135. The Court’s holding is supported by the finding that the government-enforced restrictions on the rollout of nevirapine meant that the state had interfered with the ability of many pregnant women to obtain the drug and that the government has, at the very least, a negative duty not to prevent access essential services. *Id.* ¶ 80.

166. TAC, 2002 (10) BCLR 1033 (CC) at ¶ 115.

167. Decree No. 1543 (1997) (Colom.); see also Hogerzeil et al., *supra* note 151, at 309.

168. *Luis Guillermo Murillo Rodríguez et al. v. Caja Costarricense de Seguro Social*, Constitutional Chamber of the Supreme Court of Justice, Decision No. 6096-97 (1997) (Costa Rica); *William García Álvarez v. Caja Costarricense de Seguro Social*, Constitutional Chamber of the Supreme Court of Justice, Decision No. 5934-97 (1997) (Costa Rica) [hereinafter *Alvarez*].

169. *Cruz Bermudez et al. v. Ministerio de Sanidad y Asistencia Social*, Supreme Court of Justice of Venezuela, Case No. 15.789, Decision No. 916 (1999) (Venez.). See also Mrs. Glenda

right-to-health guarantee in the Venezuelan Constitution and unspecified international human rights instruments related to healthcare. The *Cruz Bermudez* Court's holding also had profound procedural implications. "This ruling meant that the right to health, as interpreted by the Court, had the broadest possible application in Venezuela, giving every HIV positive person in the country the right to access ARV therapies."¹⁷⁰

In Argentina,¹⁷¹ Brazil, Chile,¹⁷² Ecuador,¹⁷³ Mexico,¹⁷⁴ and Peru¹⁷⁵ too — all low or middle-income countries — litigation has resulted in judgments requiring affirmative action on the part of the state to uphold the rights to life and health. As one expert has observed, the decisions "have generally been complied with by Latin American states. Often they are followed by national decrees, adopted as a function of the constitutional right to health, explicitly establishing the responsibility of the state to provide necessary medications to persons living with HIV/AIDS."¹⁷⁶ In Brazil, in tandem with thousands of mid-1990s amparo proceedings for treatment of HIV based on the Constitution's right-to-health guarantee, the state passed Law 9313 which today provides antiretroviral drugs free of charge in the public health system for all Brazilians living with HIV/AIDS.¹⁷⁷ The same is true in Panama where activists staged demonstrations and blockaded downtown streets until the Panamanian Social Security Fund announced that it would extend

López et al. v. Instituto Venezolano de Seguros Sociales, Supreme Court, Expediente No. 15789 (1999) (Venez.).

170. Mary Ann Torres, *The Human Right to Health, National Courts, and Access to HIV/AIDS Treatment: A Case Study from Venezuela*, 3 CHI. J. INT'L L. 105, 112 (2002).

171. See UNAIDS & Canadian HIV/AIDS Legal Network, *Courting Rights: Case Studies in Litigating the Human Rights of People Living with AIDS*, 81-83, UNAIDS/06.01E (Mar. 2006) (describing AV & CM v. Ministerio de Salud de la Nación, Federal Civil & Commercial Court No. 7 (Apr. 26, 2002) (Arg.)), available at <http://www.unhcr.org/refworld/docid/46cc4a072.html>; Tara J. Melish, *Rethinking the "Less as More" Thesis: Supranational Litigation of Economic, Social and Cultural Rights in the Americas*, 39 NYU J. INT'L L. & POL. 171, 281 n. 305 (2006).

172. See, e.g., Court of Appeals of Santiago, Petition for Protection, no. 2,614-99, 14/6/99 (finding that respondents had failed to provide essential medicines and therefore jeopardized claimants' lives in violation of Article 1, section 4 and Article 19 of the Chilean Constitution and Article 6 of the ICCPR and that the cost of the drugs was "unacceptable"). On appeal, the Supreme Court reversed the Court of Appeal, finding that the issuance of medicines is a decision for health officials, not the courts. See Rodolfo Figueroa, *Enforcing the Right to Health before the Courts: The Case of HIV/AIDS in Chile*, HUM. SERVICES TODAY, Spring 2005, <http://hst.coehs.uwosh.edu/sp2005articles/HIV.html>; Jorge Contesse & Domingo Lovera Parmo, *Access to Medical Treatment for People Living with HIV/AIDS: Success Without Victory in Chile*, 8 SUR - INT'L ON. J. HUM. RTS. 143 (2008) (discussing cases seeking writs of protection to acquire anti-retrovirals).

173. See, e.g., UNAIDS & The Canadian HIV/AIDS Legal Network, *supra* note 171, at 97 (discussing *Edgar Carpio Castro Joffe Mendoza & Ors v. Ministry of Public Health and the Director of the National HIV/AIDS Programme*, Amparo 28 (2004) (Ecuador)).

174. See, e.g., *Jose Luis Castro Ramirez v. Instituto Mexicano del Seguro Social*, Amparo Decision 2231/97 (Plenary Court of the Supreme Court of Justice, Apr. 2000).

175. See, e.g., *Azanca Alheli Meza Garcia v. el Estado Peruano*, Tribunal Constitucional [Constitutional Court], Exp. No. 2945-2003-AA/TC (2003) (Peru).

176. Melish, *supra* note 171, at 283.

177. See Lei No. 9.313, de 13 de Novembro de 1996, D.O.U. de 14.11.1996 (Brazil).

coverage under its health care plan to include ARVs.¹⁷⁸

Although there is no constitutionally protected or actionable right to health in the U.S.,¹⁷⁹ the treatment jurisprudence extends to American prisons in a series of cases alleging inadequate care for HIV-positive inmates. Since prisoners are denied the freedom to attend to their own healthcare needs, correctional facilities are the one place where all Americans enjoy a minimal right to health.¹⁸⁰ In *Montgomery v. Pinchak*¹⁸¹ and *Smith v. Carpenter*¹⁸² the Court of Appeals found that HIV-positive prisoners have a right to ART and that treatment has become the enforced norm. A recent survey demonstrates that virtually all county, state and federal correctional facilities provide ART as outlined in guidelines set by the National Institutes for Health.¹⁸³ Thus, in *Montgomery*, the Third Circuit found reversible error where the trial court had dismissed a suit in which a prisoner had adequately alleged that he was deprived of ART, blood tests and prescription medicine refills despite the fact that prison officials were aware of his HIV-positive status.¹⁸⁴ In *Brown v. Johnson*,¹⁸⁵ the Eleventh Circuit upheld an injunction compelling prison officials to provide proper medical care of HIV-positive inmates based on the finding that defendants were deliberately indifferent to a prisoner's needs and had stopped providing prescribed medications. Likewise, advocates for an Alabama prison recently settled a case seeking to compel the Director of Treatment for the Alabama Department of Corrections, the Limestone Security and Medical Staff, and NaphCare Inc., a private company under contract to give medical services to inmates, to provide 250 HIV-positive

178. UNAIDS & The Canadian HIV/AIDS Legal Network, *supra* note 171, at 59.

179. See, e.g., *Abigail Alliance for Better Access to Developmental Drugs v. C. Von Eschenbach*, 495 F.3d 695 (D.C. Cir. 2007), *cert. denied*, 128 S.Ct. 1069 (2008), holds that the U.S. Constitution does not provide terminally ill patients with a due process right of access to experimental drugs that have passed limited safety trials but have not yet been proven safe and effective.

180. The same result was reached in the South African case of *N v Government of Republic of South Africa & Others* (No 1) 2006 (6) SA 543 (D) at 544 (S. Afr.) (Westville Prison case) in which the Court found respondents legally and Constitutionally bound to provide adequate medical care to prisoners, including the provision of ART to HIV-positive inmates under Section 35(2)(e) of the Constitution.

181. 294 F.3d 492 (3d Cir. 2002).

182. 316 F.3d 178 (2d Cir. 2003). In *Smith*, the Court applied a two-prong test of (i) deliberate indifference to (ii) serious medical need, to determine whether the defendant prison authorities violated the Eighth Amendment prohibition against cruel and unusual punishment where an inmate's ART was interrupted for a short period of time.

183. See Theodore M. Hammett, Sofia Kennedy & Sarah Kruk, *National Survey of Infectious Diseases in Correctional Facilities: HIV and Sexually Transmitted Diseases*, 26 (2007) available at <http://www.ncjrs.gov/pdffiles1/nij/grants/217736.pdf>. See also *Gates v. Fordice*, No. CIV.A. 4:71CV6-JAD, 1999 WL 33537206, at *4 (N.D. Miss. July 19, 1999); *Laube v. Campbell*, 333 F. Supp. 2d 1234, 1255 (M.D. Ala. 2004) (resulted in a settlement that included a right to ARVs for 30 days following an inmate's release from prison).

184. See *Montgomery*, 294 F. 3d 505. But see, *Sims v. Dretke*, 212 Fed. Appx. 276, 277 (5th Cir. 2006) (observing that the "United States Department of Health and Human Services has stated an HIV-positive individual need not necessarily undergo anti-HIV treatment," and that "whether to undergo such treatment depends on an individual's medical assessments and particular circumstances.").

185. 387 F.3d 1344, 1352 (11th Cir. 2004).

prisoners with access to competent medical specialists, adequate and appropriate emergency care, adequate end-of-life treatment, and adequate diagnosis and medical treatment for opportunistic infections.¹⁸⁶ Notwithstanding the skepticism of many scholars,¹⁸⁷ the American prison treatment cases suggest a significant departure from the establishment view that socioeconomic rights cases infringe on separation of powers or tax judicial competency.¹⁸⁸

Taken together, the global treatment cases reflect a convergence of principles and reasoning in support of ART as an expression of a right to health. The task is easiest in those jurisdictions, like South Africa, which explicitly recognize the right. Thus, in Venezuela, *Cruz Bermudez* pivots on the proposition that the denial of ART violates the constitutionally-guaranteed right to health. But one survey of Latin American jurisprudence identified eighteen cases from Bolivia, Colombia, and Costa Rica — many of them the HIV treatment cases cited above — in which courts have found a justiciable right to health on a less obvious standard and announced that the provision of treatment is appropriate where it is “not restricted by social security coverage.”¹⁸⁹ Whether or not the domestic cases constitute another expression of AIDS exceptionalism, the justiciability of ARV treatment in many national courts is no longer in question.

D. Supranational Decisions

The decisions of international tribunals and treaty bodies mirror the national case law on treatment. The European Court of Human Rights has addressed the right to treatment in a number of deportation cases involving HIV-positive refugee seekers. In *D. v. United Kingdom*, the European Court of Human Rights (ECHR) prohibited deportation of an otherwise excludable HIV-positive citizen of Saint Kitts on the grounds that D. would be unable to obtain treatment in his country of origin. The ECHR found that deporting D. would amount to inhuman or degrading treatment contrary to Article 3 of the European Convention on Human Rights.¹⁹⁰ Likewise, in *B.B. v. France*, a deportable HIV-positive Congolese national sought to remain in France where he received treatment while serving a prison sentence. In view of the applicant’s deteriorating health

186. Case filed as *Leatherwood v. Campbell*, No. CV-02-BE-2812-W (N.D. Al. 2004). See also Adam Liptak, *Alabama Prison at Center of Suit Over AIDS Policy*, N.Y. TIMES, Oct. 26, 2003 at A14, available at <http://query.nytimes.com/gst/fullpage.html?sec=health&res=9E05E1D81331F935A15753C1A9659C8B63>. The case settled in 2004. TheBody.com, *Alabama: Settlement Reached in HIV Inmates’ Health Care Suit*, <http://www.thebody.com/content/whatis/art26303.html> (last visited Mar. 17, 2009).

187. See, e.g., CASS R. SUNSTEIN, *THE SECOND BILL OF RIGHTS* 175-76 (2004). But see, Frank L. Michelman, *The Constitution, Social Rights and Liberal Political Justification*, 1 INT’L J. CONST. L. 13 (2003) (addressing objections to the constitutionalization of social rights).

188. See Chris F. Sabel & William H. Simon, *Destabilization Rights: How Public Law Litigation Succeeds*, 117 HARV. L. REV. 1016, 1037-43 (2004).

