AFTER AIDS

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This article argues that the transformative potential of Human Immunodeficiency Virus ('HIV') and Acquired Immunodeficiency Syndrome ('AIDS') treatment litigation has failed to produce a fundamental shift in the judicial enforceability of other manifestations of the right to health or to a broader range of social and economic rights claims. There are three fundamental reasons for this reality: (i) the inability of proponents of other social and economic rights to create a broad-based social movement capable of articulating urgent demands in the language of rights; (ii) a shift in focus by HIV/AIDS activists toward intellectual property rules and away from generalised human rights-fulfilment; and (iii) doctrinal weaknesses in the treatment cases themselves, particularly the focus on right to life provisions in leading opinions. To resurrect the legacy of AIDS advocacy, this article points to other means of rights observance and the enduring effect of institutional changes wrought by the struggle for life-saving medicines.

CONTENTS

I INTRODUCTION

For nearly a decade, the judicialisation of Human Immunodeficiency Virus ('HIV') and Acquired Immunodeficiency Syndrome ('AIDS') treatment promised to transform the world. Between 1996 and 2005, AIDS activists, people living with HIV and AIDS ('PLWHA') and non-governmental organisations ('NGOs') used diverse judicial processes to compel states to provide life-saving medications. In a thousand Brazilian *amparo* proceedings (proceedings for the protection of constitutional rights) and in test cases before domestic, regional and international tribunals, courts and legislatures gave voice to the previously unthinkable — the direct implementation of one manifestation of social and economic rights.[1]

How and why this phenomenon occurred is worth considering, for it surely has a bearing on whether other rights to health — and expensive positive rights

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1 See generally Francisco Inácio Bastos et al, 'Treatment for HIV/AIDS in Brazil: Strengths, Challenges, and Opportunities for Operations Research' (2001) 15 *AIDScience* <http://aidscience.org/Articles/aidscience012.asp>; Allan R. Brewer-Carías, *Constitutional Protection of Human Rights in Latin America: A Comparative Study of* Amparo *Proceedings* (Cambridge University Press, 2009) 77.

more generally[2] — are judicially enforceable. The success of court-compelled treatment represents the delivery of immediate remedies in an arena 'where it is customary to speak of inalienable rights and to wait decades or centuries to see them vindicated'.[3] With few exceptions, however, the wellspring of legal support for HIV/AIDS treatment has not produced a wider paradigm shift with respect to the enforceability of social and economic rights.[4] And while litigation has been an effective trigger for desperately needed HIV/AIDS medications, judicial activism to enforce other aspects of quality of life remains a rarity. To be sure, some of the legal achievements of the treatment movement, principally in the field of access to medicines, have been applied to diseases for which generic medicines exist or are in development.[5] But the judicial success of HIV/AIDS advocates has had a negligible impact on other expressions of the right to health, much less the promotion or protection of rights to food, clean water, housing, education or a living wage. In short, the AIDS revolution has stalled and proponents of other social and economic rights are asking why other advocacy movements cannot replicate the success of AIDS advocates.[6]

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[2] The false binary between positive and negative rights in the context of international norms has always been problematic. International human rights treaties, including the *International Covenant on Civil and Political Rights*, famously require states parties to undertake 'to respect and to ensure to all individuals … the rights recognized in the present *Covenant*': *International Covenant on Civil and Political Rights*, opened for signature 16 December 1966, 999 UNTS 171 (entered into force 23 March 1976) art 2.1. See also Aoife Nolan, Bruce Porter and Malcolm Langford, 'The Justiciability of Social and Economic Rights: An Updated Appraisal' (Working Paper No 15, Center for Human Rights and Global Justice, 2007) 7–8. Nolan, Porter and Langford state that '[w]hile admittedly social and economic rights often require relatively greater state action for their realisation than do civil and political rights, this difference separates the two sets of rights more in terms of degree than in kind': at 8, quoting Philip Alston and Gerard Quinn, 'The Nature and Scope of States Parties' Obligations under the *International Covenant on Economic, Social and Cultural Rights*' (1987) 9 *Human Rights Quarterly* 156, 183–4.

[3] Paul Farmer, *Pathologies of Power: Health, Human Rights, and the New War on the Poor* (University of California Press, 2003) 232.

[4] See K A Kelly McQueen et al, 'Essential Surgery: Integral to the Right to Health' (2010) 12(1) *Health and Human Rights* 137; Siri Gloppen, 'Litigation as a Strategy to Hold Governments Accountable for Implementing the Right to Health' (2008) 10(2) *Health and Human Rights* 21. Gloppen explains, at 22, that

> [w]hile there seems to be a clear trend toward more court cases — some brought by individuals with a specific health problem, others by activists (sometimes backed by international organizations and donors) seeking to hold governments accountable for health rights obligations — we have limited knowledge about the rate of success, the effects on health systems and policies, or the economic and social implications of these cases.

McQueen et al argue that essential surgical services have generally not been part of this discussion of the right to the 'highest attainable standard of health': McQueen et al, above n 4, 139, 137–8. See also *International Covenant on Economic, Social and Cultural Rights*, opened for signature 16 December 1966, 993 UNTS 3 (entered into force 3 January 1976) art 12 ('*ICESCR*').

[5] See, eg, Eyal Benvenisti, 'Reclaiming Democracy: The Strategic Uses of Foreign and International Law by National Courts' (2008) 102 *American Journal of International Law* 241, 268. Benvenisti describes the application of the *Agreement on Trade-Related Aspects of Intellectual Property Rights* to leukaemia drugs in India: see *Marrakesh Agreement Establishing the World Trade Organization*, opened for signature 15 April 1994, 1867 UNTS 3 (entered into force 1 January 1995) annex 1C ('*Agreement on Trade-Related Aspects of Intellectual Property Rights*') ('*TRIPS*').

[6] See Michael Manganiello and Margaret Anderson, 'Back to Basics: HIV/AIDS Advocacy as a Model for Catalyzing Change' (Report, FasterCures and HCM Strategists, June 2011).

This article offers three explanations for the limited uptake of the treatment legacy by champions of the many social and economic rights outside the arena of HIV/AIDS. The first recognises the importance of rooting legal change in broad-based social movements and the momentum effects of successful advocacy. The struggle to obtain treatment for PLWHA has been fundamentally intertwined with diverse and impassioned social mobilisation. Most successful legal efforts in this area have not occurred in a vacuum; the judicial controversies resulting in treatment orders are predated by decidedly non-legal action and have galvanised change agents and institutional actors in ways that transcend the immediate demands of the cases.[7]

The second reason for a failure to translate the legal victories surrounding HIV treatment into additional arenas is the desystematisation of the AIDS movement. In important respects, the treatment movement has become highly specialised and is now a victim of its own success. What was once a diverse collection of grassroots actors demanding empathy, recognition, funding and multifaceted expressions of social justice has grown into a formidable and hyper-legal group of experts, many of whom are focused on arcane intellectual property rules.[8] As a consequence, the unique attention and institutionalisation of AIDS treatment has meant that the disease is increasingly disconnected from its history as a mirror of poverty, public health, homophobia and the subordination of women.

The third account is located in the doctrinal weaknesses of the AIDS cases themselves. Although properly hailed as a breakthrough in the enforcement of the right to health, the case law has proven to be stubbornly difficult to replicate. Rather than a coherent expansion of social, economic and cultural rights-realisation grounded in shared conceptions of human rights and dignity, the jurisprudential and legislative advances associated with treatment appear to have extended to select diseases amenable to pharmacological intervention but have gone no further than that. Should wealthy states be compelled to provide expensive, life-extending heart disease care? Can poor communities lacking access to clean water challenge their condition as a rights-based deprivation in court?[9] No one knows with certainty because these claims are so infrequently made.

This article concludes by identifying some of the work that legal and other socio-economic rights activists are doing to promote social and economic rights that may yet redeem the legacy of judicially-mandated AIDS treatment.

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[7] See Amy Kapczynski and Jonathan M Berger, 'The Story of the *TAC* Case: The Potential and Limits of Socio-Economic Rights Litigation in South Africa' in Deena R Hurwitz, Margaret L Satterthwaite and Doug Ford (eds), *Human Rights Advocacy Stories* (Foundation Press, 2009) 43.

[8] See, eg, Duncan Matthews, 'When Framing Meets Law: Using Human Rights as a Practical Instrument to Access Medicines in Developing Countries' (Research Paper No 92/2011, Queen Mary University of London, 2011).

[9] See *Mosetlhanyane v A-G (Botswana)* (Botswana Court of Appeal, Civ App No CACLB-074-10, 27 January 2011); *Mazibuko v City of Johannesburg* [2010] 4 SA 1 (Constitutional Court).

II THE IMPORTANCE OF SOCIAL MOVEMENTS

AIDS was an unlikely locus for a rights revolution because the early years of the pandemic were marked by widespread fear and loathing of both the disease and those persons unfortunate enough to have become HIV-positive. From epidemiologists to the general public, AIDS was initially framed as a disease blamed on infected persons — gay men, intravenous drug users, prostitutes and their sexual partners. Faced with antipathy both inside and outside of the public health field,[10] early AIDS campaigners fought to dispel the opprobrium directed toward HIV-positive people and to protect the privacy of affected individuals.[11] As alarming numbers of people succumbed to AIDS, activists and caregivers developed effective mobilisation techniques to dispel the stigma associated with the virus. North American and European groups including the AIDS Coalition to Unleash Power and the Gay Men's Health Crisis broke the silence surrounding the disease by loudly and effectively demanding help for infected people.[12] Through the use of public performances (including die-ins, blood-splattered demonstrations and choreographed appearances of persons bound and gagged) activists in the developed world generated a deep reservoir of sympathy for PLWHA.[13] The outreach and education of health workers, community organisers and high-profile celebrities succeeded in convincing the general public that AIDS was both readily transmitted and easily preventable. Just as the legal efforts to advance civil rights in the United States relied on the bus boycotts and mass marches of an earlier era, the first generation of AIDS law was firmly embedded in a multi-scalar campaign for social justice characterised by affinity and solidarity networks that extended far beyond AIDS. Those efforts — which included destigmatising HIV-positive people in film, spreading the AIDS quilt on the national mall in Washington DC, confronting homophobia in schools and the workplace and decrying housing and insurance discrimination — all buttressed legal work on behalf of PLWHA.