189. See Hogerzeil et al., *supra* note 151.

190. *D. v. United Kingdom*, 24 Eur. H.R. Rep. 423 (1997).

and the impossibility of receiving treatment in the Congo, the European Human Rights Commission referred the case to the European Court of Human Rights with the view that deportation would violate Article 3. France replied by quashing the deportation order.¹⁹¹ Although such cases have been limited to “exceptional circumstances” in recent years, where treatment is the difference between life and death, European human rights authorities have been reluctant to permit the discontinuation of ART.¹⁹²

In Latin America too, between 2000 and 2002, the Inter-American Commission on Human Rights granted precautionary measures in cases involving care of HIV-positive people to more than four hundred claimants in cases from Bolivia, Chile, Colombia, the Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, and Peru.¹⁹³ In several of these cases, the Commission requested that the state provide the beneficiaries with the “medical examination and treatment indispensable for their survival.”¹⁹⁴ In *Cortez v. El Salvador*, for example, the Commission specified that the government of El Salvador was to provide antiretroviral medication necessary to prevent death, as well as essential hospital, nutritional and pharmacological care to prevent the development of opportunistic infections.¹⁹⁵ In *Luis Rolando Cuscul Pivaral and Others Affected by HIV/AIDS v. Guatemala*, the Commission cited Article 4 of the Convention (the right to life) in issuing precautionary measures against Guatemala in the case of HIV-positive persons requiring ART who were receiving inadequate medication through the Guatemalan public health system.¹⁹⁶

In the concluding observations of U.N. Treaty Bodies, the Committee has strongly criticized States Parties for their failure to provide ART. In its review of Zambia, the CESCR observed that it “is alarmed about the devastating impact of the HIV/AIDS pandemic on the enjoyment of

191. B.B. v. France, App. No. 30930/96, 89 Eur. Ct. H.R. 2595 (1998). *But see* Karara v. Finland, App. No. 40900/98, 26 Eur. Comm’n H.R. CD220 (1998) (holding that asymptomatic HIV-positive Ugandan national was deportable, in part because Uganda has taken measures to improve the treatment of AIDS patients); SCC v. Sweden, App. No. 46553/99 Eur. Comm’n H.R. (2000) (holding that admissibility is determined by the potential deportee’s present medical condition); M.M. v. Switzerland, App. No. 43348/98, Eur. Comm’n H.R. (1998) (refusing claim by asymptomatic HIV-positive national of the Democratic Republic of the Congo seeking to remain in Switzerland); Tatete v. Switzerland, App. No. 41874/98, Eur. Ct. H.R. (2000) (mirroring the holding in *Karara*, SCC and *M.M.*, *Tatete* provides further evidence that as the possibility of ART has emerged in the developing world over the past decade, the European Court of Human Rights is increasingly reasoning that HIV-positive individuals may be deported to non-EU states, since doing so will not necessarily result in death).

192. See *N (FC) v. Secretary of State for the Home Department* [2005] UKHL 31 (holding that an HIV-positive woman’s need for treatment does not, as a matter of Convention rights, entitle her to remain in the United Kingdom).

193. Since the end of 2002, the Commission has issued precautionary measures less frequently in cases of demands for ART by requiring additional information, including CD4 counts. See Tara Melish, *The Inter-American Commission on Human Rights: Defending Social Rights Through Case-Based Petitions in SOCIAL RIGHTS JURISPRUDENCE: EMERGING TRENDS IN COMPARATIVE AND INTERNATIONAL LAW* 339, 369 (M. Langford ed., 2007).

194. See *id.* at 368.

195. See, e.g., *Cortez v. El Salvador*, Case 12.249, Inter-Am. C.H.R., Report No. 29/01, OEA/Ser.L/V/II.111, doc. 20, ¶ 32 (2001).

196. *Luis Rolando Cuscul Pivaral and Others Affected by HIV/AIDS v. Guatemala*, Inter-Am. C.H.R., Report No. 32/05, OEA/Ser.L/V/II.124, doc. 5 ¶ 41 (2006).

economic, social and cultural rights by the people of Zambia. The Committee is also concerned that people afflicted with HIV/AIDS seldom have adequate access to the necessary health-care services, including antiretroviral drugs, appropriate facilities and food." The Committee, "in line with its general comment No. 14 (2000) on the right to the highest attainable standard of health" recommended that Zambia "provide adequate health care for people suffering from HIV/AIDS, taking into account the particular needs of widows and orphans."¹⁹⁷ Similarly, in its review of Honduras, the Committee urged the Honduran government "to undertake effective measures to address the high level of persons living with HIV/AIDS, and in particular facilitate access to essential drugs, and to seek international cooperation to this effect."¹⁹⁸ Even the United Kingdom has been chastised during the Committee's periodic reports for the high incidence of HIV/AIDS in some of the U.K.'s Caribbean territories and "the lack of availability of, and access to, anti-retroviral medication for migrant workers and AIDS orphans."¹⁹⁹ The Committee on the Rights of the Child and the Human Rights Committee, which interpret state obligations under the Convention on the Rights of the Child and the Covenant on Civil and Political Rights respectively, have recently observed that Tanzania,²⁰⁰ Mexico,²⁰¹ Namibia,²⁰² and Uganda²⁰³ have each failed to adopt comprehensive measures enabling greater numbers of HIV-positive people to obtain ART.

197. ESCOR, Comm. on Econ., Soc., and Cultural Rts., *Concluding Observations of the Committee on Zambia*, U.N. Doc. E/C.12/1/Add.106 (June 23, 2005).

198. ESCOR, Comm. on Econ., Soc., and Cultural Rts., *Concluding Observations of the Committee on Honduras*, U.N. Doc E/C.12/1/Add.57 (May 21, 2001).

199. ESCOR, Comm. on Econ., Soc., and Cultural Rts., *Concluding Observations of the Committee on The United Kingdom*, U.N. Doc E/C.12/1/Add.79 (June 5, 2002).

200. See Comm. on the Rights of the Child, *Concluding Observations of the Committee on the Rights of the Child: Tanzania*, CRC/C/TZA/CO/2, at 11 (June 21, 2006) (recommending that "Tanzania 'provid[e] all pregnant women with adequate health and social services free of charge, and [ensure] the provision of antiretroviral drugs and formula-feeding for infants. . . .").

201. See Committee on the Rights of the Child, *Concluding Observations of the Committee on the Rights of the Child: Mexico*, CRC/C/MEX/CO/3, at 8 (June 8, 2006) ("The Committee recommends that the State party, taking into account the Committee's general comment no. 3 (2003) on HIV/AIDS and the rights of the child and the International Guidelines on HIV/AIDS and Human Rights: . . . (e) Ensure the free access to anti-retroviral treatment.").

202. See Human Rights Committee, *Concluding Observations of the Human Rights Committee: Namibia*, CCPR/CO/81/NAM, at 3 (Aug. 2004) ("The Committee appreciates the efforts undertaken by the State party to combat HIV/AIDS and to provide wider sexual education in this regard. However, these efforts are not adequate in view of the magnitude of the problem (art. 6). The State Party should pursue its efforts to protect its population from HIV/AIDS. It should adopt comprehensive measures encouraging greater numbers of persons suffering from the disease to obtain adequate antiretroviral treatment and facilitating such treatment.").

203. See Human Rights Committee, *Concluding Observations of the Human Rights Committee: Uganda*, CCPR/CO/80/UGA, at 3 (May 4, 2004) ("The State party is urged to adopt comprehensive measures to allow a greater number of persons suffering from HIV/AIDS to obtain adequate antiretroviral treatment.").

E. A Duty of Treatment

What then are the consequences of an increasingly well-defined right to treatment? For the more than 100 states that guarantee the right to health in the Constitution or by statute,²⁰⁴ the right to treatment creates a justiciable question that may lead to a correlative duty.

To be sure, most domestic Constitutional and statutory health assurances are drafted at a level of generality that does not explicitly address ART.²⁰⁵ To interpret any given Constitutional or statutory health scheme, however, courts may now engage numerous domestic and foreign exemplars concerning individual demands for ART.²⁰⁶ The application of case law and principles on the subject operates vertically (from the supranational to the national) as the Inter-American Commission case of *Cortez v. El Salvador* and the CESCR concluding observations illustrate,²⁰⁷ and horizontally, as norms and concepts migrate from state to state.²⁰⁸ In the context of right to health claims, the growing use of transnational judicial borrowing,²⁰⁹ particularly in Commonwealth countries,²¹⁰ offers courts a rich vein of comparative material for adjudicating common questions.²¹¹

International treaty obligations provide an additional source for the duty. With several notable exceptions, the vast majority of states have ratified the ICESCR.²¹² Each state party to the ICESCR has an affirmative

204. Eleanor D. Kinney, *The International Human Right to Health: What Does This Mean for Our Nation and World?*, 34 IND. L. REV. 1457, 1464-65 (2001); Mary Ann Glendon, *Rights in Twentieth-Century Constitutions*, 59 U. CHI. L. REV. 519 (1992) (comparing the U.S. Bill of Rights to social rights protection in Denmark, Sweden, and Italy, among other states).

205. Brazil's Law 9313 appears to be an exception to the rule. See Decreto No. 9.313, de 13 de Novembre de 1996, D.O.V. de 14.11.1996 (Brazil).

206. The voice of the South African Constitutional Court in *TAC* is decidedly comparativist. For example, at the level of remedies, the Court cited *Brown v. Board of Education*, as well as cases from Canada, Germany, India, and the United Kingdom to support its use of a structural injunction against the government. See *TAC* 2002 (10) BCLR 1033 (CC) at 1065 (S. Afr.). For an analysis of the ways in which national courts employ foreign and comparative law, see Vicki Jackson, *Constitutional Comparisons: Convergence, Resistance, Engagement*, 119 HARV L. REV. 109 (2005).

207. *Cortez*, Case 12.249, Inter-Am. C.H.R., Report No. 29/01 (2001).

208. See *THE MIGRATION OF CONSTITUTIONAL IDEAS*, (Sujit Choudry ed. 2006) (describing the transnational movement and adoption of Constitutional norms).

209. See Gil Carlos Rodríguez Iglesias, *The Judge Confronts Himself as Judge*, in *JUDGES IN CONTEMPORARY DEMOCRACY: AN INTERNATIONAL CONVERSATION* 281 (Robert Badinter & Stephen Breyer eds., 2004); Melissa A. Waters, *Mediating Norms and Identity: The Role of Transjudicial Dialogue in Creating and Enforcing International Law*, 93 GEO. L. J. 487, 492 (2005) ("courts are engaging each other out of a developing sense that they are part of a common enterprise . . .").

210. See Forman, *supra* note 157, at 720 (observing that the widespread respect for judicial authorities like the South African Constitutional court may hold powerful didactic value for how judges themselves perceive the possibility of enforcing health rights including demands for ART).

211. Paul Schiff Berman, *The Globalization of Jurisdiction*, 151 U. PENN. L. REV. 311, 537 (2002) (recognizing the legal cross-fertilization between imperial powers and their colonies and among foreign judiciaries); Maureen T. Upton, *Global Health Trumps the Nation-State*, 21 WORLD POL. J. 73 (2004).

212. As of 2006, there were 155 States Parties to the ICESCR. ECSR-Net, Background

obligation to fulfill the right to health, including moving progressively toward greater access to ART through legislation, policies and international cooperation.²¹³ General Comment No. 14 instructs states parties to allocate sufficient budgetary resources to fulfilling the right to health. Specifically, states parties must make “every effort” using “all” available resources to ensure fulfillment of the right, a process that the South African Constitutional Court’s holding in *TAC* would suggest now extends to treatment.²¹⁴ As the cost of first-line ART has dropped precipitously, states can now treat far greater numbers of people within the meaning of “available resources.” What constitutes “available resources” remains undefined although it is apparent that state parties to the ICESCR that are unwilling to use the maximum available resources for the realization of the right to health are in violation of their obligations under Article 12 of the Covenant.²¹⁵

Several courts have rejected the blanket assertion that ART or related expenses are “too costly” to ensure treatment. Increasingly, those arguments are belied by the existence of the Global Fund and other sources of funding assistance, as well as international benchmarks based on a state’s development status. The pre-eminent yardstick, the WHO list of essential drugs, has determined that ARVs qualify as required medicines, in part because the price to individuals and communities is now broadly affordable.²¹⁶ The WHO defines essential medicines as “those drugs that represent the best balance of quality, safety, efficacy and cost for a given health setting.”²¹⁷ Many states explicitly adopt a list of essential drugs as part of their national drug regulations.²¹⁸

To ensure that states meet the obligation to deploy the maximum available resources, NGOs are now monitoring government expenditures and using publicly available information and budget analysis to uncover government failures, to meet promises and to document incidences of discrimination in the provision of health care and other services.²¹⁹ Civil

Information on the ICESCR, http://www.escr-net.org/resources_more/resources_more_show.htm?doc_id=425251 (last visited Mar. 17, 2009).

213. Even critics of an expansive reading of socio-economic rights acknowledge that the ICESCR confers progressive rights and that “they are binding on states that ratified the ICESCR.” Dennis & Stewart, *supra* note 120, at 514.

214. See generally *TAC*, 2002 (10) BCLR 1033 (CC) at 27.

215. General Comment No. 14, *supra* note 104, para. 52. Only developing countries can avail themselves of the “available resources” qualifier. See Todres, *supra* note 45; Robertson, *supra* note 121.

216. See Hogerzeil et al., *supra* note 151, at 305. (According to the WHO, essential medicines satisfy the priority health care needs of the population and “are selected with due regard to disease prevalence, evidence on efficacy and safety, and comparative cost-effectiveness.”).

217. See WHO, *WHO Medicines Strategy: Framework for Action in Essential Drugs and Medicines Policy 2000-03*, at 7, WHO Doc. WHO/EDM/2000.1 (2000).

218. Laurence R. Helfer, *Regime Shifting: The TRIPS Agreement and the New Dynamic of International Intellectual Property Law-Making*, 29 YALE J. INT’L L. 1, 42 n. 186 (2004).