When scientists discovered effective antiretroviral treatments (described variously as highly active antiretroviral therapy, antiretroviral therapy ('ART') or antiretrovirals ('ARVs')) for infected persons in 1996, the AIDS movement quickly moved to demand treatment for all, particularly since the drugs were available in developed countries and to wealthy individuals around the world. The arrival of ART motivated a number of groups, including the mass member

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10 See generally Randy Shilts, *And the Band Played on: Politics, People, and the AIDS Epidemic* (Penguin, first published 1987, 1988 ed).

11 See Noah Novogrodsky, 'The Duty of Treatment: Human Rights and the HIV/AIDS Pandemic' (2009) 12 *Yale Human Rights and Development Law Journal* 1.

12 On the specific tactics of the AIDS Coalition to Unleash Power ('ACT UP'): see generally Kevin Michael DeLuca, 'Unruly Arguments: The Body Rhetoric of Earth First!, ACT UP, and Queer Nation' (1999) 36 *Argumentation and Advocacy* 9. DeLuca argues that contemporary protesters 'slight formal modes of public argument while performing unorthodox political tactics that highlight bodies as resources for argumentation and advocacy': at 9. See also Lawrence O Gostin, *The AIDS Pandemic: Complacency, Injustice, and Unfulfilled Expectations* (University of North Carolina Press, 2004) xxvi–xxvii.

13 ACT UP and other groups also offered a blueprint for performative activism that has been appropriated and rearticulated by the Treatment Action Campaign ('TAC') 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' (2008) 60 *Maine Law Review* 165.

Treatment Action Campaign ('TAC') in South Africa, the Health Global Access Project ('HealthGAP') and guerrilla activists, all committed to organising for research, prevention, care and, perhaps most importantly, treatment.[14] Their urgent insistence was that states and public insurance plans cover the costs of life-saving ART. Through a series of test cases and quasi-legal legislative crusades, courts and administrative organs, which are generally reluctant to adjudicate claims for social and economic rights much less dictate to legislatures how scarce resources should be allocated, were asked to rule on legal demands for treatment. Critically, the demand came largely from the first generation of infected persons: transvestites in Brazil, pregnant women reliant on public health services in South Africa, prisoners, sex workers and injecting drug users in a host of states. Such persons all belonged to marginalised populations in high- and middle-income countries with functioning judiciaries where the state could have provided treatment but chose not to.

In a series of landmark global cases, treatment advocates prevailed. The Constitutional Court of Colombia was the first tribunal to hold that the state must provide AIDS treatment to its citizens regardless of financial hardship. In *Ubaque v Director de la Cárcel Nacional Modelo* [Director of the National Prison Model] ('*Ubaque*'), the Court ordered ART for inmates unable to provide for their own healthcare.[15] ART was added to the official medicines list in Colombia following a successful lobbying campaign.[16] In *Bermúdez v Ministerio de Sanidad y Asistencia Social* [Ministry of Health and Social Assistance] ('*Bermúdez*') too, the Venezuelan Supreme Court held that that HIV-positive people could demand treatment from the Ministry of Health and Social Assistance.[17] The Constitutional Court's holding in *Bermúdez* had profound

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[14] See Amy Kapczynski, 'The Access to Knowledge Mobilization and the New Politics of Intellectual Property' (2008) 117 *Yale Law Journal* 804, 828. See also Jonathan Michael Berger, 'Litigation Strategies to Gain Access to Treatment for HIV/AIDS: The Case of South Africa's Treatment Action Campaign' (2002) 20 *Wisconsin International Law Journal* 595, 595–7; James Thuo Gathii, 'The Structural Power of Strong Pharmaceutical Patent Protection in US Foreign Policy' (2003) 7 *Journal of Gender, Race and Justice* 267, 290; Barton Gellman, 'A Conflict of Health and Profit; Gore at Center of Trade Policy Reversal on AIDS Drugs to S Africa', *The Washington Post* (Washington DC), 21 May 2000, A1.

[15] Corte Constitucional [Colombian Constitutional Court], Case No T-40184, Decision No T-502/94, 4 November 1994. The Court found that conditions in a prison ward of Human Immunodeficiency Virus-positive ('HIV') prisoners violated the prisoners' right to health and dignity in view of their compromised immune systems. See also *Morales v Ministerio de Salud* [Minister of Health], Corte Constitucional [Colombian Constitutional Court], Case No T-154570, Decision No T-328/98, 3 July 1998 ('*Morales*'); Alicia Ely Yamin, 'Not Just a Tragedy: Access to Medications as a Right under International Law' (2003) 21 *Boston University International Law Journal* 325, 340. In *Morales*, the Court held that the denial of costly antiretroviral treatment prescribed for the applicant under social security system violates the constitutional right to life.

[16] *Decreto No 1543 de 1997* (Colombia) 12 June 1997. See also Hans V Hogerzeil et al, 'Is Access to Essential Medicines as Part of the Fulfilment of the Right to Health Enforceable through the Courts? (2006) 368 *Lancet* 305, 309.

[17] Sala Político Administrativa de la Corte Suprema de Justicia [Administrative Chamber of the Venezuelan Supreme Court], Case No 15789, Decision No 916, 15 July 1999. This case established necessary government procedures and required the Ministry to secure specific budget allocations. See also *Lopez v Instituto Venezolano de los Seguros Sociales* [Venezuelan Institute of Social Security], Sala Constitucional del Tribunal Supremo de Justicia [Constitutional Chamber of the Venezuelan Supreme Tribunal of Justice], Case No 00-1343, Decision No 487, 6 April 2001.

procedural implications since the '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'.[18] In Brazil, countless *amparo* proceedings for treatment of HIV based on the Brazilian Constitution's right to health guarantee[19] provided the preconditions for *Law 9313*.[20] The law ensures that ARVs are provided free of charge in the public health system to all HIV-positive Brazilian citizens. In the most famous of the global treatment cases, South Africa's Constitutional Court issued a structural injunction against the government in *Minister of Health v Treatment Action Campaign (No 2)* ('*TAC Case*'), forcing the government to monitor rollout of a national ART program.[21] The success of each case made subsequent treatment claims easier to win, one version of the 'justice cascade' that Kathryn Sikkink has described in the context of mass crimes trials.[22]

The proliferation of treatment, specifically the delivery of ART in low- and middle-income countries in tandem with the emergence of globalised civil society groups, generated international pressure for national authorities to adopt accessible and affordable medicines policies. In Brazil, according to Eduardo Gómez,

> the lack of response in the face of high disease prevalence and mortality eventually prompted international criticism and pressure on Brazil to respond. This external pressure created an opportunity for presidential reputation building. That is, seeking to use the external pressure as an opportunity to enhance Brazil's reputation as a modern state committed to meeting health care needs and eradicating disease, in Brazil the office of the president had incentives to respond first to AIDS, followed later by a limited response to [tuberculosis].[23]

The movement's worldwide institutional accomplishments were equally impressive. Building on the work of Jonathan Mann, the first World Health Organization Global AIDS Director, HIV/AIDS campaigners converted the international response to a disease once characterised by stigma and avoidance

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18 Mary Ann Torres, 'The Human Right to Health, National Courts, and Access to HIV/AIDS Treatment: A Case Study from Venezuela' (2002) 3 *Chicago Journal of International Law* 105, 112.

19 *Constituição da República Federativa do Brasil 1988* [Constitution of the Federative Republic of Brazil 1988] art 6.

20 *Lei No 9313, de 13 de Novembro de 1996* [Law 9313 of 13 November 1996] (Brazil) 13 November 1996.

21 [2002] 5 SA 721 (Constitutional Court) ('*TAC*').

22 See generally Kathryn Sikkink, *The Justice Cascade: How Human Rights Prosecutions are Changing World Politics* (W W Norton & Company, 2011). The legal recognition of an enforceable right to treatment has extended beyond national courts to international bodies that have required that low-income states treat HIV-infected persons as a matter of law. 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 400 claimants from 10 member states of the Organization of American States: see Tara J Melish, 'The Inter-American Commission on Human Rights: Defending Social Rights through Case-Based Petitions' in Malcolm Langford (ed), *Social Rights Jurisprudence: Emerging Trends in International and Comparative Law* (Cambridge University Press, 2009) 339.

23 Eduardo J Gómez, 'An Interdependent Analytic Approach to Explaining the Evolution of NGOs, Social Movements, and Biased Government Response to AIDS and Tuberculosis in Brazil' (2013) 38 *Journal of Health Politics, Policy and Law* 123, 126.

into defined structures, modalities and unprecedented levels of attention as measured by funding dollars. Today, the combination of bilateral (mainly the US President's Emergency Plan for AIDS Relief ('PEPFAR')),[24] multilateral and private philanthropic efforts (including the Clinton Foundation[25] and the Bill & Melinda Gates Foundation[26]) ensures that vastly more money is directed to AIDS globally than to any other international health or development problem.[27] The creation of dedicated funding vehicles, principally the Global Fund to Fight AIDS, Tuberculosis and Malaria ('Global Fund')[28] and the (RED) campaign,[29] have focused billions of dollars on the virus. Indeed, success has been so great that a growing number of critics now decry the disproportionate share of global health spending directed to HIV and AIDS.[30]

Organisationally, AIDS advocates have also built on court victories to champion the additional needs of PLWHA. South Africa's AIDS Law Project became SECTION27, a public health NGO named after the constitutional provision addressing health rights.[31] HealthGAP dedicated an arm of the

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24 See 22 USC ch 83 (2003) ('*United States Leadership against HIV/AIDS, Tuberculosis, and Malaria*'). The President's Emergency Plan for AIDS Relief ('PEPFAR') was initially funded for 2003–08 with US$15 billion, at least US$10 billion of which was new funding: 22 USC § 7601(28) (2003). PEPFAR's stated goal for this period was to avert 7 million new HIV infections, begin 2 million people on antiretroviral therapy ('ART') and extend care to 10 million HIV-positive people: Office of the United States Global AIDS Coordinator, 'Engendering Bold Leadership: The President's Emergency Plan for AIDS Relief' (Annual Report to Congress, 2005) 11. In July 2008, the United States Congress authorised an additional US$48 billion for the program for the period 2009–13: 22 USC § 7671 (2008).

25 The Clinton Foundation has been instrumental in negotiating price reductions and bulk procurement opportunities from pharmaceutical companies: see Clinton Foundation, *HIV/AIDS* <http://www.clintonfoundation.org/our-work/clinton-health-access-initiative/programs/hivaids>.

26 The Bill & Melinda Gates Foundation has given more than US$2.5 billion to HIV initiatives, including more than US$1.4 billion to the Global Fund to Fight AIDS, Tuberculosis and Malaria ('Global Fund'): see Bill & Melinda Gates Foundation, *What We Do: HIV Strategy Overview* (2013) <http://www.gatesfoundation.org/What-We-Do/Global-Health/HIV>.