219. See FUNDAR, International Human Rights Internship Program and International Budget Project, *DIGNITY COUNTS: A GUIDE TO USING BUDGET ANALYSIS TO ADVANCE HUMAN RIGHTS* (2004); Kaiser Network, *Legal Group Calls Namibia’s New Budgetary Allocations for Health Inadequate* (Mar. 21, 2008), http://www.kaisernetwork.org/daily_reports/rep_index.cfm

society's skepticism of the government defense that treatment is too expensive is mirrored by judicial authorities in the litany of Latin American treatment cases ordering ART.²²⁰

The CESCR has added its voice to the effort to monitor the budgetary commitment of states parties and related attempts to scale up treatment. Paragraph 43 of General Comment No. 14, defines the provision of essential drugs as a non-derogable, core obligation that a state party cannot evade under any circumstances.²²¹ In all cases, the Committee has announced that the State Party has the burden of justifying that it is using the maximum available resources in order to satisfy, as a matter of priority, the obligations contained in the Covenant. Those states that genuinely cannot afford to provide comprehensive ART, including a number of least developed countries in East and Southern Africa, may satisfy the responsibility to fulfill by demonstrating a national pharmaceutical policy,²²² healthcare delivery mechanisms and the good faith commitment of domestic resources in the service of treatment and other rights obligations. In this context, transparent national institutions and consistent political support²²³ for expanded treatment serve as critical symbols of rights fulfillment.

For states parties that are too poor to provide treatment directly, the country's relationship with the international community assumes added importance. Although adequate funding has been slow to materialize,²²⁴ unprecedented sums are now available to states committed to the treatment, care, and prevention of AIDS.²²⁵ The availability of money coupled with the ICESCR obligation of each state party "to take steps, individually and through international assistance and cooperation, especially economic and technical" may also necessitate cooperation with the Global Fund, the World Bank, bilateral donors and the non-profit sector to achieve the greatest possible levels of treatment.²²⁶ Challenges to a

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220. See, e.g., *Alvarez*, Constitutional Chamber of the Supreme Court of Justice, Decision No. 5934-97 (1997) (Costa Rica); *Cruz Bermudez*, Supreme Court of Justice of Venezuela, Case No. 15.789, Decision No. 916 (1999) (Venez.).

221. General Comment No. 14, *supra* note 104, para. 43.

222. *Id.* ¶ 52.

223. Michael Specter, *The Denialists: The Dangerous Attacks on the Consensus About HIV and AIDS*, NEW YORKER, Mar. 12, 2007.

224. See BEHRMAN, *supra* note 72, at 113. In 1997, a year after the efficacy of ART was recognized, sub-Saharan African countries as a group spent \$160 million to deal with tens of millions of infections.

225. See The Global Fund, Revised Guidelines on the Purpose, Structure and Composition of Country Coordinating Mechanisms and Requirements for Grant Eligibility (2005).

226. In the language of the Covenant, poor states must take steps to fulfill the right to health by allocating the maximum available resources, including seeking international assistance. In practice, this requires states seeking multilateral funding to implement the "Three Ones": one truly strategic national plan, one coordinating authority, and one monitoring and implementation system. See THE WORLD BANK, THE WORLD BANK'S GLOBAL HIV/AIDS PROGRAM OF ACTION 24 (2005). Many developing countries find the process of applying for donor funds to be onerous and emblematic of neo-colonial relationships. This criticism is particularly trenchant in the context of democratic countries confronting odious debts and sometimes capricious international financial institutions. See FARMER, *supra* note 39,

given state's failures to scale up ART thus occur in a climate of mutually reinforcing legal obligation.

III. TRANSFORMING THE LANDSCAPE

To the extent that judicial recognition of the demand for ART is being used to spur affirmative government action, the case law and related social movements are fruitful sites for investigating the enforcement of social, economic, and cultural rights more generally.

The treatment jurisprudence has helped move the emerging right "from articulation to clarification to enforcement."²²⁷ The judicial recognition of rights, as Brazil demonstrates, has also galvanized domestic legislation and contributed to committed political will.²²⁸ There, the identification of a legal right paved the way for universal access, a mantra that aims to make treatment routine and to integrate funding, delivery, monitoring, and care into government services.²²⁹ The Brazilian illustration shows that where people have an enforceable right to treatment, most people are treated.²³⁰ In states that have embraced a duty of treatment, the failure to provide ARVs is becoming the exception rather than the norm.²³¹

The impact of the juridical, advocacy, and enforcement revolution surrounding treatment is apparent in at least three ways. First, the successful demand for ARVs has had a *synthesizing* effect on the corpus of human rights law as a whole. Enforcing right-to-health claims serves to collapse the distinction, if any exists, between civil and political, and economic, social, and cultural rights. With ever greater frequency, courts, government officials, and advocates are defining the interest in treatment as a core human rights concern rather than as a policy priority. Second, the treatment cases have generally been decided in domestic courts and have been announced within national laws and processes, not at the supranational level. We might refer to this as the *grounding* effect of socioeconomic rights adjudication. Third, the global treatment cases have *catalyzed* treatment claims, investing them with a sense of urgency and priority, a process that has elevated public health and development claims

at 86.

227. For this particular formulation of the way in which human rights norms ripen over time, see M. Cherif Bassiouni, *The Proscribing Function of International Criminal Law in the Processes of International Protection of Human Rights*, 9 YALE J. WORLD PUB. ORD. 193, 195 (1982).

228. Florian F. Hoffman & Fernando R.N.M. Bentes, *Accountability for Social and Economic Rights in Brazil*, in COURTING SOCIAL JUSTICE: JUDICIAL ENFORCEMENT OF SOCIAL AND ECONOMIC RIGHTS IN THE DEVELOPING WORLD 136 (Varun Gauri & Daniel M. Brinks eds., 2008).

229. JOÃO BIEHL, *WILL TO LIVE: AIDS THERAPIES AND THE POLITICS OF SURVIVAL* 375 (2007) (arguing that Brazil's AIDS policy is "emblematic of novel forms of state action on and toward public health").

230. See Dirceu B. Greco & Mariangela Simão, *Brazilian Policy of Universal Access to AIDS Treatment: Sustainability Challenges and Perspectives*, 21 AIDS S37-S45 (Supp. 4) (2007).

231. Brazil is widely regarded as the best example of a state that has embraced the duty of treatment. By contrast, until recently, the government of South Africa resisted the notion that all HIV-positive South Africans have a right to ART, despite the favorable treatment decisions concerning prisoners and pregnant women.

while simultaneously devaluing private intellectual property rights.

A. The Indivisibility of Human Rights

Even as some scholars have insisted that giving teeth to social and economic rights cases promotes “rights inflation” and cheapens first generation human rights²³² – particularly negative rights of the person – the global treatment cases have upended this conclusion by providing tangible proof of the interconnected, co-equal, and interdependent nature of the two categories of human rights.

To be sure, the indivisibility of all human rights has long been proclaimed by international bodies. Between 1948 and 1966, the General Assembly worked to draft “a single covenant, setting forth all human rights in the same document.”²³³ Unable to forge agreement, however, negotiators settled on the simultaneous adoption of two treaties in December 1966, the International Covenant on Civil and Political Rights (ICCPR) and the ICESCR, wrapped in the rhetoric of formal equality. Two decades later, the Inter-American Court declared, “Economic, social and cultural rights are the same in substance as political and civil rights. All derive from the essential dignity of man, all are inalienable right[s] of the individual, and all must be promoted, guaranteed and protected nationally, regionally and globally.”²³⁴ More recently, the 1993 Vienna Declaration and Programme of Action, as adopted by the World Conference on Human Rights, reiterated that “[a]ll human rights are universal, indivisible, and interdependent and interrelated,”²³⁵ and in 2001, the U.N. Human Rights Commission publicly affirmed “the universality, indivisibility, interdependence and interrelatedness of all human rights and fundamental freedoms.”²³⁶

In reality, however, the primacy accorded to civil and political rights – and to the obligation to respect embedded within social, economic, and cultural rights instruments²³⁷ – was cemented with the creation of separate civil and political and socioeconomic rights covenants and the

232. See MICHAEL IGNATIEFF, *HUMAN RIGHTS AS POLITICS AND IDOLATRY* 90 (2001).

233. Dennis & Stewart, *supra* note 120, at 476.

234. Inter-Am. Ct. H.R., *Annual Report of the Inter-American Court of Human Rights 1986* at 42, ¶ 2, OEA/Ser.L/V/III.15 Doc. 13.

235. World Conference on Human Rights, June 14-25, 1993, Vienna Declaration and Programme of Action, U.N. Doc. A/CONF.157/23, ¶ 5 (July 12, 1993).

236. Comm’n on Human Rights Res. 2001/30, Question of the Realization in all Countries of the Economic, Social and Cultural Rights Contained in the Universal Declaration of Human Rights and in the International Covenant on Economic, Social and Cultural Rights, and Study of Special Problems which Developing Countries Face in the Efforts to Achieve these Human Rights, 6(d), U.N. Doc. E/CN.4/RES2001/30 (Apr. 20, 2001).

237. Marcus, *supra* note 134, at 80 (demonstrating that the experiences of supranational tribunals confirm that socioeconomic guarantees are justiciable at the obligation to respect level, although they underscore discomfort with obligation to protect and fulfill); Chapman, *supra* note 147, at 399-414 (focusing on violations of commission, including torture; violations of the obligation to protect, including the failure of states to protect women against violence or prosecute perpetrators, and violations related to gender discrimination).

rejection of a redress mechanism and a treaty body for the enforcement of the ICESCR.²³⁸ The concern that many Western states voiced during the human rights treaty drafting process that judicial or juridical implementation of socio-economic rights was inappropriate and impracticable has been consistently reflected by powerful nations which insist that claims to health, food, water, and housing are aspirational in nature and do not amount to legal entitlements.²³⁹

This argument draws some support from the text of the ICESCR, specifically the progressivity and maximum available resources provisions. The second-class status traditionally accorded to socio-economic rights has further manifested itself in the tentative language of regional human rights instruments.²⁴⁰ Only the African Charter, which explicitly guarantees the rights to education, health, and other socioeconomic rights, describes these rights in absolute terms without attaching a progressive realization caveat.²⁴¹ But neither the African Commission on Human and Peoples' Rights, nor the recently formed African Court of Human Rights has ever addressed a case involving AIDS, much less demands for treatment as a human right.²⁴²

In an attempt to imagine enforcement of socio-economic rights, some scholars have located norms contained in the ICESCR in overlapping provisions of the ICCPR and observed that certain of these rights can be adjudicated under the individual petition procedure of the ICCPR's Optional Protocol.²⁴³ Even the CESCR has joined this chorus by publicly listing a number of ICESCR articles that contain many civil and political rights attributes and that "would seem to be capable of immediate application in . . . many national legal systems"²⁴⁴ including "Articles 2 (nondiscrimination), 3 (equal rights of men and women), 7(a)(i) (equal pay for equal work), 8 (rights to form and join trade unions, and to strike), 10(3) (states "should" set age limits for child labor), 13(2)(a)(primary education compulsory and free for all), 13(3) (liberty of parents to chose schools), 13(4) (liberty to establish educational institutions), and 15(3) (freedom for scientific research)."²⁴⁵

The Inter-American Commission on Human Rights has echoed this logic in a number of cases involving mixed socio-economic and civil and

238. Dennis & Stewart, *supra* note 120, at 485-87.

239. See, e.g., Katherine Grove, *Shifting Norms in International Health Law*, 98 AM. SOC'Y INT'L L. 18 (2004).

240. For example, article 26 of the American Convention on Human Rights repeats the ICESCR framework by obliging state parties to take steps to achieve progressively socioeconomic rights. Inter American Convention on Human Rights art. 26, Nov. 22, 1969.

241. See African Charter on Human and Peoples' Rights, *supra* note 115.

242. See Sabelo Gumedze, *HIV/AIDS and Human Rights: The Role of the African Commission on Human and Peoples' Rights*, 4 AFR. HUM. RTS. L.J. 181, 195 (2004).

243. See, e.g., Craig Scott, *The Interdependence and Permeability of Human Rights Norms: Towards a Partial Fusion of the International Covenants on Human Rights*, 27 OSGOOD HALL L.J. 769, 771 (1989).

244. See ESCOR, Comm. on Econ., Soc. & Cultural Rights, *Report of the Fifth Session, Supp. No. 3*, Annex III, ¶ 10, U.N. Doc. E/1991/23 (1991) [hereinafter *General Comment No. 3*].

245. Dennis & Stewart, *supra* note 120, at 512 n. 330.

political rights violations where the civil and political rights claims are used to bolster contentious social, economic or cultural rights demands.²⁴⁶ In that forum, human rights advocates have learned to privilege civil and political rights claims over alternative arguments,²⁴⁷ a practice that is particularly common in the realm of health law.²⁴⁸ Some large human rights organizations have adopted the same strategy in the area of social, economic, and cultural rights promotion and have self-consciously focused their documentation-gathering and shaming efforts on the arbitrary or discriminatory nature of socio-economic rights deprivations rather than on violations alone.²⁴⁹ Audrey Chapman, for one, has theorized that a focus on violations of discrimination in healthcare fits within well worn human rights traditions.²⁵⁰

Other socio-economic rights proponents have attempted to locate a "minimum core"²⁵¹ content for economic and social rights that have, historically, been poorly defined. What is meant by a minimum core is debatable and several scholars have asked whether the idea is universal or whether it contemplates resource limitations.²⁵² The CESCR, the first international body to articulate the concept has muddled the waters by "variously equat[ing] the minimum with a presumptive legal entitlement, a nonderogable obligation, and an obligation of strict liability."²⁵³ The appeal is intuitive: proponents of underenforced rights claims seek a hard legal standard by which to measure state performance in this arena. As a consequence, even the South African Constitutional Court's decision in TAC has been condemned for its refusal to embrace the minimum core

246. See, e.g., *Maya Indigenous Communities of the Toledo District v. Belize*, Case 12.053, Inter-Am. C.H.R., Report No. 40/04, OEA/Ser.L/V/II.122, doc. 5 rev. 1 (2004) (affirming the rights of indigenous Maya communities to their ancestral lands and resources and declaring those rights protected by the Constitution and international law).