27 See Laurie Garrett, 'The Challenge of Global Health' (2007) 86(1) *Foreign Affairs* 14, 21–4.

28 The Global Fund is a public/private partnership to attract, manage and disburse resources to fight infectious disease: see Global Fund, *About the Global Fund* <http://www.theglobalfund.org/en/about/>. The Global Fund has spent in excess of US$8 billion on the prevention, care and treatment of HIV and Acquired Immunodeficiency Syndrome ('AIDS'): Global Fund, *Funding and Spending* (2013) <http://www.theglobalfund.org/en/about/fundingspending/>.

29 Founded in 2006, the (RED) campaign has raised over US$215 million through the sale of brand-name products stamped with the (RED) logo. The revenue is intended to offset the cost of treatment for people living with HIV: see (RED), *Our Story* <http://www.red.org/en/about>.

30 See, eg, David J Casarett and John D Lantos, 'Have We Treated AIDS Too Well? Rationing and the Future of AIDS Exceptionalism' (1998) 128 *Annals of Internal Medicine* 756, 756–9; Kelly Morris, 'The Effect of HIV/AIDS on International Health' (2008) 8 *Lancet* 468; Roger England, 'The Writing Is on the Wall for UNAIDS' (2008) 336 *British Medical Journal* 1072.

31 See SECTION27, *About Us* <http://www.section27.org.za/about-us/>:

> SECTION27 seeks to contribute towards the progressive realisation of socio-economic rights, with a particular focus on the right of access to health-care services, the positive and negative obligations the *Constitution* [*of South Africa*] places on public and private bodies, and the legal and political conditions necessary for sustaining rights under the rule of law.

organisation to remedying the shortage of healthcare workers.[32] TAC engaged in a medical literacy campaign of education and outreach.[33] Today, veterans of the treatment wars are actively engaged in global trade law and have played a leading role in conferences focused on non-communicable disease control and the negotiations over a proposed anti-counterfeiting trade agreement, particularly since the agreement could threaten the supply of generic ARVs from India, Brazil and other states.[34]

The story of treatment success in the legal arena is thus a tale of strategic litigation sourced from within mass mobilisation. Born of a social movement desperate for life-saving pills, HIV/AIDS campaigners deployed litigation strategies asserting the justiciability principle as but one means of ensuring the delivery of essential medicines. The struggle to gain access to ARVs neither began nor ended with legal demands. Treatment advocates certainly mounted legal arguments, but they did so while simultaneously exploiting the indirect social and political opportunities that litigation presents and stretching the enforcement and implementation potential of the demand for ARVs. In case after case, advocates

> craft[ed] structural remedies that enlist[ed] judges and stakeholders to redesign entire governmental systems … to make those systems consistent with human rights values like inclusion, distributional equity and voice.
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> At the same time that they litigate[d], these advocates use[d] all of the other familiar lawyering tools, plus more. … They also [participated in] grassroots organizing, community development, policy advocacy, and global networking. They use[d] the media. And they often orchestrate[d] such tactics in sequence, to leverage great power.[35]

One technique developed by health-based social movements was the intentional creation of 'moral panic', a crisis of conscience among movements' target audiences that they were not doing enough to meet their moral (and hence material) obligations to victims of the disease.[36] Other approaches involved appeals to well-known or celebrity spokespeople who championed a cause that had not yet enjoyed legislative or electoral support.[37] While some '[m]arginalized groups … used legal reform precisely because they lacked

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[32] See Health Global Access Project, *About Health GAP* <http://healthgap.org/about-health-gap/>.

[33] William Forbath et al, 'Cultural Transformation, Deep Institutional Reform, and ESR Practice: South Africa's Treatment Action Campaign' in Lucie E White and Jeremy Perelman (eds), *Stones of Hope: How African Activists Reclaim Human Rights to Challenge Global Poverty* (Stanford University Press, 2011) 51, 53–4.

[34] See generally Knowledge Ecology International, *The Anti-Counterfeiting Trade Agreement (ACTA)* <http://keionline.org/acta>.

[35] Jeremy Perelman and Lucie E White, 'Stones of Hope: Experience and Theory in African Economic and Social Rights Activism' in Lucie E White and Jeremy Perelman (eds), *Stones of Hope: How African Activists Reclaim Human Rights to Challenge Global Poverty* (Stanford University Press, 2011) 149, 149–50 (citations omitted).

[36] See Angelique Harris, 'Panic at the Church: The Use of Frames, Social Problems, and Moral Panics in the Formation of an AIDS Social Movement Organization' (2010) 34 *Western Journal of Black Studies* 337.

[37] See Matthew Rimmer, 'The Lazarus Effect: The (RED) Campaign and Creative Capitalism' in Thomas Pogge, Matthew Rimmer and Kim Rubenstein (eds), *Incentives for Global Public Health: Patent Law and Access to Essential Medicines* (Cambridge University Press, 2010) 313.

power', AIDS advocates were careful to exploit all potential avenues for relief.[38] Accordingly, the formula for lasting changes of the kind won by treatment proponents would appear to include generating popular and diverse bases of support, in addition to concrete legal protections.

III DESYSTEMISATION

Long before AIDS pharmacological breakthroughs, Mann et al observed that the disease spreads in an environment of prejudice, discrimination and vulnerability.[39] In the early 1990s, Mann articulated what social scientists were beginning to recognise — that combating the virus requires linking human rights with public health, two fields that had not previously been connected.[40] It is now an article of faith that a strong response to HIV/AIDS includes respect for the needs of individuals, a climate of non-discrimination, access to healthcare and education and trust between public health personnel and the community.[41]

Helen Epstein has observed that the HIV/AIDS pandemic is exacerbated by poor economic conditions, a phenomenon that results in the loosening of family ties and traditional sexual mores, allowing the disease to become a mirror of poverty and deprivation.[42] For many leading activists, understanding the connection between HIV and surrounding socio-economic conditions has provided tools for combating both the virus and the conditions that lead to massive social disruptions:

> HIV has exposed the vulnerability of humanity: poverty, greed, xenophobia, and stigma threaten our survival more than microbes. Human rights and personal dignity of every human being must be the battle cry.
>
> The moral character of the human race has been severely tested by the scourge of an amoral microscopic virus. There will always be microbes that lie waiting to propagate by destroying human life. HIV will continue to test us, as it does not appear that we will eradicate the virus from the world any time soon. This history will continue be written [sic], chronicling the will of our species to ultimately place human life ahead of petty differences and hatred of the 'other'.[43]

Of course, AIDS is different from other health challenges because of the remarkable efficacy of ARVs as measured by the biomedical outcomes of

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38 Orly Lobel, 'The Paradox of Extralegal Activism: Critical Legal Consciousness and Transformative Politics' (2007) 120 *Harvard Law Review* 937, 988.

39 Jonathan M Mann et al, 'Health and Human Rights' (1994) 1 *Health and Human Rights* 6, 20–1.

40 See generally ibid 6–23.

41 See Gerhard Erasmus, 'Socio-Economic Rights and Their Implementation: The Impact of Domestic and International Instruments' (2004) 32 *International Journal of Legal Information* 243.

42 Helen Epstein, *The Invisible Cure: Africa, the West, and the Fight against AIDS* (Picador, 2007) xiii–xiv. See also Nana K Poku and Fantu Cheru, 'The Politics of Poverty and Debt in Africa's AIDS Crisis' (2001) 15(6) *International Relations* 37, 42–6.

43 Marshall Forstein, 'AIDS: A History' (2013) 17 *Journal of Gay & Lesbian Mental Health* 40, 62.

treatment.[44] ART has dramatically reduced rates of morbidity and mortality of infected persons and has turned the disease from a death sentence to a manageable illness.[45] This fact is not lost on donors, NGOs eager to deliver measurable results or judges capable of saving lives with the stroke of a pen. Indeed, the Joint United Nations Programme on HIV/AIDS, the only UN agency devoted to a single disease, directs much of its attention to monitoring the scale-up and implementation of treatment.[46]

But however laudable the sustained attention to HIV is, the reality that funding exists for AIDS but not other diseases generates peculiar distortions.[47] For example, medical staff in Takeo, Cambodia, note a highly inequitable situation wherein HIV/AIDS patients receive free treatment while diabetes patients are charged the costs of drugs and diagnosis. In addition, diabetic patients' access to treatment is limited by a lottery system while all HIV-positive patients are admitted for care.[48] AIDS treatment is increasingly characterised by institutionalisation (the tying of treatment to official structures), not systematisation (practices which recognise the interconnectedness of public health and human rights regimes). The injection of dollars from the Global Fund and PEPFAR into poorer countries has produced gains in the battle against HIV/AIDS but most other public health indicators have not enjoyed corresponding improvements. Richard Horton summarises the dilemma: 'AIDS is not a disease living in splendid isolation. AIDS is inextricably tied to other diseases and health predicaments. Well over a million people with tuberculosis are also infected with HIV'.[49]

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[44] For the HIV Outpatient Study Investigations, see Frank J Palella et al, 'Declining Morbidity and Mortality among Patients with Advanced Human Immunodeficiency Virus Infection' (1998) 338 *New England Journal of Medicine* 853. Treatment of HIV is therefore biomedically and conceptually different from 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: see Berger, above n 14, 595; National Institute of Allergy and Infectious Diseases, *HIV Vaccine Research* (20 September 2013) <http://www.niaid.nih.gov/topics/hivaids/research/vaccines/Pages/default.aspx>.

[45] See Palella et al, above n 44; Scott Hammer et al, 'Scaling Up Antiretroviral Therapy in Resource-Limited Settings: Treatment Guidelines for a Public Health Approach (2003 Revision)' (Treatment Guidelines, World Health Organization, 2004) 5.

[46] See Rachel Hammonds and Gorik Ooms, 'World Bank Policies and the Obligation of Its Members to Respect, Protect and Fulfill the Right to Health' (2004) 8(1) *Health and Human Rights* 26. Hammonds and Ooms argue that member states of international financial institutions routinely disregard their human rights obligations in health-related funding decisions.

[47] See, eg, Pascal Canfin, 'Tuberculosis and Major Pandemics Remain a Critical Challenge to Development' on *The Global Fund to Fight AIDS, Tuberculosis and Malaria* (26 March 2013) <http://www.theglobalfund.org/en/blog/31750/>: 8.7 million new cases of tuberculosis ('TB') were detected worldwide in 2011, impacting 'the poorest and most vulnerable populations'. The costliness of treating TB is multiplied as drug-resistant pathogens develop, which is an augmented burden on resource-challenged countries. TB is also a companion to HIV, with people living with HIV/AIDS ('PLWHA') more vulnerable to contracting TB.