247. James L. Cavallaro & Emily J. Schaffer, *Less as More: Rethinking Supranational Litigation of Economic and Social Rights in the Americas*, 56 HASTINGS L.J. 217 (2005) (drawing on illustrations from the Inter-American system to emphasize the importance of non-litigation strategies and arguing that when cases are brought to the Court and Commission, litigants should favor reliance on civil and political rights norms to norms autonomously guaranteeing economic, social and cultural rights).

248. See Brigit Toebes, *Towards an Improved Understanding of the International Human Right to Health*, 21 HUM. RTS. Q. 661 (1999) (arguing that although it is often asserted that all human rights are interdependent, interrelated, and of equal importance, in practice, advocates have a role in shaping priorities).

249. Kenneth Roth, *Defending Economic, Social and Cultural Rights: Practical Issues Faced by an International Human Rights Organization*, 26 HUM. RTS. Q. 63 (2004).

250. Chapman, *supra* note 147, at 393.

251. See General Comment No. 3, *supra* note 120.

252. See, e.g., Craig Scott & Philip Alston, *Adjudicating Constitutional Priorities in a Transnational Context: A Comment on Soobramoney's Legacy and Grootboom's Promise*, 16 S. AFR. J. ON HUM. RTS. 206, 250 (2000) ("There is thus a distinction between relative (state-specific) core minimums and absolute core minimums. For instance, Canada's core minimum will go considerably beyond the absolute core minimum while Mali's may go no further than this absolute core.").

253. Katharine G. Young, *The Minimum Core of Economic and Social Rights: A Concept in Search of Content*, 33 YALE J. INT'L L. 113, 115 (2008) (discussing the limitations of the minimum core as normative essence, minimum consensus and minimum obligation).

obligations standard contained in General Comments No. 3 and 14.²⁵⁴

The treatment cases suggest another way of bridging the false gulf between first- and second-generation rights. These cases are, after all, directed to requests for judicial action from courts capable of delivering concrete remedies. In contrast to requests made to legislators for more funding or the use of rights-strengthening rhetoric in other arenas, treatment litigation reinforces the concept that all "rights" necessarily imply the opportunity to demand that the right be pursued.²⁵⁵ Calling the claim for treatment a right also gives the declarant an urgency expressed in terms of a remediable threat to life and health, aligns his or her needs with entitlements, and offers a kind of trump.²⁵⁶ The provision of ART as a matter of rights thus connects treatment advocates to legal discourse and the legitimacy that law gives to the demands of previously marginalized groups. With each successive case, domestic courts renew the idea that they are the proper forum for the adjudication of treatment claims. Even in states like Chile, where early demands for treatment were rebuffed on standing grounds, courts have become part of a dialogue that has affirmed the justiciability of social and economic rights claims and contributed to the government-led scale up of ART.²⁵⁷

Claims for ART have also aligned this specific category of socio-economic claims with the Kelsenian view that full-fledged rights demands contain corresponding remedies. The existence of demonstrable remedies in right to treatment cases is illustrative of a kind of enforcement that is rare in the arena of socio-economic rights adjudication.²⁵⁸ Where many social and economic rights achievements are the result of negotiations in the political arena, the global case law is emphatic that claims to treatment, formulated as a human rights-based demand for health care, are remediable by courts. Equally important, in many of the cases, the demands of human rights activists have resulted in precise orders, usually the prompt delivery of anti-retroviral medications. In Brazil alone, the countless *amparo* proceedings and subsequent national legislation, led to a massive scale-up of ART programs and a 40% decline in AIDS deaths between 1997 and 2002.²⁵⁹ In this context, the treatment cases are transforming a critical expression of the right to health from rhetoric to benchmark to actionable interest. No longer simply a moral guide, treatment cases invoking the right to health have become the situs of legally-enforceable-claim rights, that is, justiciable demands enforceable by competent authorities.

254. See Bilchitz, *supra* note 161.

255. See Leary, *supra* note 110, at 36.

256. Ronald Dworkin, *Rights as Trumps*, in THEORIES OF RIGHTS 153 (Jeremy Waldron ed., 1984).

257. See Figueroa, *supra* note 172, at 1, 3, 9.

258. Jamar, *supra* note 110, at 16-17 (The right to health "should not be disqualified as a right simply because it is a progressive right, or because no court can really decide the exact content, or because no coercive mechanism currently exists or is likely to exist.")

259. See Varun Gauri, *Social Rights and Economics*, in HUMAN RIGHTS AND DEVELOPMENT: TOWARD MUTUAL REINFORCEMENT 65, 66 (Philip Alston & Mary Robinson eds., 2005).

One characteristic of this shift has been the emphasis on demands for treatment as an individual rather than a collective right.²⁶⁰ Rightly or wrongly, the interest in ARVs has focused attention on individual, biomedical needs rather than public health requirements.²⁶¹ Where “[p]ublic health is what we, as a society, do collectively to assure the conditions of people to be healthy,”²⁶² treatment is essentially an atomized, clinical exercise. While many theorists insist that the right to health is better understood as a society-level collective right focused on the underlying determinants of health, not specific case-by-case interventions,²⁶³ the treatment cases use the provision of ARVs to enforce individual claims to dignity and sustainable treatment.

Another feature of the treatment jurisprudence is the multidimensional nature of the demand for ARVs, a practice that requires defendant states to respect, protect, and fulfill rights in question. Accordingly, the success of treatment campaigners in wresting life-sustaining goods from resource-constrained states belies the view that the realization of economic and social rights is discretionary or that human rights protections only extend to enumerated negative rights. In this respect, the treatment cases appear to foster legal claims that are hybrid in nature, grounded as they are in rights to health and rights to life,²⁶⁴ individual and collective remedies and positive and negative rights claims. Like the right to due process, the treatment cases give rise to positive obligations to protect and to fulfill as well as negative obligations to respect,²⁶⁵ all within a fully justiciable

260. This trend mirrors the jurisprudence of the IACHR which has found the individual, but not the collective, dimension of Art. 26 claims to be justiciable. See Tara Melish's discussion of *VIASA Pensioners v. Venezuela*, Report No. 69/04, Petition 667/01, OEA/Ser.L/V/II.122, doc. 5, rev. 1 (2005), para. 46 in Melish, *supra* note 193, at 369.

261. See Noah Benjamin Novogrodsky, *The HIV/AIDS Pandemic and Human Security*, 100 AM. SOC'Y INT'L L. PROC. 345, 349 (2006).

262. Benjamin Meier & Larisa Mori, *The Highest Attainable Standard: Advancing a Collective Human Right to Public Health*, 37 COLUM. HUM. RTS. L. REV. 101, n.78 (2005).

263. *Id.* at 123.

264. See, e.g., *Ceballos v. Instituto de Seguros Sociales*, Constitutional Court of Colombia, Dec. No. T-484/92 (Corte Constitucional de Colombia, 1992) (requiring the social security institute to provide treatment under principles of non-discrimination and solidarity), available at <http://bib.minjusticia.gov.co/jurisprudencia/CorteConstitucional/1992/Tutela/T-48492.htm>; *Alvarez v. Caja Costarricense de Seguro Social*, Constitutional Court of Costa Rica, Exp. 5778-V-97, No. 5934-97 (1997) (“In a state of law, the right to life, and in consequence the right to health, receives particular protection. . . . without the right to life all of the other rights are useless. . . .”). See Yamin, *Not Just a Tragedy*, *supra* note 26, at 341.

265. See Lisa Forman, *Ensuring Reasonable Health: Health Rights, the Judiciary, and South African HIV/AIDS Policy*, 33 J.L. MED. & ETHICS 711, 713 (2005) (“Drawn from international human rights law this typology [in section 27 of the South African Constitution] implies both positive and negative duties with respect to each right. . . .”). In Canada, Judge Louise Arbour echoed this view by noting that “. . . any claim that only negative rights are constitutionally recognized is of course patently defective. The rights to vote (section 3), to trial within a reasonable time (s11(b)), to be presumed innocent (s 11(d)), to trial by jury in certain cases (s11(f)), to an interpreter in penal proceedings (s14), and minority language education rights (s 23) to name but some, all impose positive obligations of performance on the state and are therefore best viewed as positive rights (at least in part).” *Gosselin v. The Attorney General of Québec (Attorney General)* [2002] 4 S.C.R. 429 (Arbour, J., dissenting). The dual nature of treatment rights is also mirrored in several human rights conventions, including the Convention on the Rights of the Child, which require states parties to “respect” and “ensure”

framework.

The hybridity of treatment rights is particularly apt in the context of the HIV/AIDS pandemic since civil/political and socio-economic rights claims are deeply intertwined, particularly for the most vulnerable populations.²⁶⁶ Insofar as “political and economic forces have structured risk for AIDS, tuberculosis, and, indeed, most other infectious and parasitic diseases,”²⁶⁷ effective state responses are characterized by both the duty to ensure equity and the obligation to provide ARVs and other essential medicines. Sadly, even as treatment has become widely available, in many places where HIV is concentrated in specific populations, men who have sex with men, people who use drugs, and sex workers are driven from the HIV services they need by discrimination and violence. Punitive approaches to drug use, sex work, and homosexuality fuel stigma and hatred against socially marginalized groups, pushing them further into hiding and away from services to prevent, treat, and mitigate the impact of HIV and AIDS. People who use illicit drugs represent the smallest fraction of individuals receiving ART in many countries, despite accounting for a majority of people living with HIV in some of those places.²⁶⁸

Justiciable claims for treatment thus represent a synthesis of civil and political and socio-economic rights protection that mirrors the complex and overlapping violations that surround the pandemic. Scholars looking to demonstrate the permeability and indivisibility of the two categories of rights may now point to this body of law and the role of courts as an underappreciated method of socio-economic rights enforcement.

B. Internalizing the Norm

Most of the legal advances associated with treatment have occurred in domestic courts and national legislatures. For human rights advocates across diverse contexts, the question of how to give content and application to the bundle of rights associated with treatment has been answered locally.

Accordingly, the treatment cases have obviated aspects of the debate over the implementation of social, economic and cultural rights. Since the ICESCR lacks oversight and implementation mechanisms equal to those

the rights of every individual. See Todres, *supra* note 45, at 440.

266. See, e.g., Juliane Kippenberg et al., *Detention of Insolvent Patients in Burundian Hospitals*, 23 HEALTH POL. & PLANNING 14 (2008) (describing how many Burundian hospital patients, some of whom are in hospital to treat AIDS-related illnesses, are detained if they cannot pay their bills); see also, Jonathan Mann & Daniel Tarantola, *Responding to HIV/AIDS: A Historical Perspective*, 2 HEALTH AND HUM. RTS. No. 4, at 5, 8 (1998) (AIDS “has helped catalyze the modern health and human rights movement, which leads far beyond AIDS, for it considers that promoting and protecting health and human rights are inextricably connected.”).

267. Farmer, *supra* note 39, at 30.

268. Daniel Wolfe & Kasia Malinowska-Sempruch, *Seeing Double: Mapping Contradictions in HIV Prevention and Illicit Drug Policy Worldwide*, in PUBLIC HEALTH & HUMAN RIGHTS, EVIDENCE-BASED APPROACHES, *supra* note 81, at 333.

provided in the ICCPR and its first Optional Protocol, several prominent scholars have proposed a direct complaints mechanism for the ICESCR.²⁶⁹ But as David Marcus observes, "[t]he fifteen year effort to create an individual complaint mechanism has foundered on several shoals."²⁷⁰ One reason relates to the discomfort many states parties to the ICESCR have expressed with supranational judicial enforcement of budgetary matters.²⁷¹ A second reason is definitional. To ascertain compliance with a progressively realized right, "a court would have to plot enjoyment of rights against time to determine if a state has put itself on the right track towards full realization."²⁷² The result is that no formal mechanism exists to ensure redress of socio-economic rights violations, although the creation of the CESCR does provide an avenue for monitoring and commentary.

The Committee has used what power it has to urge domestic lawmakers to protect and promote treatment rights. Although the Committee is not directly accountable to States Parties to the Covenant since its members are elected by the 54-state membership of ECOSOC, in practice the Committee operates like other treaty bodies by reviewing State Party reports and issuing general comments. In these communications, the Committee has supported the consistent expansion of treatment as a subset of economic, social, and cultural rights that "are legally binding, enforceable, remediable, and justiciable."²⁷³ Critics of the CESCR have expressed discomfort with the quasi-legal character of the Committee's recommendations and have observed with incredulity that "[u]nder the Committee's approach, states and government officials could be found liable to individual claimants for the failure to provide essential drugs."²⁷⁴

Of course, the judicially-compelled delivery of ART is precisely what is happening in domestic fora, but under constitutional, not international, law. In virtually all of the treatment cases, the judiciary has faulted government officials for their failure to provide ART and found them to be in violation of controlling domestic law. In *TAC*, for example, the South African Constitutional Court eschewed the concept of a minimum core and instead asked whether the South African government's plan for PMTCT was a reasonable means of achieving the progressive realization of the right of access to health care services.²⁷⁵ This question served to align *TAC* with the Court's previous standard of review in the socio-economic rights cases of *Soobramoney v Minister of Health, KwaZulu-Natal*²⁷⁶ and *Government of the Republic of South Africa v Grootboom*²⁷⁷ while strongly suggesting that

269. See, e.g., Philip Alston, *Economic and Social Rights*, in *HUMAN RIGHTS: AN AGENDA FOR THE NEXT CENTURY* 137, 158-59 (Louis Henkin & John L. Hargrove eds., 1994).