[48] C Men et al, '"I Wish I Had AIDS": A Qualitative Study on Access to Health Care Services for HIV/AIDS and Diabetic Patients in Cambodia' (2012) 1(2) *Health Culture and Society* 2, 9–10 <http://www.who.int/alliance-hpsr/alliancehpsr_iwishihadaids.pdf>.

[49] Richard Horton, 'Among the Orphans', *Times Literary Supplement* (London), 7 January 2011, 8, 9.

Outside of Africa, it is also questionable whether AIDS treatment has transformed health systems.[50] Even as AIDS campaigners lobby for more money and decry recession-driven cutbacks,[51] there has been little commonality of purpose with health advocates tackling the neglected diseases of the developing world.[52] If vulnerable populations require food, security, clean water, education and economic opportunities — in addition to ART for infected people — the global architecture for AIDS addresses only some of those needs. Perhaps predictably, established AIDS organisations have criticised the Obama Administration for its attempt to broaden PEPFAR's mandate and reallocate funding to other global health concerns.[53]

At the same time, the AIDS movement has matured and the attention of HIV advocates is no longer focused mainly on the action or inaction of hostile governments. Rather, the struggle to provide AIDS medications at affordable prices has produced an increasingly specific intellectual property rights agenda, as well as a cadre of trained lawyers and experts capable of using competition law and global treaty exceptions to confront pharmaceutical patent holders. What began in 1999 as an effort to shame 39 multinational pharmaceutical companies into dropping their suit challenging a South African law[54] has grown into an organised and technically-skilled movement to challenge the monopolies of global medicines companies. Their success, including working with negotiators from poor states in securing the *Doha Declaration*[55] on the World Trade Organization's *Agreement on Trade-Related Aspects of Intellectual Property*

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50 Although ART has bettered health outcomes for individuals, AIDS treatment has failed to improve most public health metrics. AIDS advocates note that this is not the fault of those who have generated sustained funding to combat HIV. They argue that advocates for other causes should be concerned with the overall low level of governmental assistance: see Stephen Lewis, 'Dead Wrong' (Speech delivered at the Third Annual Student AIDS Conference, Harvard Medical School, 25 January 2008) <http://www.aidsfreeworld.org/Publications-Multimedia/Speeches/Dead-wrong.aspx>.

51 On current recession-sparked budget cuts, see American Public Health Association, 'Drastic Budget Cuts Put Public's Health at Risk, Says APHA: Elected Officials Must Find Balanced Approach to Deficit Reduction that Protects Public's Health' (Press Release, 1 March 2013) <http://www.apha.org/about/news/pressreleases/2013/sequestration+release.htm>. On the possible impact of future budget cuts, see Gorik Ooms et al, 'Applying the Principles of AIDS "Exceptionality" to Global Health: Challenges for Global Health Governance' (2010) 4(1) *Global Health Governance* 1, 3: 'if the assumptions are correct, by 2020 financing for salaries for those additional health workers would no longer be available, and the list of essential medicines would have to be reduced'.

52 See Lawrence O Gostin, 'Meeting Basic Survival Needs of the World's Least Healthy People: Toward a Framework Convention on Global Health' (2008) 96 *Georgetown Law Journal* 331, 364–6.

53 See Te-Ping Chen, *How Obama Backed Away From the Global War on AIDS* (17 July 2010) MyNews.in <http://www.mynews.in/News/how_obama_backed_away_from_the_global_war_on_aids_N72069.html>.

54 See Neil A Lewis, 'US Industry to Drop AIDS Drug Lawsuit against South Africa', *The New York Times* (online), 10 September 1999 <http://www.nytimes.com/1999/09/10/world/us-industry-to-drop-aids-drug-lawsuit-against-south-africa.html>; William W Fisher III and Cyrill P Rigamonti, 'The South Africa AIDS Controversy: A Case Study in Patent Law and Policy' (Harvard Law School, 10 February 2005) <http://cyber.law.harvard.edu/people/tfisher/South%20Africa.pdf>.

55 *Declaration on the* TRIPS Agreement *and Public Health*, WTO Doc WT/MIN(01)/DEC/2 (20 November 2001) ('*Doha Declaration*').

Rights ('*TRIPS*'),[56] is undeniable.[57] The *Doha Declaration* recognised 'the gravity of the public health problems afflicting many developing and least-developed countries'[58] and noted concerns about the effect of patents on the prices of medicines.[59] In light of these observations, the *Doha Declaration* recognised flexibilities in *TRIPS* which included a state's 'right to grant compulsory licenses and the freedom to determine the grounds upon which such licenses are granted'.[60] However, para 6 correctly identified that states with 'insufficient or no manufacturing capacities in the pharmaceutical sector could face difficulties in making effective use of compulsory licensing under the *TRIPS Agreement*'.[61]

In 2003, the implementation of para 6 of the *Doha Declaration* explicitly authorised the use of compulsory licensing to import essential medicines for states without manufacturing capacity[62] — a move that was made permanent in 2005.[63] Brazil, Colombia, Ecuador and Thailand, among other states, have responded to civil society pressure and issued compulsory licences for ARVs, often despite intense criticism from patent-holding pharmaceutical companies and their political allies.[64] The combined efforts of AIDS activists and a steady supply of generic drugs have dramatically lowered the cost of ART. From 1996 to 2001, the price of triple-combination HIV/AIDS therapy purchased from originator companies fell by 93 per cent and generics became widely available in many developing countries at a discount of 97 per cent.[65] The same drugs that

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56 *Marrakesh Agreement Establishing the World Trade Organization*, opened for signature 15 April 1994, 1867 UNTS 3 (entered into force 1 January 1995) annex 1C ('*Agreement on Trade-Related Aspects of Intellectual Property Rights*').

57 See Fisher and Rigamonti, above n 54, 14–16. See also *How to Survive a Plague* (Directed by David France, Public Square Films, 2012), the Academy Award nominated documentary chronicling the extraordinary efforts of a group of activists dedicated to obtaining life-saving medicines.

58 *Doha Declaration*, WTO Doc WT/MIN(01)/DEC/2, para 1. See also at para 4.

59 Ibid para 3.

60 Ibid para 5(b). Cf *TRIPS* arts 21 and 31.

61 *Doha Declaration*, WTO Doc WT/MIN(01)/DEC/2, para 6.

62 *Implementation of Paragraph 6 of the* Doha Declaration on the TRIPS Agreement and Public Health, WTO Doc WT/L/540 (2 September 2003) (Decision of 30 August 2003); *Implementation of Paragraph 6 of the* Doha Declaration on the TRIPS Agreement and Public Health, WTO Doc WT/L/540/Corr.1 (29 July 2005) (Decision of 30 August 2003: Corrigendum).

63 *Amendment of the* TRIPS Agreement, WTO Doc WT/L/641 (8 December 2005) (Decision of 6 December 2005).

64 Despite the objections of the US Ambassador in Quito, Ecuador's President Rafael Correa issued *Decreto No 118* in October 2009 to improve access to medicines and support public health programs through a protocol that would reduce drug costs: *Decreto Presidencial No 118* (Ecuador) 23 October 2009. See also Public Citizen, *Leaked Cables Show US Tried, Failed to Organize against Ecuador Compulsory Licensing* (10 May 2011) <http://www.citizen.org/leaked-cables-show-US-tried-failed-to-organize-against-ecuador-compulsory-licensing>. *Decreto No 118* established procedures for the compulsory licensing of pharmaceutical patents. Compulsory licensing authorises generic competition with patented, monopoly-protected drugs. Generic competition reduces costs and enables public agencies to scale up treatment and other services. Ecuador's protocol limits compulsory licensing to medical conditions that are priorities for public health, requiring inter-agency cooperation to grant licences on a case-by-case basis and pay royalties to patent holders.

65 AVERT, *Antiretroviral Drug Prices* (2013) <www.avert.org/antiretroviral-drug-prices.htm>. In 2001, an Indian generic pharmaceutical company was the first to combine three ARVs into one pill, making ART adherence easier for PLWHA.

cost US$10 000–US$15 000 per patient per year prior to 2001 have, since 2007, been offered in generic form for less than US$100 annually.[66]

AIDS activists have also learned to advise poor states to use *TRIPS* flexibilities and are themselves a consistent force advocating for alternatives to patent monopolies. The movement has coined the term 'access to essential medicines' to describe its agenda.[67] Many of the best organisations in the field are committed to challenging the pricing of pharmaceutical products. MSF, for example, has initiated a highly publicised campaign tracking drug prices in order to advocate for increased generic production of ARVs and to expose the ways that *TRIPS* contributes to the neglect of diseases afflicting the poor.[68] Knowledge Ecology International has worked with delegations from Barbados and Bolivia to develop a global prize system to stimulate innovation.[69] Dedicated individuals, including Professors Thomas Pogge and Aidan Hollis, have championed the idea of a Health Impact Fund,[70] a proposed alternative to the global patent registration regime protected by *TRIPS*.[71] Where significant price discrepancies between generic and brand products exist, the access community confronts would-be patent registrants. These efforts have meant that legally-compelled price reductions for each new generation of AIDS drugs are now commonplace. The right to treatment recognised in the AIDS cases has facilitated compulsory and voluntary licences for generic competitors, bulk and advance purchase agreements and legally sanctioned parallel imports.[72]

But as World Bank economist Varun Gauri notes, even as Brazil has scaled up free and universal access to ART, many basic antibiotics remain too expensive or inaccessible for millions of Brazilians.[73] Increased access to ARVs alone is not enough to protect the dignity of PLWHA, much less poor and vulnerable populations as a whole. Thus, as each new AIDS drug comes to market, access proponents engage the manufacturer, insurers and government purchasers to ensure an uninterrupted supply of safe and affordable or free pills. Since nothing comparable occurs for the drugs treating other diseases, the protracted struggle for access to ART may be seen as the strategic marshalling of

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

67 See generally Christopher Butler, 'Human Rights and the World Trade Organization: The Right to Essential Medicines and the *TRIPS Agreement*' (2007) 5 *Journal of International Law and Policy* 1.

68 See, eg, Médecins Sans Frontières, 'Untangling the Web of Antiretroviral Price Reductions' (16th ed, July 2013).

69 James Love, *Prizes to Stimulate Innovation* (12 August 2009) Knowledge Ecology International <http://keionline.org/prizes>.

70 Health Impact Fund, *Vision & Origin of the Health Impact Fund* (2013) <http://healthimpactfund.org/origin/>.

71 Incentives for Global Health, *The Health Impact Fund: A Summary Overview* (2013) Health Impact Fund <http://healthimpactfund.org/the-health-impact-fund-a-summary-overview/>.

72 See, eg, Ben Sihanya, *Patents, Parallel Importation and Compulsory Licensing of HIV/AIDS Drugs: The Experience of Kenya* (2013) World Trade Organization <http://www.wto.org/english/res_e/booksp_e/casestudies_e/case19_e.htm>.

73 Varun Gauri, 'Social Rights and Economics: Claims to Health Care and Education in Developing Countries' (2004) 32 *World Development* 465. See also Andréa Dâmaso Bertoldi et al, 'Medicine Prices, Availability and Affordability in Southern Brazil: A Study of Public and Private Facilities' (Working Paper No 18/2010, LSE Health, London School of Economics and Political Science, June 2010).

human rights language over private law interests to ensure the affordable production and delivery of a single class of goods.[74]

Two interrelated concerns emerge from this. The first centres on the way that the discourse surrounding technical pharmaceutical pricing threatens to obscure other forms of rights-speak. Advising developing states on the meaning of art 66 of *TRIPS* or designing a royalty scheme for a single voluntary licence lacks the urgency and humanity that was a hallmark of early AIDS organising and the international human rights movement's success.[75] The more technical the conversation, the further the discussion wanders from the novel and paradigm-shifting quality of the treatment jurisprudence, which found that demands for health goods are judicially enforceable and firmly anchored in domestic law. The loss is particularly acute since claims to health and other social and economic rights are still derided in some quarters as second-order rights that are perhaps aspirational but largely unrealisable.[76] Because of the varying ways states might interpret the allowance for progressive realisation of socioeconomic rights under the *International Covenant on Economic, Social and Cultural Rights* ('*ICESCR*'),[77] the right to health means different things in different places.[78] An exclusive or excessive focus on pharmaceutical pricing

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74 See Robert Howse and Makau Mutua, 'Protecting Human Rights in a Global Economy: Challenges for the World Trade Organization' [1999–2000] *Human Rights in Development Yearbook* 51. Howse and Matua observe, at 56, that

> [h]uman rights, to the extent they are obligations *erga omnes*, or have the status of custom, or of general principles, will normally prevail over … conflicting provisions of [trade laws]. The WTO laws and processes must be interpreted in a way that advances human rights, transparency, accountability and representivity.

75 See James T Tsai, 'Not Tripping over the Pebbles: Focusing on Overlooked *TRIPS* Article 66 for Technology Transfer to Solve Africa's AIDS Crisis' (2007) 11 *Michigan State University Journal of Medicine and Law* 447; Andrew D Mitchell and Tania Voon, 'The *TRIPS* Waiver as a Recognition of Public Health Concerns in the WTO' in Thomas Pogge, Matthew Rimmer and Kim Rubenstein (eds), *Incentives for Global Public Health: Patent Law and Access to Essential Medicines* (Cambridge University Press, 2010) 56.

76 As Nolan, Porter and Langford conclude, the assertion that negative rights are enforceable but positive ones are not is

> based on a misconception of the nature of both sets of rights. All human rights require a combination of negative and positive conduct from states and varying levels of resources. For instance, an individual's political right to participate in the political life of her state by exercising her right to vote cannot be ensured without the state providing that elections are held at periodic intervals. Furthermore, it is clear that social and economic rights do not merely impose positive obligations. Where someone enjoys a social and economic right, the state is prohibited from acting in a way that would interfere with or impair the individual's enjoyment of that right. This would occur where restrictive zoning forces shelters for the homeless out of a neighbourhood in violation of the right to housing, or where the state withdraws the funding necessary to maintain local health clinics, resulting in a violation of the right to health.

Nolan, Porter and Langford, above n 2, 7 (citations omitted).

77 *ICESCR*, opened for signature 16 December 1966, 933 UNTS 3 (entered into force 3 January 1976).

78 Some judges, most notably in the US, have refused to entertain alleged violations of the *ICESCR*, reasoning that its 'boundless and indeterminate principles' cannot be applied juridically since the US has not ratified it: see, eg, *Flores v Southern Peru Copper Corp*, 414 F 3d 233, 255 (2nd Cir, 2003). In the analogous education context, *San Antonio Independent School District v Rodriguez* held that because education is not a fundamental right under the *United States Constitution*, the Texas school financing plan did not violate rational basis review: 411 US 1 (1973).

runs the risk of rechannelling the conversation into the realm of resource allocation. The danger of a highly technical discourse is that it obscures what made the treatment cases so powerful in the first place; namely, the articulation of foundational principles, including justiciability, in the context access to medicines.

Equally problematic is the fact that advocates for other social and economic rights issues — many of whom work in splendid isolation — have been unable to profit from the dynamic of organised opposition to ART pricing. Indeed, the general reward structure provided by uniform intellectual property rules remains largely intact and there is scant evidence that the lessons of AIDS treatment have been applied outside the context of HIV to other diseases amenable to pharmacological interventions. To date, there are no recorded cases of demands for antimalarial drugs that derive from or synthetically copy artemisinin or for medications to treat sleeping sickness, diarrhoeal disease and many other ills of low- and middle-income states. With the exception of some communities organised to battle cancer, there appear to be few large-scale constituencies capable of battling diseases beyond AIDS.

IV EXCEPTIONALITY IN THE CASE LAW

A third explanation for the failure to translate the legal success of AIDS to other diseases may be found in the treatment cases themselves. Many of the leading decisions are properly focused on the hybrid quality of rights to life and health implicated by ART. Invoking the fundamental right to life[79] in *Ubaque*, for example, the Colombian Constitutional Court recognised that receipt of ART serves to preserve human dignity.[80] The judgment of the Costa Rican Supreme Court of Justice in *Alvarez v Caja Costarricense de Seguro Social* [Costa Rican Social Security Fund] ('*Alvarez*')[81] engages in a similar discussion of rights to health in the context of a right to life. 'In a state of law', the Court reasoned, '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'.[82] Even in the direct right to health context presented by *Bermúdez*, the Venezuelan Supreme Court relied on unspecified international human rights instruments related to rights to health and life, as well as the right to health guarantee under art 76 of the *Constitución de la República de Venezuela 1961* [Constitution of the Republic of Venezuela 1961].

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79 See *Constitución Política de la República de Colombia 1991* [Political Constitution of the Republic of Colombia 1991] art 11.

80 See also *Yakye Axa Indigenous Community v Paraguay* [2005] Inter-Am Court HR (ser C) No 125. The Court held that Paraguay had violated the indigenous community's right to a dignified life and imputed responsibility for this violation on two grounds — the government's refusal to let community members enter their ancestral territory to access their won water, food and traditional medicines (the negative rights infringement) and the inadequacy of the few positive measures the state took in terms of the provision of food, medical attention and educational materials.

81 *Alvarez v Caja Costarricense de Seguro Social* [Costa Rican Social Security Fund], Sala Constitucional de la Corte Suprema de Justicia [Constitutional Chamber of the Costa Rican Supreme Court of Justice], Case No 01-005778-0007-CO, Decision No 1997-05934, 23 September 1997 ('*Alvarez*').

82 Yamin, above n 15, 341, quoting *Alvarez*, Case No 01-005778-0007-CO, Decision No 1997-05934, 23 September 1997 [Yamin trans].

Similarly, in the US, the treatment jurisprudence extends to American prisons in a series of cases alleging inadequate care for HIV-positive inmates because of the constitutional prohibition on cruel and unusual punishment.[83] *Montgomery v Pinchak*[84] and *Smith v Carpenter*[85] hold that HIV-positive prisoners have a right to ART and that treatment has become the enforced norm. In *Brown v Johnson*, the Court of Appeal held that the withdrawal from or delay of HIV and hepatitis treatment to an inmate constitutes deliberate indifference to a prisoner's needs in violation of the Eighth Amendment to the *United States Constitution*.[86]

The ability of judges to forestall death by ordering treatment militates against any other outcome. Such an ability, elevated to judicial imperative, is reflected in Lord Nicholls's declaration in the House of Lords' decision in *N v Secretary of State for the Home Department* that 'anti-retroviral treatment can be likened to a life support machine'.[87] The same logic is present in the European Court of Human Rights' deportation case *D v United Kingdom*.[88] There, the Court enjoined the deportation of an otherwise removable HIV-positive citizen of Saint Kitts on the grounds that D would be unable to obtain treatment in his country of origin, finding that deporting D would amount to inhuman or degrading treatment contrary to art 3 of the European *Convention for the Protection of*

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83 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. The same result was reached in South Africa: see *N v Government of Republic of South Africa (No 1)* [2006] 6 SA 543 (High Court). In that case, the Court found the respondents legally and constitutionally bound to provide adequate medical care to prisoners, including the provision of ART to HIV-positive inmates under ss 27, 35(2)(e) and 237 of the *Constitution of the Republic of South Africa Act 1996* (South Africa).

84 294 F 3d 492 (3rd Cir, 2002).

85 316 F 3d 178 (2nd Cir, 2003). In this case, 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 *United States Constitution* amend VIII prohibition against cruel and unusual punishment where an inmate's ART was interrupted for a short period of time. See also *Estelle v Gamble*, 429 US 97, 104–6 (1976) ('*Estelle*').

86 387 F 3d 1344, 1351–2 (11th Cir, 2004). See also *Estelle*, 429 US 97, 104–5 (1976).

87 [2005] 2 AC 296, 316 [49].

88 [1997] III Eur Court HR 777.

Human Rights and Fundamental Freedoms.[89] In each of these cases, courts have joined rights to health and rights to life.[90]

Like the right to due process, the treatment cases give rise to governmental obligations to protect and to fulfil, as well as negative obligations to respect,[91] all within a justiciable framework. However, insofar as the treatment cases rest on the efficacy of pills that ensure survival and a minimum quality of life, application to right to health or right to housing claims that merely alleviate suffering is problematic since it is difficult to equate sustained misery with a clear and present threat to life.[92] In the absence of the health–life hybridity of the treatment cases, courts and legislatures may be reluctant to address similar claims on the basis of health protection or demands for education and adequate housing alone. A focus on the socioeconomic rights necessary to secure life runs

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89 Ibid 792–4 [47]–[54]; *Convention for the Protection of Human Rights and Fundamental Freedoms*, opened for signature 4 November 1950, 213 UNTS 221 (entered into force 3 September 1953), as amended by *Protocol No 14bis to the Convention for the Protection of Human Rights and Fundamental Freedoms*, opened for signature 27 May 2009, CETS No 204 (entered into force 1 September 2009) ('*European Convention on Human Rights*'). See also *BB v France* [1998] VI Eur Court HR 2595. In that case, 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 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 art 3 of the *European Convention on Human Rights*. The case was, however, struck out of the list as France had undertaken not to deport the applicant. Thus, the risk of deportation and violation of art 3 no longer existed.