270. Marcus, *supra* note 134, at 54.

271. See generally Dennis & Stewart, *supra* note 120, at 498-99.

272. Marcus, *supra* note 134, at 61.

273. Dennis & Stewart, *supra* note 120, at 492.

274. *Id.*

275. *Minister of Health v Treatment Action Campaign* 2002 (10) BCLR 1033 (CC) at 1046 (S. Afr.).

276. 1998 (1) SA 765 (CC) at 766-67 (S. Afr.) (evaluating a patient's demand for dialysis service under a reasonableness of government action standard).

277. *Government of the Republic of South Africa & Others v Grootboom & Others* 2001 (1)

the Court has taken ownership of rights protection in its own voice.²⁷⁸ Although the South African Constitutional Court has ruled that courts must first evaluate the reasonableness of the legislative and executive measures taken to ensure realization of socio-economic rights before proceeding to direct enforcement, the eventual scope for relief may be just as broad.²⁷⁹

International law enters the treatment jurisprudence not as the forum for dispute resolution or a standard of review but as a source of additional authority and an inspiration for domestic strategies perfected in other states. To be sure, the U.N. and other international entities have become intensely focused on the containment of HIV/AIDS and the importance of treatment. The dizzying list of international resolutions includes: the 2000 U.N. General Assembly Millennium Declaration, which established a series of Millennium Development Goals (MDGs), including the sixth goal, combating HIV, malaria, and tuberculosis;²⁸⁰ the 2001 Organization of African States (now the African Union) meeting in Abuja, Nigeria to develop a common platform for combating HIV and AIDS,²⁸¹ that led to the establishment of the Global Fund;²⁸² the June 2001 U.N. General Assembly Special Session on HIV/AIDS (UNGASS) which recognized that AIDS constitutes a global emergency that challenges human life, dignity and rights, and undermines socioeconomic development around the globe;²⁸³ the passage of U.N. Human Rights Commission Resolution 2002/33, entitled "Access to Medication in the Context of Pandemics such as HIV/AIDS," and the WHO/UNAIDS "3 x 5" program, a global initiative that aimed to provide ART to three million people with HIV/AIDS in developing countries by the end of 2005. But notwithstanding the volume

SA 46 (CC) (considering the right to housing in the context of squatters who had been evicted).

278. See Joan Fitzpatrick & Ron C. Slye, *International Decisions*, 97 AM. J. OF INT'L L. 669 (2003).

279. See Jonathan Klaaren, *A Remedial Interpretation of the Treatment Action Campaign Decision*, 19 S. AFR. J. ON HUM. RTS. 455 (2003).

280. United Nations Millennium Declaration, G.A. Res. 55/2, *supra* note 21, ¶ 19. The MDGs are accompanied by an implementation panel of experts drawn from the World Bank, the U.N., the International Monetary Fund and the Organization for Economic Cooperation and Development who are tasked with, among other duties, halting and beginning to reverse the spread of AIDS. States have since reaffirmed the Millennium Development Goals (MDG's) at U.N. Development conferences, including the Monterrey Consensus and the World Summit on Sustainable Development. The global consensus on the importance of the MDG's is so strong that Philip Alston has argued that, "it can plausibly be claimed that at least some of the MDGs reflect norms of customary international law [I]t can be observed that the case would be most easily made in relation to the first six of the Goals." See PHILIP ALSTON, *A HUMAN RIGHTS PERSPECTIVE ON THE MILLENNIUM DEVELOPMENT GOALS*, 21-22 (2003), www2.ohchr.org/english/issues/development/docs/millennium.doc.

281. Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, OAU/SPS/Abuja/3 (Apr. 27, 2001). Following the Abuja Summit, former U.N. Secretary General Kofi Annan appointed Stephen Lewis as his Special Envoy on HIV and AIDS in Africa.

282. The call for money to seed the Global Fund was matched by a pledge on the part of African leaders to raise domestic spending to 15% of national budgets. *Id.* ¶ 26.

283. Declaration of Commitment on HIV/AIDS, Global Crisis — Global Action, G.A. Res. S-26/2, U.N. FAOR, 26th Special Sess., U.N. Doc. A/RES/S-26/2 (Aug. 2, 2001).

of international activity, it has generally taken domestic entities to move pills into bodies.

In many of the Latin American cases, where the domestic constitution enshrines the right to health and includes a provision that international treaties, including the ICESCR, enjoy constitutional rank,²⁸⁴ international human rights instruments are marshaled as additional support for the normative values contained in domestic law. As claims against states for the provision of essential medicines have proliferated, courts have primarily used constitutional rights to life, health, and social security to support their decisions. In several of the Latin American cases, however, domestic courts have also considered “the American Declaration, the San Salvador Protocol, and the ICESCR – which are viewed as creating binding, legally-enforceable commitments for Latin American states.”²⁸⁵ Thus, in Ecuador, the Constitutional Tribunal strengthened its interpretation of domestic law by invoking the American Declaration and the San Salvador Protocol; in Costa Rica, the Supreme Court cited directly to the country’s commitments under the ICESCR.²⁸⁶ In *Festus Odafe & 3 Others v. AG Federation & 3 Others*, the Nigerian Federal High Court relied on the African Charter of Human and People’s Rights to compel the provision of medical care and treatment for HIV-positive prisoners.²⁸⁷ Argentina’s Constitutional Court invoked the ICESCR in a case involving a threat to the treatment of a child with a potentially fatal blood disease although there is no right to health in Argentina’s Constitution.²⁸⁸

The use of international human rights law as a support rather than a forum or direct enforcement opportunity has served to redirect advocacy and jurisprudence to domestic courts and national legislative processes. In addition to the jurisprudential movement, the state-by-state struggle for treatment is generating distinctly local activity that serves to reinforce the core demand for ART from government health authorities. These efforts involve creative attempts by advocates to force governments to increase the supply of ARVs for PLWHA, expressly or impliedly recognizing that the judicial pronouncements of social and economic rights may not be enough

284. See, e.g., Cruz Bermudez et al. v. Ministerio de Sanidad y Asistencia Social, Supreme Court of Justice of Venezuela, Case No. 15.789, Decision No. 916 (1999) (Venez.).

285. Melish, *supra* note 171, at 283.

286. UNAIDS & The Canadian HIV/AIDS Legal Network, *supra* note 178, at 55-56, 97. See also, *N (FC) v. Secretary of State for the Home Department* [2005] UKHL 31 (interpreting the United Kingdom’s obligations under the European Convention on Human Rights).

287. Suit No. FHC/PH/CS/680/2003, Judgment of Honorable Justice R. O. Nwodo (Feb. 23, 2004), unreported, cited in Chidi Anselm Odinkalu, *The Impact of Economic and Social Rights in Nigeria: An Assessment of the Legal Framework for Implementing Education and Health as Human Rights*, in *COURTING SOCIAL JUSTICE*, *supra* note 228, at 213.

288. See Corte Suprema de Justicia [SCJN], 24/10/2000, “Campodonico v. Beviacqua, Ana Carina v. Ministerio de Salud Acción Social,” J.A. (2001-I-464) (Arg.). See also Vicki Jackson, *Constitutional Engagement with the Transnational* (forthcoming 2009 on file with the YHRDLJ) (observing that the constitutions of Argentina and Colombia seek to achieve convergence between the interpretation of constitutional rights and international human rights law; Argentina does so directly by incorporating human rights treaties into the constitution).

to assure enforcement.²⁸⁹ As an illustration, Zackie Achmat, the HIV-positive former head of the Treatment Action Campaign in South Africa, publicly refused to take his ARV regimen until the ruling African National Congress developed a treatment plan.²⁹⁰ In Haiti, the NGO Partners in Health trains community health workers called "accompagnateurs" to distribute ARVs, supervise home-based therapy, and ensure adequate feeding.²⁹¹ Botswana, for its part, developed a national program, funded by foundations and mining companies and implemented through large-scale drug donations by pharmaceutical companies, to place record numbers of people on treatment.²⁹²

In sum, the treatment case law and accompanying activism represents the operationalization of socio-economic rights in national and sub-national settings. The dynamic interaction of state, non-state, and international actors reinforces domestic strategies and legal structures necessary for coordinated treatment efforts.²⁹³ Since judicial recognition may be a necessary but insufficient condition to scale up services, treatment campaigners have used their legal achievements to monitor progress and agitate for increased enrollment in ARV programs.²⁹⁴ On this subject, the success of treatment advocates in one state often resonate elsewhere; in South Africa, Brazil, and the U.S., legal victories expanding treatment are a consequence of local political movements operating in solidarity with activists organizing around similar issues in other countries.²⁹⁵ The movement is global but the legal achievements and programmatic advances are local.

289. Holly Burkhalter, *Advocacy Strategies for Affording the Right to Health*, in PUBLIC HEALTH AND HUMAN RIGHTS, *supra* note 132, at 419.

290. See Samantha Power, *The AIDS Rebel*, NEW YORKER, Sept. 19, 2003, at 56.

291. Paul Farmer, *From "Marvelous Momentum" to Health Care for All*, 86 FOREIGN AFF. 155, 156 (2007).

292. Garrett, *supra* note 18, at 24. ("The goal of the new program was to put every single one of Botswana's infected citizens in treatment and to give ARVs to all who were at an advanced stage of the disease. Merck donated its anti-HIV drugs, Bristol-Myers Squibb discounted its, Merck and the Gates Foundation subsidized the effort to the tune of \$100 million, and Harvard helped the Botswanan government design its program.")

293. See Harold Hongju Koh, *Transnational Legal Process*, 75 NEB. L. REV. 181, 206 (1996) (arguing that as transnational actors interact, they create patterns of behavior and generate norms of external conduct which in turn become part of domestic law).

294. See, e.g., Treatment Action Campaign, <http://www.tac.org.za> (last visited Mar. 17, 2009).

295. See, e.g., The AIDS & Rights Alliance for Southern Africa, <http://arasa.info> (last visited Jan. 28, 2009). The AIDS & Rights Alliance for Southern Africa is a regional partnership of NGOs working to promote a coordinated human rights approach to the pandemic in Southern African countries through capacity building and advocacy. See also, SMITH & SIPLON, *supra* note 11, at 81-116 (discussing the transnational social movement that has been built around the struggle for expanded treatment).

C. Treatment as Catalyst

1. Intellectual Property Issues

The justiciability of demands for ART has also served to elevate treatment claims above other rights. Specifically, the urgent need for treatment has pitted access to medicine campaigners against pharmaceutical patent holders in a protracted struggle across time and space. Domestic courts in middle-income countries around the world are privileging the demand for ART over the rights of pharmaceutical patent holders, a process best described as the desacrilization of intellectual property rights.²⁹⁶

The conflict between AIDS patients and patent holders erupted in 1999 and 2000, when thirty-nine multinational pharmaceutical companies challenged a South African law that would have allowed parallel importing and compulsory licensing while encouraging generic competition.²⁹⁷ Following civil society protests, the pharmaceutical firms withdrew the suit, but not before treatment campaigners had publicly embarrassed then-presidential candidate Al Gore by demonstrating at campaign events and loudly drawing attention to his support for the pharmaceutical industry.

In 2001, treatment advocates working with negotiators from developing countries secured an amendment to TRIPS, the World Trade Organization's (WTO)²⁹⁸ global compact on Trade-Related Aspects of Intellectual Property Rights.²⁹⁹ The amendment permits member states to "adopt measures necessary to protect the public health and nutrition, and to promote the public interest in sectors of vital importance to their socio-economic and technological development," including the issuance of compulsory licenses as a remedy for anticompetitive practices.³⁰⁰ The amendment, promulgated as the Doha Ministerial Declaration, clarified that members may lift patent protections in a state of emergency and reaffirmed the understanding that member states should not be prevented

296. See Avert, AIDS, Drug Prices and Generic Drugs, <http://www.avert.org/generic/htm> (describing Brazil and Thailand's compulsory licensing efforts for ART); MÉDECINS SANS FRONTIÈRES, *supra* note 10, at 8; Peter Maybarduke, Colombian NGOs File Compulsory License Request on Lopinavir/Ritonavir, <http://www.wcl.american.edu/pijip/go/blog-post/colombian-ngos-file-compulsory-license-request-on-lopinavir/ritonavir-kaletra> (last accessed Mar. 23, 2009).

297. *Pharm. Mfrs.' Ass'n.s v President of South Africa*, High Court of South Africa, Transvaal Provincial Division, Case No. 4183/98 (2001), available at <http://www.tac.org.za/Documents/MTCTPrevention/pharmace.txt>.