90 See, eg, *Ceballos v Instituto de Seguros Sociales* [Colombian Institute of Social Security], Corte Constitucional [Colombian Constitutional Court], Case No 2130, Decision No T-484/92, 11 August 1992 ('*Ceballos*'); *Alvarez*, Case No 01-005778-0007-CO, Decision No 1997-05934, 23 September 1997. In *Ceballos*, the Court held that the social security institute is required to provide treatment under principles of non-discrimination and solidarity. See also Yamin, above n 15, 341.

91 See Lisa Forman, 'Ensuring Reasonable Health: Health Rights, the Judiciary, and South African HIV/AIDS Policy' (2005) 33 *Journal of Law, Medicine & Ethics* 711. Forman writes that '[d]rawn from international human rights law this typology [in s 27 of the *Constitution of the Republic of South Africa Act 1996* (South Africa)] implies both positive and negative duties with respect to each right': at 713. In Canada, Arbour J echoed this view regarding the *Canadian Charter of Rights and Freedoms* in *Gosselin v A-G (Quebec)* by noting that

> any claim that only negative rights are constitutionally recognized is of course patently defective. The rights to vote (s 3), to trial within a reasonable time (s 11(b)), to be presumed innocent (s 11(d)), to trial by jury in certain cases (s 11(f)), to an interpreter in penal proceedings (s 14), 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).

[2002] 4 SCR 429, 605 [320], citing *Canada Act 1982* (UK) c 11, sch B pt I ('*Canadian Charter of Rights and Freedoms*'). 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" the rights of every individual': Jonathan Todres, 'Rights Relationships and the Experience of Children Orphaned by AIDS' (2007) 41 *UC Davis Law Review* 417, 440. See also *Convention on the Rights of the Child*, opened for signature 20 November 1989, 1577 UNTS 3 (entered into force 2 September 1990) art 2.

92 See *A-G (British Columbia) v Auton* [2004] 3 SCR 657 ('*Auton*'). The Court refused to order the province of British Columbia to fund specialised Applied Behavioural Analysis or Intensive Behavioural Intervention treatment for autism as it did not fall within the meaning of 'core … physician-delivered services' covered by the *Canada Health Act*: at 676 [43]. See also *Canada Health Act*, RSC 1985, c C-6, s 9 (as interpreted by *Auton* [2004] 3 SCR 657, app B, 693).

the risk of defining such claims as more important than other social and economic rights claims.

The scale of the threat posed by HIV constitutes another point of distinction vis-a-vis other social and economic rights claims. Both the Constitutional Court of South Africa in the *TAC Case* and the Costa Rican Supreme Court of Justice in *Alvarez* emphasised the vast magnitude of the human toll of the pandemic.[93] 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 — may prove hard to replicate in other contexts, particularly for neglected diseases or problems that do not threaten states as a whole.

Finally, the greatest strength of the treatment cases — their resolution in domestic courts — demonstrates why judicial enforcement of non-AIDS cases has been relatively rare. International human rights law plays a supporting, not a central, role in most of the treatment jurisprudence and it provides no uniform standard against which to evaluate government action. Since enforcement of the *ICESCR* has been governed by a diluted reporting mechanism that lacks meaningful sanctions, domestic courts addressing health rights and other socio-economic cases have largely rejected the inclusion of international obligations that might provide a template for the resolution of similar issues.

In order to develop a concrete legal standard by which to measure state performance in this arena, some socioeconomic rights proponents have attempted to locate a 'minimum core' content for economic and social rights.[94] That is no easy task and several scholars have asked whether the idea contemplates resource limitations.[95] The Committee on Economic, Social and Cultural Rights ('CESCR'), the group tasked with interpreting the *ICESCR*, has muddied the waters by 'variously equat[ing] the minimum core with a presumptive legal entitlement, a nonderogable obligation, and an obligation of strict liability'.[96] As a consequence, even the Constitutional Court of South Africa's decision in the *TAC Case* has been condemned for its refusal to embrace the minimum core obligations standard contained in the CESCR's *General Comment No 3*[97] and *General Comment No 14*.[98] Still, fulfilment of discrete demands for

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93 *TAC* [2002] 5 SA 721, 728 [1].

94 See Committee on Economic, Social and Cultural Rights, *Report on the Fifth Session*, UN ESCOR, Supp No 3, UN Doc E/1991/23 and E/C.12/1990/8 (1 January 1991) annex III ('*General Comment No 3 (1990): The Nature of States Parties Obligations (art 2, para 1 of the* Covenant*)*') [10] ('*General Comment No 3*').

95 See Craig Scott and Philip Alston, 'Adjudicating Constitutional Priorities in a Transnational Context: A Comment on *Soobramoney*'s Legacy and *Grootboom*'s Promise' (2000) 16 *South African Journal on Human Rights* 206, 250.

96 Katharine G Young, 'The Minimum Core of Economic and Social Rights: A Concept in Search of Content' (2008) 33 *Yale Journal of International Law* 113, 115. Young discusses the limitations of the minimum core as normative essence, minimum consensus and minimum obligation: at 126–64.

97 *General Comment No 3*, UN Doc E/1991/23 and E/C.12/1990/8, annex III.

98 Committee on Economic, Social and Cultural Rights, *General Comment No 14 (2000): The Right to the Highest Attainable Standard of Health (Article 12 of the* International Covenant on Economic, Social and Cultural Rights*)*, UN ESCOR, Agenda Item 3, UN Doc E/C.12/2000/4 (11 August 2000) ('*General Comment No 14*'). See also David Bilchitz, 'Towards a Reasonable Approach to the Minimum Core: Laying the Foundations for Future Socio-Economic Rights Jurisprudence' (2003) 19 *South African Journal on Human Rights* 1.

socio-economic rights will fit well with upcoming trends in HIV/AIDS and related tuberculosis treatment and prevention, all based on technological advances whose fruits will initially be available to a select few countries.[99] Additionally, the *Optional Protocol to the International Covenant on Economic, Social and Cultural Rights* ('*Optional Protocol*'),[100] which recently entered into force, establishes a new complaints mechanism[101] which could alter the rights-articulation landscape by providing the CESCR with an opportunity to declare that some deprivations constitute violations of the *ICESCR*.[102] In its current form, the *Optional Protocol* also includes an inquiry mechanism: parties may permit the CESCR to investigate, report on and make recommendations on 'grave or systematic violations' of the *ICESCR*.[103]

One way for the international human rights regime to build on the treatment cases so as to provide content to social and economic rights-fulfilment would be for the CESCR to announce clearly articulated rights for which any violation would amount to a breach of customary international law. Instead of the tepid criticism found in most CESCR reports,[104] an unqualified statement that a given state has violated its people's human rights (for example, to inoculations or an

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99 Research into TB drugs has led to what has recently been called 'the most promising pool of new [TB] drug and vaccine candidates in more than 40 years, with several new drugs and drug regiments poised to enter late-stage clinical trials throughout the next few years': Renaud F Boulanger et al, 'Engaging Communities in Tuberculosis Research' (2013) 13 *Lancet Infectious Diseases* 540, 540. See also IRIN, *Political Leadership Needed to Deal with Drug-Resistant TB* (26 March 2013) <http://www.irinnews.org/report/97735/political-leadership-needed-to-deal-with-drug-resistant-tb>. Diagnostic technology currently under development to treat drug-resistant TB provides an interesting case study of the divide between technological possibility and distributive reality. One new device can 'identif[y] DNA sequences and their mutations' and trace exactly how drug-resistant strains may be created and, conversely, prevented. But equipment and software are cost-prohibitive:

> Even at the most discounted price for the poorest countries, the equipment and software amount to [US]$17 000, plus just under [US]$10 for the cartridge needed for each individual test. In South Africa, which has gone furthest in adopting the technology, it is expected to increase the annual cost of the TB diagnosis programme by more than 50 percent. … [T]he equipment is delicate. It needs air-conditioned surroundings with constant power, and a good supply chain for the cartridges, which don't have a long shelf life. These requirements make it difficult to put the equipment where it is needed most — the clinics, often in rural areas, where patients first arrive with TB symptoms.

See also Stephen D Lawn et al, 'Advances in Tuberculosis Diagnostics: The Xpert MTB/RIF Assay and Future Prospects for a Point-of-Care Test' (2013) 13 *Lancet Infectious Diseases* 349, 355–6.

100 *Optional Protocol to the International Covenant on Economic, Social and Cultural Rights*, opened for signature 10 December 2008, UN Doc A/RES/63/117 (entered into force 5 May 2013).

101 Ibid art 2.

102 Ibid art 9.

103 Ibid art 11.

104 See, eg, Committee on Economic, Social and Cultural Rights, *Report on the Twentieth and Twenty-First Sessions*, UN Doc E/2000/22 and E/C.12/1999/11 (2000) ('The Committee is concerned that the right to health is not being fully implemented in the State party': at [271]; 'The Committee is concerned about the health of pregnant women, in particular the relatively high maternal mortality rate, and the high adolescent pregnancy figures': at [272]).

elementary school education) would offer a useful benchmark.[105] Alternatively, the CESCR could provide an economic definition of available resources against which state fulfilment of under-enforced rights might be judged. With several notable exceptions, the vast majority of states have ratified the *ICESCR*, which means that they are subject to the interpretive comments of the CESCR.[106] *General Comment No 14* instructs states parties to the *ICESCR* to allocate sufficient budgetary resources to fulfil the right to health, an admonition that applies equally to other rights.[107] *General Comment No 3* says that states parties must make 'every effort' to use *all* available resources to ensure fulfilment of the right.[108] Human rights advocates would benefit from the ability to ask domestic courts and legislatures (whose authority is beyond dispute) to hold states to accepted international standards. Such benchmarks are particularly important because utilising the treatment analogy or finding binding precedent in the right to life or human security language of the global case law has not been easy.

V THE FUTURE

Legal actions modelled on the ART jurisprudence are common in many social and economic rights causes, including demands for literacy and rights to education,[109] to satisfactory housing,[110] to social services that protect against child abuse[111] and to the redress of degrading working conditions.[112] The absence of broad social mobilisation, the desystematisation of AIDS in favour of specialised advocacy and the internal frailties of the treatment cases may explain why very little conceptual translation work has occurred. There are, however, pockets of progress that point to at least three means of fulfilling economic, social and cultural rights that were driven by legal advances: test-case litigation, international institutional reform and the development of new theories of human rights obligations.

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105 See Sital Kalantry, Jocelyn E Getgen and Steven Arrigg Koh, 'Enhancing Enforcement of Economic, Social, and Cultural Rights Using Indicators: A Focus on the Right to Education in the *ICESCR*' (2010) 32 *Human Rights Quarterly* 253.

106 For a detailed discussion of the status of general comments in international law, see International Law Association, 'Final Report on the Impact of Findings of the United Nations Human Rights Treaty Bodies' (Report, Berlin Conference, 2004) pt B. There are 160 states parties to the *ICESCR*: see Office of the High Commissioner for Human Rights, *Ratification Status for CESCR* — International Covenant on Economic, Social and Cultural Rights <http://tbinternet.ohchr.org/_layouts/TreatyBodyExternal/Treaty.aspx?Treaty=CESCR&Lang=en>.

107 *General Comment No 14*, UN Doc E/C.12/2000/4, 9 [33].

108 *General Comment No 3*, UN Doc E/1991/23 and E/C.12/1990/8, annex III [10].

109 See *Jain v State of Karnataka* (1992) AIR SC 1858.

110 This issue was famously explored in: Frank I Michelman, 'The Advent of a Right to Housing: A Current Appraisal' (1970) 5 *Harvard Civil Rights/Civil Liberties Law Review* 207.

111 Claims for the preservation of human dignity could have a future bearing on cases such as *Deshaney v Winnebago County Department of Social Services*, in which the US 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 amend XIV of the *United States Constitution*: 489 US 189 (1989).

112 See Jo Hunt, 'Fair and Just Working Conditions' in Tamara K Hervey and Jeff Kenner (eds), *Economic and Social Rights under the EU Charter of Fundamental Rights: A Legal Perspective* (Hart, 2003) 45.

The most straightforward example of socio-economic rights litigation beyond ART has occurred in the realm of cancer medications. On 1 April 2013, the Supreme Court of India ruled that the global pharmaceutical company Novartis should not be awarded a patent for its leukaemia drug Gleevec because the product was too similar to an earlier version of the medicine.[113] The decision repudiated some drug companies' practice of 'evergreening', the assertion that small changes to a drug warrant extended patent protection.[114] The multi-year Gleevec patent battle reversed, at least temporarily, the trend toward granting greater patent protection for non-ART pharmaceutical products, despite pressure from civil society for access to essential medicines.[115] An MSF employee hailed the decision as a breakthrough and concluded that '[w]hile the case centered around a cancer drug, the implications … will help secure the supply of affordable medicines for millions of the world's poorest people in the future'.[116]

The ongoing global epidemic of maternal mortality is another site of litigation over responsibility for healthcare, codified in the language of human rights. The WHO defines maternal mortality as

> the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.[117]

Against this backdrop, Ugandan activists have begun to use right to life and health rights discourse to argue that the government has an obligation to lower maternal mortality rates.[118] Over the past two years, civil society groups have shifted from protests to comprehensive action that seeks to improve health statistics using mass mobilisation and legal action. Between 2011 and 2012, more than 50 organisations joined forces to charge Uganda's Government with failing to prevent the deaths of expectant mothers.[119] The Centre for Health, Human Rights and Development and other groups have taken their right to treatment case, informed by the litigation of individual cases on maternal

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113 *Novartis AG v Union of India* (Supreme Court of India) [2013] Civil Appeal No 2706-2716 of 2013. See also Amy Kapczynski, 'Engineered in India: Patent Law 2.0' (2013) 369 *New England Journal of Medicine* 497.

114 See Dean Nelson, 'Novartis Loses Landmark Patent Case in India', *The Telegraph* (online) 2 April 2013 <http://www.telegraph.co.uk/finance/newsbysector/pharmaceuticalsandchemicals/9964960/Novartis-loses-landmark-patent-case-in-India.html>. Predictably, one side lauded the Novartis ruling as 'a victory for the country's poor' while another lamented the threat of the ruling to research, development and innovation.

115 Sarah Boseley, 'Analysis: Progress in the Battle for Affordable Medicines', *The Guardian* (London) 2 April 2013, 14.

116 Unni Karunakara, 'Pharmacy of Developing World Turned the Tide against HIV', *The Independent* (London), 2 April 2013, 26.

117 World Health Organization, *Maternal Mortality Ratio (per 100 000 Live Births)* (2013) <http://www.who.int/healthinfo/statistics/indmaternalmortality/en>.

118 On maternal health conditions in Uganda, see Moses Nampala, 'Kibuku Mothers Deliver on Floor', *New Vision* (online), 9 May 2013 <http://www.newvision.co.ug/news/642499-kibuku-mothers-deliver-on-the-floor.html>.

119 IRIN, *Uganda: Activists to Pursue Maternal Health Case against Government* (15 June 2012) <http://www.irinnews.org/report/95659/uganda-activists-to-pursue-maternal-health-case-against-government>.

mortality, to the Supreme Court of Uganda.[120] Activists involved in the litigation point out that, even if they lose in court, the legal action and social protest has already resulted in 'improved maternal health services in general hospitals, and … a growing number of individual cases' brought before various courts.[121]

Similarly, human rights advocates in Mexico recently brought an innovative challenge against the country's federal tobacco control law. They claimed that the government's policies failed to protect the fundamental right to health and that the law did not fulfil the minimum standards of protection that the state recognised through its ratification of the *WHO Framework Convention on Tobacco Control*.[122] The judicial enunciation of socio-economic rights principles is equally present in India's right to food case law;[123] the Colombian Constitutional Court's decision outlawing student tuition fees in public primary schools;[124] and the 2008 Argentinean Supreme Court's environmental rulings regarding the Matanza-Riachuelo River Basin.[125] The same trend is apparent in the Economic Community of West African States' Community Court of Justice's judgments against Niger for condoning modern forms of slavery[126] and against Nigeria for failing to regulate the pollution of multinational corporations.[127]

Thus far, none of these cases or controversies have directly invoked the socio-legal campaign for universal ART. Yet each of these struggles stand to benefit from the treatment legacy while emboldening courts and legislatures to declare that economic, social and cultural rights demands are fully enforceable human rights.[128] In this respect, the promise of successful future action may lie

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120 Ronald Musoke, 'Civil Society to Take Maternal Mortality Case to Supreme Court', *The Independent* (online), 19 February 2013 <http://www.independent.co.ug/news/news/7481-civil-society-to-take-maternal-mortality-case-to-supreme-court>.

121 Ibid.

122 Oscar A Cabrera and Alejandro Madrazo, 'Human Rights as a Tool for Tobacco Control in Latin America' (2010) 52(Supp 2) *Salud Pública de México* 288, 294; *Woolrich*, Tribunal Pleno de la Suprema Corte de Justicia [Full Court of the Supreme Court of Justice], (Mexico) Amparo Case No 315/2010, 28 March 2011. See also *WHO Framework Convention on Tobacco Control*, opened for signature 21 May 2003, 2303 UNTS 166 (entered into force 27 February 2005).

123 For a background and overview of the procedural history, see Human Rights Law Network, *PUCL vs Union of India & Others* (2013) <http://www.hrln.org/hrln/right-to-food/pils-a-cases/255-pucl-vs-union-of-india-a-others-.html>.

124 *Sánchez*, Corte Constitucional [Colombian Constitutional Court], Case No D-7933, Decision No C-376, 19 May 2010.

125 *Mendoza v Estado Nacional* [State of Argentina], Corte Suprema de Justicia de la Nación [Argentinian Supreme Court of Justice], Case No M 1569 XL, 8 July 2008.

126 *Koraou v Republic of Niger* (Court of Justice of the Economic Community of West African States, General List No ECW/CCJ/APP/0808, Judgment No ECW/CCJ/JUD/06/08, 27 October 2008).

127 See generally Karen J Alter, Laurence R Helfer and Jacqueline R McAllister, 'A New International Human Rights Court for West Africa: The ECOWAS Community Court of Justice' (2013) 107 *American Journal of International Law* (forthcoming).

128 Calls for such redistributive international policies will no doubt increase in 2013. Recently, Dr Margaret Chan, Director-General of the World Health Organization ('WHO'), and Dr Mark Dybul, Executive Director of the Global Fund, announced that without at least an additional US$1.6 billion in international funding for treatment and prevention of TB, drug-resistant strains of the disease could 'spread widely' — ominous phrasing in a time where the threat of pandemics seems as real as the threat of armed conflict: see eHEALTH, *WHO Cites TB Threat*, (26 March 2013) <http://ehealth.eletsonline.com/2013/03/who-cites-tb-threat>:

in the adoption of the organising efforts — or strategic litigation — of AIDS campaigners by advocates for adequate nutrition; effective TB, malaria and cancer treatment; and the right to water and emergency shelter.[129]

The identification of a justiciable right to treatment of AIDS communicates the message that legal recognition stemming from individual cases is an integral part of the fulfilment of social and economic rights and that the law has materially adaptive power. It also indicates that plaintiffs may turn to legal processes rather than relying solely on naming and shaming techniques coupled with the good graces of charitable organisations or readily-broken political promises. Judicial declarations of rights and wrongs promote norm development and can shape the behaviour of state and non-state actors alike, all while compelling governments to address socio-economic demands.

Secondly, rights observance — as found in legal decisions and progressive legislation — 'begets funding and the creation of institutions capable of effecting systemic change'.[130] On this theme, Gorik Ooms and Rachel Hammonds have conceptualised the global response to the HIV/AIDS pandemic as a new paradigm of international health assistance.[131] Ooms and Hammonds argue that the Global Fund is helping to delineate global and national responsibilities for global health challenges while simultaneously developing a vision for social and economic justice.[132]

The admirable proposal of Larry Gostin and others for a Framework Convention on Global Health builds on the way in which the Global Fund bolsters national health systems through international support and obligations to conceive of a new international legal instrument.[133] Should it succeed in gaining traction, the Framework Convention will clarify which health goods and services should be enjoyed by all people, the national and global responsibilities necessary to secure the health of the world's population and the governance

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> WHO and the Global Fund have identified an anticipated gap of US$1.6 billion in annual international support for the fight against tuberculosis in 118 low- and middle-income countries on top of an estimated US$3.2 billion that could be provided by the countries themselves. Filling this gap could enable full treatment for 17 million TB and multidrug-resistant TB patients and save 6 million lives between 2014–2016.