298. One hundred and fifty three states have joined the WTO. World Trade Organization, Members and Observers, http://www.wto.org/English/theWTO_e/whatis_e/tif_e/org6_e.htm (last visited Mar. 19, 2009).

299. See Agreement on Trade-Related Aspects of Intellectual Property Rights, Annex 1C, Apr. 15, 1994, Marrakesh Agreement Establishing the World Trade Organization, Annex 1C1869 U.N.T.S. 299, 33 I.L.M. 1197 (1994) [hereinafter TRIPS].

300. *Id.* art. 8.

by WTO rules from taking measures to protect public health.³⁰¹ The Doha Declaration specifically recognized that “[e]ach Member has the right to determine what constitutes a national emergency or other circumstances of extreme urgency, it being understood that public health crises, including those related to HIV/AIDS, tuberculosis, malaria and other epidemics, can represent a national emergency”³⁰² In 2003, a second Doha Accord explicitly authorized the use of compulsory licensing to import essential medicines for states without manufacturing capacity,³⁰³ a move that was made permanent in 2005.³⁰⁴

That same year, India amended its Patent Act to become formally TRIPS-compliant, but embedded important procedural and substantive protections which may affect the price of ARVs and other essential medicines in India and around the world.³⁰⁵ Rwanda, Brazil, Thailand,³⁰⁶ and other states have issued compulsory licenses for ARVs, often over intense criticism from patent-holding pharmaceutical companies and their political allies. The AIDS Law Project, acting on behalf of the Treatment Action Campaign, filed a complaint with the South African Competition Commission to investigate the refusal by Merck and its South African subsidiary to allow sufficient competition to lower the price of efavirenz.³⁰⁷

Nowhere is the contestation over access to treatment more acute than in India. Prior to the 2005 Patent Act, India granted process, not product, patents, which promoted a thriving generic pharmaceutical industry.³⁰⁸ As a consequence, India provides half of all HIV drugs used in developing countries.³⁰⁹ While conforming to TRIPS in many respects, Article 3(d) of India’s 2005 Act narrows patentable intellectual property to substantial inventions that increase efficacy.³¹⁰ Article 3(d) excludes from the definition of patentable property “the mere discovery of a new form of a known substance which does not result in the enhancement of the known

301. World Trade Organization, Ministerial Declaration of 14 November 2001, WT/MIN(01)/DEC/2, ¶6-7 Declaration on the TRIPS Agreement and Public Health, WT/MIN(01)/DEC/W/2, Nov. 14, 2001 (01-5770) at ¶ 6 and 17.

302. *Id.* ¶5(c).

303. World Trade Organization, Decision of the General Council of 30 August 2003, WT/L/540 and WT/L/540/Corr.1.

304. Press Release, World Trade Org., Members OK Amendment to Make Health Flexibility Permanent (Dec. 6, 2005), available at http://www.wto.org/English/news_e/pres05_e/pr426_e.htm (last accessed Jan. 29, 2009).

305. The Patents (Amendment) Act, No. 15(2005) (India).

306. *See, e.g.,* AIDS Access Foundation et al. v. Bristol Myers-Squibb Co. and Dep’t of Intellectual Property, Cent. I.P. & Int’l Trade Crt., Black Case No. Tor Por 34/2544, Red Case No. 92/2545 (2002) (Thai.).

307. Complaint, of Treatment Action Campaign against MSD and Merck, Competition Comm’n of S. Afr., available at www.tac.org.za/documents/TACvMSDFinalComp.CompapersFinalOF041107.

308. Sierra Dean, *India’s Controversial New Patent Regime: End of Affordable Generics?*, 40 INT’L LAW. 725, 726-27 (2006).

309. Doctors Without Borders, *On Patents in India and the Novartis Case*, Dec. 18, 2006, http://www.doctorswithoutborders.org/news/access/novartis_qa.cfm.

310. The Patents (Amendment) Act, *supra* note 305, art. 3 (amending § 3(d) of Patents Act, 1970).

efficacy of that substance”³¹¹ In 2006, the Swiss pharmaceutical company Novartis sought patent protection under the new Act for its leukemia drug Gleevec.³¹² Relying on Article 3(d), Indian authorities rejected Novartis’ application, finding that Gleevec was simply a new form of a known substance.³¹³ In response, Novartis brought suit in the Chennai High Court, alleging that Article 3(d) was unconstitutional and incompatible with India’s TRIPS obligations.³¹⁴ Novartis maintained that Article 3(d) is inconsistent with — and requires more than — TRIPS, which asks only that patentable inventions involve an “inventive step.” In August 2007, the court dismissed Novartis’ constitutional claim, sustaining Article 3(d) as squarely within India’s legislative prerogative.³¹⁵

The Novartis matter was hailed by global health advocates as an extension of the ARV successes in the realm of cancer treatment.³¹⁶ The reduction of legal barriers and expanded production and distribution of medicines reflect the institutional extension of treatment, a critical development in light of the exceptional position that HIV/AIDS has come to occupy. Like the HIV cases, the Novartis challenge also demonstrated that judges are highly responsive to life-saving opportunities and will look askance at obstacles to treatment. Ordering the provision of ART or allowing the generic production of Gleevec is as clear a life-sustaining exercise as commuting a death sentence.

Much of the scholarship at the intersection of patents and access has focused on the importance of humanizing trade law or understanding the incentive structure for the creation of new medicines.³¹⁷ Far less attention has been paid to the ways in which the protracted struggle for access to ART represents the triumph of public law and human rights over private

311. *Id.*

312. Under patent, Gleevec costs \$2600 per month; generic versions of the drug cost less than \$200 per month. Novartis Boycott Campaign, Brief Background of the Gleevec Case, <http://novartisboycott.org/brief-background-of-the-gleevec-case/> (2007).

313. Vijay Yalamanchili, *State of India’s TRIPS Compliant Regime*, 26 BIOTECHNOLOGY L. REP. 211, 223-24 (2007).

314. Novartis argued that Article 3(d) is inconsistent with TRIPS, which requires only that patentable inventions involve an “inventive step” and nothing further. See Janice M. Mueller, *Taking TRIPS to India: Novartis, Patent Law, and Access to Medicines*, 356 NEW ENG. J. MED. 541, 542-43 (2007).

315. Press Release, Doctors Without Borders, Indian Court Ruling in Novartis Case Protects India as the “Pharmacy of the Developing World” (Aug. 6, 2007), <http://www.doctorswithoutborders.org/press/release.cfm?id=2096>.

On the question of technical TRIPS compliance, the court deferred to the WTO Dispute Settlement Body. Media Release, Novartis, Novartis Concerned Indian Court Ruling Will Discourage Investments in Innovation Needed to Bring Better Medicines to Patients (Aug. 6, 2007), available at www.novartis.com/newsroom/media-releases/en/2007/1144199.shtml.

316. Thailand, too, has signaled its intention to issue compulsory licenses for HIV and cancer treatments. These activities are succored by the NGOs Medecins Sans Frontiers, Knowledge Ecology International, Health Gap and other civil society groups including contributors to the IP-Health list serve. See Kapczynski, *supra* note 61, at 828.

317. See generally Thomas Pogge, *Introduction*, in *FREEDOM FROM POVERTY AS A HUMAN RIGHT: WHO OWES WHAT TO THE VERY POOR* 1, 6 (Thomas Pogge ed., 2007); Aidan Hollis & Thomas Pogge, *THE HEALTH IMPACT FUND: MAKING NEW MEDICINES AVAILABLE FOR ALL* (2008), available at www.yale.edu/macmillan/igh/hif_book.pdf.

law interests,³¹⁸ specifically patent protection and the reward structure of intellectual property rules. While the consequences for future innovation are uncertain — AIDS is a disease of the developed and developing world which creates strong incentives for continued pharmaceutical innovation and profits in the global north — the fact of accumulated judicial subordination of pharmaceutical property rights in AIDS drugs is beyond dispute. Treatment campaigners have learned that organized social movements with a claim to specific and affordable demands are likely to produce highly sympathetic responses from judges as well as the court of public opinion.

2. Development

The persistent legal challenges to TRIPS and to domestic intellectual property regimes posed by advocates for greater access to ARVs may also have important development consequences. As Margaret Chon argues, the global struggle to obtain patented drugs for people in poor states is one piece of evidence that the standard intellectual property balancing test between protection of knowledge goods and access by consumers to information embedded within the protected goods often fails to promote either development or social welfare maximization.³¹⁹ The plain reality is that AIDS drugs are priced, protected and challenged according to a different set of rules than those that govern less contested knowledge goods. Indeed, the struggle over patents, the issuance of voluntary and compulsory licenses for generic ARVs and the creation of a global funding architecture has challenged the notion that AIDS and underdevelopment are mutually reinforcing phenomena.

Beginning with Jonathan Mann's work, the relationship between the pandemic and poverty has been carefully documented over a fifteen-year period. Treatment impacts development by disrupting the cycle of early death and economic stagnation. Nonetheless, until 2001, many international development experts rejected the notion of using ARVs to save the lives of individuals suffering from late-stage AIDS.³²⁰ In this view, efforts to ensure widespread treatment carried with them the potential to cause distortions in health and development spending and risked wasting resources on individuals who were certain to die premature deaths.³²¹

318. See Robert Howse & Makau Mutua, Int'l Ctr. for Human Rights & Democratic Dev., *Protecting Human Rights in a Global Economy: Challenges for the World Trade Organization* 7 (2000), available at www.ichrdd.ca/english/commddoc/publications/globalization/wtoRightsGlob.html ("[h]uman rights . . . will normally prevail over [trade laws]. The WTO laws and processes must be interpreted in a way that advances human rights, transparency, accountability and representivity.")

319. Margaret Chon, *Intellectual Property and the Development Divide*, 27 CARDOZO L. REV. 2821, 2831 (2006).

320. JEFFREY SACHS, *THE END OF POVERTY* 205 (2005).

321. In 1997, a year's worth of ARV treatment cost \$10,000 per patient; the same sum of money in that year could have been used to save 9,900 children from potentially fatal bouts of dehydration. See ROBERT CLARK, *GLOBAL AWARENESS* 28 (2002).

Between 2003 and 2008, treatment skeptics were sidelined by the medical reality that highly effective ART can banish the virus to undetectable levels while prolonging life and the gathering political consensus that treatment is necessary and fiscally viable. The current understanding is that treatment assures survival and in many high-prevalence societies creates conditions where individuals may reach the first rung on the development ladder.

Conversely, if left unchecked, the pandemic leads to a “spate of absenteeism, lower productivity, higher overtime costs, escalating death benefits, excessive health expenditures, and additional costs for recruiting and training new employees to replace the dead and dying.”³²² UNAIDS has labeled the virus a “destabilizing factor” because as parents and workers are felled by disease, the “structures and divisions of labour in households, families, workplaces and communities are disrupted.”³²³ The human resources crisis that follows is so dire that AIDS threatens to prevent – and potentially reverse – the democratic development of high prevalence states. Military and police forces in many places suffer especially high infection rates, and would-be participants in civil society (almost always women) are burdened by care-giving responsibilities. In a particularly cruel twist, research shows that some HIV-positive caregivers have difficulty remembering to take their own medications and that “those least likely to comply [with prescribed drug regimens] are usually those least able to comply.”³²⁴ As caregivers leave school and jobs to attend to the sick and dying, they are consigned to the poverty that heightened their vulnerability to infection in the first place.

Economists and public health officials have also demonstrated that the failure to provide treatment, that is, the global rationing of ARVs, actually exaggerates the gap between rich and poor. As Paul Farmer points out,

[i]f marginally effective treatments for HIV disease are not available to the poor, then their health suffers only marginally. But if highly effective therapies – such as the more active “cocktails” of antiretroviral drugs – are unavailable to those living in poverty, then class-based inequalities of outcome worsen with time.³²⁵

Against this backdrop, the Global Fund was established to direct funds for prevention, care, and treatment of HIV and AIDS to low and middle-income states with the avowed purpose of promoting development. The Fund’s website acknowledges the social, economic, and development impact of AIDS and makes poverty alleviation a central part of its

322. Spectar, *supra* note 22, at 486.

323. U.N. Special Session on HIV/AIDS, Fact Sheet: Global Crisis – Global Action, AIDS as a Security Issue (June 2001), http://www.U.N.org/ga/aids/ungassfactsheets/word/fssecurity_en.doc.

324. FARMER, *supra* note 39, at 165.

325. *Id.*

mission.³²⁶ In turn, the World Bank has shifted its position from the belief that health improves in tandem with general economic development to the realization that AIDS impedes economic development in the first place.³²⁷

Low and middle-income countries have started to apply the same lessons internally. "By 2003 . . . Tanzania [had begun to] spend nearly 13 percent of its national budget on health-related goods and services . . ."³²⁸ Ghana has instituted a dedicated 2.5% health tax.³²⁹ Experts estimate that the provision of universal ART in Brazil has generated an annual cost savings of as much as \$360 million.³³⁰

Where a justiciable rights framework has advanced claims to ART, states now appear to be aligning this manifestation of health praxis with Amartya Sen's development index of "capabilities to function."³³¹ Sen argues that in crafting economic development policies, the most important metric is people's ability to do and engage in certain activities and to enjoy a positive state of being. Policy development, according to Sen, should be focused on the capabilities to function.³³² In this view, positive freedoms represent the elimination of vulnerabilities that enable empowerment and liberty.³³³ Rights to treatment, to the means of sustaining life, facilitate the enjoyment of other capabilities and represent an investment in positive freedom.

While it may be impossible to detail exactly how and whether treatment rights have generated health funding, it is clear that calling the claim for treatment a right is an example of asserting actionable development rights, claims that, of necessity, compel the state to spend

326. See The Global Fund to Fight AIDS, Malaria and Tuberculosis, <http://www.theglobalfund.org> (last visited Mar. 2, 2009).

327. SACHS, *THE END OF POVERTY*, *supra* note 320, at 203-05; Kerry Rittich, *The Future of Law and Development*, 26 MICH. J. INT'L L. 199, 227-29 (2004). Since 2006, the Bank has also been engaged in a review of its programs to ensure compliance with international human rights law. See Ana Palacio, *The Way Forward: Human Rights and the World Bank*, DEV. OUTREACH, Oct. 2006, available at <http://www1.worldbank.org/devoutreach/october06/article.asp?id=388>; Roberto Dañino, *The Legal Aspects of the World Bank's Work on Human Rights: Some Preliminary Thoughts*, in HUMAN RIGHTS AND DEVELOPMENT, *supra* note 259, at 509. The Bank's actions followed sustained criticism by human rights activists and U.N. officials who argued that the imposition of school fees pursuant to World Bank-mandated structural adjustment programs discouraged attendance, depriving children of education in violation of the Convention on the Rights of the Child. LEWIS, *supra* note 1, at 71-107.

328. Garrett, *The Challenge of Global Health*, *supra* note 18, at 21 (also noting that "the Central African Republic, Namibia, and Zambia each spent about 12 percent of their budgets on health; and in Mozambique, Swaziland, and Uganda, the figure was around 11 percent.")

329. See U.N. Office for the Coordination of Humanitarian Affairs, *Ghana National Health Insurance Scheme Launched*, IRIN: HUMANITARIAN NEWS AND ANALYSIS, Mar. 18, 2004, <http://www.irinnews.org/report.aspx?reportid=49172>.

330. The Brazilian cost savings came from hospitalizations that were not required. See Varun Gauri, Chris Beyrer & Denise Vaillancourt, *From Human Rights Principles to Public Health Practice: HIV/AIDS Policy in Brazil*, in PUBLIC HEALTH AND HUMAN RIGHTS, *supra* note 80, 289, 320-21.

331. AMARTYA SEN, *RESOURCES, VALUES AND DEVELOPMENT* 497 n. 21 (1984).

332. Amartya Sen, *Gender Inequality and Theories of Justice*, in WOMEN, CULTURE AND DEVELOPMENT: A STUDY IN HUMAN CAPABILITIES 259, 266-67 (Martha Nussbaum & Jonathan Glover eds., 1995).

333. See George, *supra* note 39, at 1489.

money.³³⁴ It is perhaps no accident that in Latin America, where the right to treatment is most firmly established, 75% of eligible patients are on treatment.³³⁵

Broadly speaking, a right to treatment also contains the potential to destabilize existing development axioms and to move beyond the charitable impulse that lies at the core of needs-based development models. When individuals and NGOs have asserted a right to treatment, states have been forced to prioritize the scale up of ART.³³⁶ Even as the pure right to development is infrequently adjudicated,³³⁷ the demand for ARVs offers a well-developed counterpoint of judicial engagement with foundational claims to human development, the fulfillment of which is necessary to activate other rights. In this fashion, the global treatment cases have cemented rights-based understandings and helped to catalyze the unprecedented rise in public and private funding for AIDS. As Kofi Annan has posited:

A rights-based approach to development describes situations not simply in terms of human needs, or of development requirements, but in terms of society's obligations to respond to the inalienable rights of individuals; empowers people to demand justice as a right, not as charity; and gives communities a moral basis from which to claim international assistance when needed.³³⁸

The legalization of claims to treatment thus serves as a first and potentially paradigm-shifting means of securing "some measure of dignity to those in our world who continue to live in conditions of extreme poverty and deprivation."³³⁹

D. Toward a Definition of Enforceable Socio-Economic Rights

Can this model be replicated for more than AIDS drugs? What makes treatment justiciable where other claims to social and economic rights are

334. Louise Arbour, *Using Human Rights to Reduce Poverty*, 8 DEV. OUTREACH 1 (Oct. 2006).

335. See WHO, *Towards Universal Access by 2010: How WHO Is Working with Countries to Scale-up HIV Prevention, Treatment, Care, and Support* 12, available at <http://www.who.int/hiv/toronto2006/towardsuniversalaccess.pdf>.

336. Ángel R. Oquendo, *The Solitude of Latin America: The Struggle for Rights South of the Border*, 43 TEX. INT'L L.J. 185, 195 (2005) (noting that in *Cruz Bermudez* the Venezuelan justices rejected government's assertions that ART was too costly and ordering the state to make budgetary adjustments necessary to meet its constitutional obligations). See also Shylashri Shankar & Pratap Bhanu Mehta, *Courts and Socioeconomic Rights in India*, in *COURTING SOCIAL JUSTICE*, *supra* note 228, at 160-61 (recognizing that plaintiff-friendly judgments in India have served to expand access to free ARVs).

337. See generally Gauri, *supra* note 259, at 71-72.

338. Kofi Annan, *quoted in* Hans V. Hogerzeil, *Essential Medicines and Human Rights: What Can They Learn From Each Other?* 84 BULL. OF THE WHO 371, 373 (2006).

339. Varun Gauri & Daniel M. Brinks, *Introduction: The Elements of Legalization and the Triangular Shape of Social and Economic Rights*, in *COURTING SOCIAL JUSTICE*, *supra* note 228, at 35.

ignored by courts and governments alike? Will the success of the HIV drug cases serve as another example of AIDS exceptionalism? Several elements embedded within the treatment cases offer clues to the enforceability of other social and economic rights claims.

The first is rooted in the efficacy of HAART and the ease with which judges can order its provision. By any standard, ARVs provide therapeutic value; few other drugs work so successfully to bring sick people back from the brink of death.³⁴⁰

Second, the steep reduction in prices caused by generic competition means that first-line ARVs are also increasingly cost effective. As the cost of treatment has dropped, ART for infected persons has been likened to other precursors for a dignified life, including inoculations against readily preventable diseases. Increasingly, the infusion of dollars from the Global Fund and PEPFAR to poorer countries is reducing the budgetary burden on states to ensure treatment.³⁴¹ Additionally, increasing the number of patients on treatment is relatively easy for governments to do and amenable to immediate and demonstrable progress.³⁴² In turn, judges from South Africa to Brazil to Alabama, have demonstrated that they are comfortable monitoring compliance with measurable orders to provide ART.

The magnitude of the threat posed by the virus constitutes a third element. At least two of the leading treatment cases have recognized the risk to human security posed by the HIV/AIDS pandemic. The South African Constitutional Court in *TAC* prefaces its order for the nationwide expansion of PMTCT treatment with the observation that the AIDS pandemic "has claimed millions of lives, inflicting pain and grief, causing fear and uncertainty, and threatening the economy."³⁴³ The same human security consequences are apparent in the Costa Rican Supreme Court judgment in *Alvarez*:

[I]f it is necessary to put the problem in the cold light of financial imperatives, this Court believes that it would be no less appropriate to ask ourselves how many millions of *colones* [the national currency of Costa Rica] are wasted because ill persons have no possibility of reintegrating themselves into the labor force and contributing, even if in a very small way, to the national wealth . . . [i]t seems reasonable to postulate that the country loses more in direct and indirect costs due to the state of incapacity of those who are prostrated by a disease, which alternatively could be

340. Malawi recently announced that the increased availability of free ART had slashed AIDS deaths by 75%. *Malawi: AIDS Deaths Drop by 75%*, N. Y. TIMES, Aug. 16, 2008, at A8.

341. It is important to note that many of the Latin American cases, including the Brazil and El Salvador cases, were decided at a time when ART was prohibitively expensive and required significant budgetary allotments. See Hogerzeil et al., *supra* note 151, at 306.

342. The World Bank, the Global Fund, and PEPFAR all track the number of patients on treatment.

343. *Minister of Health v Treatment Action Campaign* 2002 (10) BCLR 1033 (CC) (S. Afr.) 1.

invested providing treatment that would permit them to return to a productive life.³⁴⁴

The judicial exercise in accounting for the totality of the pandemic, a move that casts the provision of ART as both rights-protective and a responsible economic decision, provides another filter to assess comparable claims.

The fourth – and potentially most expansive element – pivots on the dangers associated with the absence of judicial intervention. In the treatment cases, courts have expressed the right to ART as necessary to safeguard the human dignity of infected persons. Indeed, the predictably fatal consequences of AIDS have emboldened courts to fashion rights-based solutions appropriate to the imminent threat to both health and life. Accordingly, the Colombian Constitutional Court has tied the constitutional right to life to the conception of a life lived with dignity. In the prison treatment case of *Pedro Orlando Ubaque v. Director*,³⁴⁵ the Colombian Court emphasized the fundamental nature of the right to health as a predicate to the rights to life and dignity.³⁴⁶ In Costa Rica too, the Supreme Court explained in *Alvarez v. Caja Costarricense de Seguro Social* that “[i]n a state of law, the right to life, and in consequence the right to health, receives particular protection [W]ithout the right to life all of the other rights are useless. . . .”³⁴⁷ Lord Nicholls’ opinion in *N (FC) v. Secretary of State for the Home Department* acknowledges that the health and dignity of the HIV-positive asylum seeker was entirely dependent on her receipt of ART. “[W]ithout these drugs and facilities her prognosis is ‘appalling’: she will suffer ill-health, discomfort, pain and death within a year or two.”³⁴⁸ In each of these cases, courts have amalgamated protections associated with the right to health and the right to life in order to discover a commitment to human dignity.

Dignity, as Maxine Goodman points out, is an unassailable value and may serve as an irrefutable argument.³⁴⁹ It is, however, an ambiguous concept and it only enjoys constitutional status as an express right in a limited number of countries.³⁵⁰ Nonetheless, where treatment forestalls

344. *Alvarez*, Exp. 5778-V-97, No. 5934-97 (Sala Constitucional de la Corte Suprema de Justicia de Costa Rica 1997), *quoted in* Yamin, *supra* note 26, at 362.

345. *Orlando Ubaque v. Director*, Dec. No. T-502/94 (Corte Constitucional de Colombia 1994) (finding that conditions in a prison ward of HIV-positive prisoners violated the prisoners’ right to health and dignity in view of their compromised immune systems).

346. Protection Writ, *Judgment of Fabio Moron Diaz, Magistrado Ponente*, Constitutional Court of Colombia, Dec. No. T-328/98 (1998); *see* Yamin, *supra* note 26, at 340 (holding denial of costly antiretroviral treatment prescribed for plaintiff under social security system violates constitutional fundamental right to life).

347. *Alvarez*, Exp. 5778-V-97, No. 5934-97 (Sala Constitucional de la Corte Suprema de Justicia de Costa Rica), *quoted in* Yamin, *supra* note 26, at 341.

348. *N (FC) v. Secretary of State for the Home Department* [2005] UKHL 31, ¶ 3.

349. Maxine D. Goodman, *Human Dignity in Supreme Court Constitutional Jurisprudence*, 84 NEB. L. REV. 740, 751 (2006).

350. *See* Jeanne M. Woods, *Justiciable Social Rights as a Critique of the Liberal Paradigm*, 30 TEX. INT’L L.J. 763 (2003); Lorraine E. Weinrib, *Constitutional Conceptions and Constitutional Comparativism*, in *DEFINING THE FIELD OF COMPARATIVE CONSTITUTIONAL LAW* 3, 15 (Vicki C.

death, the global case law is emphatic that the mere interruption of ART constitutes an affront to human dignity. As Lord Nicholls declares in *N (FC)*, "Antiretroviral treatment can be likened to a life support system. Although the effects of terminating treatment are not so immediate, in the longer term they are just as fatal."³⁵¹ Even in the U.S. prison cases, the conclusion that treatment sustains life imbues the right to specific medicines with meaning and constitutional pathos.³⁵²

Significantly, dignity of the person also finds expression in the jurisprudence of cruel and unusual punishment, antidiscrimination law³⁵³ and the protection of due process.³⁵⁴ The penumbra of overlapping protections identified by this literature suggests that the concept of human dignity extends to quality of life and health arguments too.³⁵⁵ Anne-Marie Slaughter has written that "as human beings, we all seek to live our lives in dignity, free from fear and from want. We need not be guaranteed prosperity, but at least the health and education necessary to strive for it."³⁵⁶ Grotesque inequalities, avoidable stigma and the assault on self-worth are all closely linked to an assault on dignity.³⁵⁷ To the extent that judicially-compelled treatment serves to make HIV-positive people whole again,³⁵⁸ the intervention is rooted in the same imperative that informs school desegregation and the social welfare guarantee of most developed states.³⁵⁹

Affirmative rights fulfillment of this kind echoes Henry Shue's argument that all human beings enjoy basic rights to minimum

Jackson & Mark Tushnet eds., 2002) (recognizing dignity as a salient feature of post-war constitutions).

351. [2005] UKHL 31, at ¶ 49.

352. The same concern was expressed in *Lavira v. Attorney General*, 478 F.3d 158 (3d Cir. 2007), which remanded the case for a decision consistent with the respondent's HIV status and the Court's fear that returning an asylum applicant to Haiti would subject him to pain and suffering.

353. See Gauri, *supra* note 259, at 70 (noting that one conception of human dignity posits that "being denied education and health care is tantamount to being excluded from modern society, which its attendant social and psychological consequences").

354. *Lawrence v. Texas*, 539 U.S. 558 (2003) (striking down Texas' anti-sodomy statute as a violation of the Due Process Clause).

355. See generally Jordan J. Paust, *Human Dignity as a Constitutional Right: A Jurisprudentially Based Inquiry Into Criteria and Content*, 27 HOW. L. J. 145, 146 (1984); Vicki C. Jackson, *Constitutional Dialogue and Human Dignity: States and Transnational Constitutional Dialogue*, 65 MONT. L. REV. 15, 15 (2004).

356. Slaughter, *supra* note 52 at 619.

357. See *S. v. Makwanyane* 1995 (3) SA 391 (CC) at para. 506 (S. Afr.) ("[I]t is not life as mere organic matter that the Constitution cherishes, but the right to human life: the right to live as a human being, to be part of a broader community, to share in the experience of humanity . . .").

358. See Sandra Liebenberg, *The Value of Human Dignity in Interpreting Socio-Economic Rights*, 21 S. AFR. J. HUM. RTS. 1, 7 (2005) ("Human dignity is closely related to the notion of human beings as agents capable of making moral choices, of shaping our identity, resisting injustice and participating in the shaping of society.").

359. See *Brown v. Board of Education*, 347 U.S. 483, 494 (1954) (recognizing that segregated education perpetuates feelings of inferiority among non-white school children); see also AUSTRALIAN ANTI-DISCRIMINATION LAW: TEXT, CASES AND MATERIALS 29 (Neil Rees, Katherine Lindsay & Simon Rice, eds., 2008)

subsistence. “[B]asic rights arguments suggest that satisfying a right to health does not require granting universal access to the latest technological and scientific resources for health, but rather a minimum that provides the basis for leading a dignified life.”³⁶⁰ This notion is supported by agency-based theories which hold that abject poverty, disease, disability, illiteracy, and ignorance can so impair a person’s sense of self-worth that his or her life fails to be fully realized.³⁶¹

Shue writes:

Many causes of death and illness are outside the control of society, and many deaths and illnesses are the result of very particular conjunctions or circumstances that general social policies cannot control When death and serious illness could be prevented by different social policies regarding the essentials of life, the protection of any human right involves avoidance of fatal or debilitating deficiencies in these essential commodities. And this means fulfilling subsistence rights as basic rights.³⁶²

The justiciability of treatment claims is proof, if any were needed, that death and debilitation from HIV are not outside the control of society. Although treatment is almost never isolated as an autonomous interest or an expression of subsistence rights, the protection of dignity through treatment now informs nevirapine administration in South Africa, Brazil’s universal treatment programs, and delivery of ART in U.S. prisons. The project of defining dignity for judicial application is challenging but to the extent that treatment constitutes a safe, proven and affordable intervention, the totality of cases ordering ART suggests a floor beneath which there can be no human dignity. In that sense, the treatment jurisprudence permits the definable realization of a right to health while acting as a precursor to the fulfillment of other essential rights.

The efficacy, measurability, affordability, human security, and dignity rationales also provide a framework for understanding when courts will enforce specific demands for the implementation of social and economic rights. That framework is most readily applied to other aspects of the right to health for diseases that are amenable to efficacious pharmacological interventions.³⁶³ It is easy to imagine the extension of the treatment reasoning in cases demanding new antimalarial drugs that derive from or

360. Evans, *supra* note 126, at 206.

361. Gauri, *supra* note 259, at 77-78.

362. HENRY SHUE, BASIC RIGHTS: SUSTENANCE, AFFLUENCE, AND U.S. FOREIGN POLICY 25 (1980).

363. The contours of dignity protection could also inform the specific obligations of Lawrence Gostin’s Framework Convention on Global Health or provide interpretive guidance to judges and lawmakers. Gostin conceives of a flexible international health instrument along the lines of the Framework Convention on Tobacco Control that would be augmented over time by specific protocols reflecting more detailed norms, structures and processes. See Lawrence O. Gostin, *Meeting Basic Survival Needs of the World’s Least Healthy People: Toward a Framework Convention on Global Health*, 96 GEO. L.J. 333, 374-90 (2008).

synthetically copy artemisinin. These drugs are dramatically more effective than their predecessor therapies and would benefit millions of people in the developing world.³⁶⁴ The same is true for drugs to treat sleeping sickness, diarrheal disease, and many other ills of low and middle income states.³⁶⁵ Where medical interventions have a dramatic impact on such a large scale, the recognition of positive rights to health goods provides judges — who undoubtedly like to save lives — with myriad paths to the same conclusion.

The logic of treatment applies equally to the right to food. Here too, courts have decided public interest cases in which litigants have asserted the right to adequate nutrition. Indian judges, for example, have ordered the government to provide petitioners with food stocks containing prescribed minimum quantities of protein and daily calories to vulnerable individuals in order to prevent starvation.³⁶⁶ Like the treatment cases, right to food claims benefit from discrete and effective interventions, domestic law reinforced by international declarations, as well as the institutional assistance of the World Food Programme and the aid policies of donor states.³⁶⁷ From this perspective, right to water³⁶⁸ and emergency shelter claims, without which millions of lives are immediately imperiled, should also be justiciable.

When efficacy, dignity, and human security are present — however weighted — the application of the treatment legacy is obvious. In such cases, the treatment precedent can act to dispel the myths and constraints that surround right to health or environment claims and the appropriateness of their resolution in a judicial forum. What remains is for social movements to galvanize behind particular instantiations of inequality and injustice and for lawyers to invoke those aspects of the treatment cases that are firmly lodged within the social and economic rights tradition.³⁶⁹ In this respect, the organizing efforts, if not actual litigation, by advocates for effective tuberculosis, malaria, and leukemia treatment hold the promise of successful future action.

At the same time, the key to the AIDS treatment legacy's ability to function as a template for the justiciability and enforcement of other social and economic rights claims — the provision of discrete and effective goods in support of a human dignity and human security analysis — also signals a substantial limitation. Because the treatment cases rely so heavily on

364. See Donald G. McNeil, Jr., *A Cheaper, Easier Malaria Pill*, INT'L HERALD TRIB., Mar. 1, 2007 (describing how a new drug called ASAQ has entered the global market for less than \$1 per day and requires only two pills per day for three days).

365. See Gostin, *supra* note 363, at 368.

366. See People's Union for Civil Liberties v. Union of India, Interim Order of May 2, 2003 (India), http://www.escri-net.org/usr_doc/Interim_Order_of_May_2.doc.

367. Smita Narula, *The Right to Food: Holding Global Actors Accountable Under International Law*, 44 COLUM. J. TRANSNAT'L L. 691 (2006).

368. Ramin Pejan, *The Right to Water: The Road to Justiciability*, 36 GEO. WASH. INT'L L. REV. 1181 (2004).

369. See Hoffman & Bentes, *supra* note 228, at 144 (observing that the organized HIV/AIDS movement in Brazil often files demands for new AIDS drugs as they are developed and sometimes before they are certified for distribution in Brazil).

highly effective pills to ensure survival and a minimum quality of life, the justiciability of this manifestation of the right to health suggests that demands to alleviate suffering constitute another magnitude of difficulty.³⁷⁰ As World Bank economist Varun Gauri notes, even as Brazil has scaled up universal ART, many basic antibiotics remain too expensive or inaccessible for millions of Brazilians.³⁷¹

Intuitively, legal actions meeting the efficacy, security and dignity criteria are recognizable in a full range of social and economics rights cases including the right to education,³⁷² to social services that protect against child abuse,³⁷³ to an adequate standard of housing,³⁷⁴ and to redress degrading working conditions. But it is difficult to equate sustained misery with a clear and present threat to life. In the absence of the health-life admixture of the treatment cases, courts may be reluctant to address similar claims on the basis of dignity alone. As courts and commentators address these doctrinal issues, it will be important to guard against the conclusion that socio-economic rights necessary to secure life occupy a hierarchical position vis-a-vis other socio-economic rights.³⁷⁵

CONCLUSION

The story of treatment is at stark odds with the recognition of other social and economic norms "where it is customary to speak of inalienable rights and to wait decades or centuries to see them vindicated."³⁷⁶ As Laurie Garrett has observed, "The HIV/AIDS pandemic . . . continues to be the primary driver of global concern and action about health . . . but efforts

370. See *Auton (Guardian ad litem of) v. Attorney General of British Columbia*, [2004] 3 S.C.R. 657, 2004 SCC 78 (refusing to order the province of British Columbia to fund specialized ABA/IBI treatment within the meaning of "core, physician-funded services" covered by the Canada Health Act).

371. Varun Gauri, *Social Rights and Economics: Claims to Health Care and Education in Developing Countries*, 32 *WORLD DEV.* 465 (2004).

372. See *Mohini Jain v. State of Karnataka*, AIR (1992) SC 1858 (India); Robynn K. Sturm & Julia A. Simon-Kerr, *Justiciability and the Role of Courts in Adequacy Litigation: Preserving the Constitutional Right to Education*, Yale Law School Student Scholarship Series, Paper 78 (2008), <http://lsr.nellco.org/yale/student/papers/78> (recognizing that while many U.S. state courts have interpreted the education clauses of their state constitutions to guarantee an "adequate" education for all students, since 2005, separation of powers concerns regarding budgetary allotment have driven state courts from this avenue for education reform.).

373. Claims for the preservation of human dignity could have a future bearing on cases such as *Deshaney v. Winnebago County Social Services Department*, 489 U.S. 189 (1989), in which the United States Supreme Court held that a state's failure to protect a boy who was violently abused by his father over a long period of time did not violate the Due Process Clause of the Fourteenth Amendment of the U.S. Constitution.

374. This issue was famously explored by Frank Michelman in *The Advent of a Right to Housing: A Current Appraisal*, 5 *HARV. C.R.-C.L. L. REV.* 207, 207 (1970).

375. The inference that claims involving a right to life are more important than other rights assertions would violate the bedrock human rights principle that all rights are equal and indivisible.

376. FARMER, *supra* note 39, at 232. The implementation of economic, social and cultural rights is often focused on non-judicial remedies or directed toward a particular constitutional system (i.e. South Africa). See also Kristen Boon, *The Role of Courts in Enforcing Social and Economic Rights*, 39 *GEO. WASH. INT'L L. REV.* 449, 458 (2007).

to combat HIV/AIDS have so far managed to bring more money to the field but have not always had much beneficial impact on public health outside of their own niche."³⁷⁷ Can increased AIDS funding contribute to improving the infrastructure for health in the developing world? And if a right to ARVs is galvanizing the right to health, can it play the same role for a right to food (without which ARVs are ineffective)?

Whether claims to ART become a wedge for the implementation of other social and economic rights or remain a judicial illustration of AIDS exceptionalism depends in large measure on the instrumental and normative lessons of the treatment revolution. This Article has demonstrated that courts are recognizing demands for ART as justiciable human rights. In so doing, the treatment cases have transformed the discourse surrounding the fulfillment of social and economic rights, demonstrated the indivisibility of all human rights, and given priority to a previously subordinate category of claims. Viewed as a type, these cases also suggest an important role for litigation as the driver of health rights and invite inquiry into using this method of promoting unrealized socioeconomic rights.

As significant as these achievements are, the legal advances related to AIDS treatment raise as many questions as they answer. Foremost among them is the most basic inquiry: at what cost? Do price reductions have a bearing on the right? How elastic is the term "available resources"? And should a right to treatment exist for medical interventions that merely alleviate suffering?³⁷⁸

The identification of a justiciable right to treatment of AIDS does not itself resolve these dilemmas. It nonetheless communicates the message that legal recognition stemming from individual cases is an integral part of the fulfillment of social and economic rights. Ingenuity and competition have created medicines and lowered prices to levels that make universal ART a reasonable goal, even for people living in desperately poor places. Although human rights discourse has been slow to conceptualize AIDS treatment and the importance of domestic law in articulating socioeconomic rights, the justiciability of demands for ARVs reflects the power of law to adapt to calamitous realities while providing a principled alternative to charity. Over time, rights observance begets funding and the creation of institutions capable of effecting systemic change.

In that, the expansion of HIV activism and jurisprudence into the arena of treatment honors the legacy of the AIDS law pioneers. As the new frontier in the promotion of rights to health, life, and human dignity, the treatment cases are beginning to fill the lacuna of social and economic rights enforcement. Judicial engagement with the complexities of a right to

377. Garrett, *supra* note 18, at 23-24 (arguing that instead of directing so much attention to AIDS, the world health community should focus on increasing maternal survival and increasing overall life expectancy).

378. To date, the lessons of the treatment revolution have been limited to other highly effective medicines used to control life-threatening illnesses. The closer future cases hew to the core elements of the treatment jurisprudence, the greater the chance of judicial success.

ARV treatment also facilitates the alignment of law, responsibility and the better angels of the human spirit while mapping the terrain for future socioeconomic rights cases.