129 See generally Smita Narula, 'The Right to Food: Holding Global Actors Accountable under International Law' (2006) 44 *Columbia Journal of Transnational Law* 691; Russell Rutherford, 'An International Human Right to Water: How to Secure the Place of People Ahead of Profits in the Struggle for Water Access' (2011) 62 *Alabama Law Review* 857.

130 Novogrodsky, above n 11, 60.

131 Gorik Ooms and Rachel Hammonds, 'Taking up Daniels' Challenge: The Case for Global Health Justice' (2010) 12(1) *Health and Human Rights* 29. See also Ooms et al, 'Applying the Principles of AIDS Exceptionality', above n 51.

132 Ooms and Hammonds, 'Taking Up Daniels' Challenge', above n 131, 30.

133 Gostin conceives of a Framework Convention on Global Health, a flexible international health instrument that would be augmented over time by specific protocols reflecting more detailed norms, structures and processes: see Gostin, 'Meeting Basic Survival Needs', above n 52, 386–91. See also Scott Burris and Evan D Anderson, 'A Framework Convention on Global Health, Social Justice Lite or a Light on Social Justice?' (2010) 38 *Journal of Law, Medicine & Ethics* 580.

structures required to realise these responsibilities.[134] At the level of treaty-building too, the success of *TRIPS* exemptions and domestic intellectual property challenges has empowered access to medicines campaigners to tackle the Trans-Pacific Partnership Agreement and other trade deals to ensure that hard-fought patent flexibilities are not eroded.[135]

Perhaps most significantly, advocates for a capacious vision of social, economic and cultural justice have identified how the World Bank and the International Monetary Fund ('IMF') impede or enable rights-fulfilment in attempting to reduce poverty.[136] IMF and World Bank members are, largely, states parties to both the *ICESCR* and the *Convention on the Rights of the Child* ('*CRC*'),[137] both of which contain provisions concerning a right to health.[138] Hammonds and Ooms insist that such agreed-upon rights require material facilitation, pointing out that

> [t]he right to health cannot be realized in isolation from other rights because good health is dependent on factors other than those just related to access to health facilities — including education, clean water, sanitation, and adequate housing.[139]

Defined as 'the entitlement to the highest attainable standard of physical and mental well-being',[140] the right to health represents a core obligation that permits no derogation and which may be proactively violated when health sectors are under-funded.[141] From this perspective, even the progressive realisation caveat of art 12.1 of the *ICESCR* and art 24.4 of the *CRC* 'should not be misinterpreted as justifying endless delays in the realization of economic, social and cultural rights, while waiting for economic growth and sufficient domestic resources to become available'.[142] Rather, those states that can move more expeditiously than others must do so. The more states that are involved, the easier it will be to bear the costs: based on data from the IMF, Ooms and Hammonds estimate that only US$40–US$50 per person per capita is required to meet the costs of global health justice in low- and lower-middle-income countries.[143]

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134 See generally Rachel Hammonds, Gorik Ooms and Wouter Vandenhole, 'Under the (Legal) Radar Screen: Global Health Initiatives and International Human Rights Obligations' (2012) 12 *BMC International Health and Human Rights* <http://www.biomedcentral.com/content/pdf/1472-698X-12-31.pdf>; Lawrence O Gostin et al, 'The Joint Action and Learning Initiative: Towards a Global Agreement on National and Global Responsibilities for Health' (2011) 8(5) *PLOS Medicine* <http://www.plosmedicine.org/article/fetchObject.action?uri=info%3Adoi%2F10.1371%2Fjournal.pmed.1001031&representation=PDF>.

135 See, eg, Public Citizen, 'TPP's Investment Rules Harm Public Health' (Factsheet, 15 March 2013) <http://www.citizen.org/documents/TPP-and-health.pdf>.

136 See Namita Wahi, 'Human Rights Accountability of the IMF and the World Bank: A Critique of Existing Mechanisms and Articulation of a Theory of Horizontal Accountability' (2006) 12 *UC Davis Journal of International Law & Policy* 331.

137 *Convention on the Rights of the Child*, opened for signature 20 November 1989, 1577 UNTS 3 (entered into force 2 September 1990).

138 Ibid art 24.4; *ICESCR* art 12.1. See also Hammonds and Ooms, 'World Bank Policies and the Obligation of Its Members', above n 46, 33.

139 Hammonds and Ooms, 'World Bank Policies and the Obligation of Its Members', above n 46, 28.

140 Ibid 29.

141 Ibid.

142 Ibid 34.

143 Ooms and Hammonds, 'Taking Up Daniels' Challenge', above n 131, 37–9.

In a similar vein, the Millennium Development Goals ('MDGs') advance the objective of measurable outcomes related to public health and quality of life.[144] Just as the treatment cases forced states to demonstrate that they were delivering life-saving medications, so too do the MDGs provide indicia against which to evaluate the international community's performance. Helen Clark, Administrator of the United Nations Development Programme ('UNDP'), recently lauded the 'game chang[ing]'[145] nature of the MDGs even though many of these objectives remain unmet:

> The goals brought global focus on development benchmarks that were highly relevant to [Africa]. … Particularly in areas of health, the research shows that progress on mortality in infants and children under five, and on HIV/[AIDS], can be very tightly attributed to the focus and priority that came from the MDGs.[146]

Like the UNDP, the office of UN Special Rapporteur on the Right to Health has sought to develop and apply metrics to the right to the highest attainable standard of health.[147]

Thirdly, the legal activism that imbued the global response to HIV with the language of human rights has irrevocably altered the discourse surrounding socio-economic obligations. The shift is discernible in the way proponents of non-HIV health challenges have adopted a lens of human rights and international legal responsibilities to frame their advocacy. Ooms, for example, has pointed to maternal mortality as an important barometer of the global commitment to health rights[148] and in 2010 he joined other scholars in lamenting the failure to live up to the MDGs on women's health and status.[149] Maternal mortality also recalls the multiple-stakeholder approach to health and human rights-spurred social movements. In this regard, Paul Hunt and Judith Bueno de Mesquita have noted that the number of 'stakeholders and activities that affect maternal health' make a human rights-based approach highly relevant to governments, international organisations, donors and civil society as they seek to implement broadly-framed

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144 See MDG Gap Task Force, 'The Global Partnership for Development: The Challenge We Face' (Report on Millennium Development Goal 8, United Nations, 2013) ix–x. See also United Nations, *Millennium Development Goals and Beyond 2015* <http://www.un.org/millenniumgoals/>.

145 Eleanor Whitehead, *Interview: Helen Clark, Administrator of the United Nations Development Programme* (25 February 2013) This is Africa <http://www.thisisafricaonline.com/Development2/Interview-Helen-Clark-Administrator-of-the-United-Nations-Development-Programme>.

146 Ibid. Clark lamented the failure to reduce maternal mortality in developing countries as a missed opportunity within the framework of the MDGs.

147 Paul Hunt and Sheldon Leader, 'Developing and Applying the Right to the Highest Attainable Standard of Health: The Role of the UN Special Rapporteur (2002–2008)' in John Harrington and Maria Stuttaford (eds), *Global Health and Human Rights: Legal and Philosophical Perspectives* (Routledge, 2010) 28. One consequence of the effort to give content to vague normative propositions is gradual institutional acceptance of the need for increased support of health resources by wealthier states for the benefit of the developing world: see David B Evans et al, 'The World Health Report: Health Systems Financing: The Path to Universal Coverage' (Report, World Health Organization, 2010).

148 See Ooms and Hammonds, 'Taking Up Daniels' Challenge', above n 131, 34.

149 Gorik Ooms et al, 'Financing the Millennium Development Goals for Health and Beyond: Sustaining the "Big Push"' (2010) 6 *Globalization and Health* <http://www.globalizationandhealth.com/content/pdf/1744-8603-6-17.pdf>.

health demands.[150] The success of such a movement depends on '[c]learly set[ting] out the responsibilities of various actors for reducing maternal mortality, including, where appropriate, the international and domestic human rights obligations of States'.[151] Different actors hold each other accountable in this process:

> A human rights-based approach to maternal mortality requires that duty bearers are accountable for both maternal mortality, and for implementing policies and programmes to reduce its incidence.
>
> Accountability devices can include a range of institutions and processes within and beyond government, ranging from impact assessments … and policy review processes, to parliamentary processes, ombuds, courts and tribunals.[152]

The holistic thinking necessary to make the connections amongst legal frameworks, HIV-treatment, maternal mortality and health systems has spurred new understandings of the relationship between these diverse factors. Until recently, much of the research on the intersection of law and social movements was focused on specific, small-scale achievements and has tended to eschew study of the ways in which legal reforms can facilitate broader paradigm shifts.[153] The story and trajectory of HIV/AIDS advocacy may be instructive on a larger scale. The first lesson of the movement is an appreciation that the process is dialectical and that the dance among targeted socioeconomic rights litigation, civil society activism and both grassroots and formal political organising must be carefully choreographed.[154] As Eduardo J Gómez argues vis-a-vis Brazil, legal reforms and social movements are mutually reinforcing:

> Evidence from Brazil suggests that the policy influence of interest groups and social movements evolves over time and is more influential after the national government implements new policies; moreover, this response is triggered by the rise of international pressures and government reputation building, not civil society.[155]

Ida Susser's study of South Africa only reinforces these themes. Susser argues that South Africa's AIDS activists succeeded in transforming a culture of

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150 Paul Hunt and Judith Bueno de Mesquita, 'Reducing Maternal Mortality: The Contribution of the Right to the Highest Attainable Standard of Health' (Report, Human Rights Centre, University of Essex, 2010) 13.

151 Ibid.

152 Ibid 12.

153 See Lobel, above n 38.

154 See generally Jack M Balkin and Reva B Siegel, 'Principles, Practices, and Social Movements' (2006) 154 *University of Pennsylvania Law Review* 927. They note, at 929, that

> [a]s social movements challenge the conventions that regulate the application of principles, longstanding principles can call into question the legitimacy of customary practices (eg, racial profiling, racial segregation, or sexual harassment) or imbue with constitutional value practices long judged illicit (eg, abortion, pornography, same-sex sodomy, or same-sex marriage). When movements succeed in contesting the application of constitutional principles, they can help change the social meaning of constitutional principles and the practices they regulate.

See also Amy Kapczynski, 'Access to Knowledge', above n 14, 804.

155 Gómez, above n 23, 123.

'denialism, stigmatizing, and silencing of AIDS'[156] into public recognition by governments and civil society alike by embracing a dynamic process of negotiation involving the convergence of media, social movements and international pressure.[157]

The application of lessons from the organisation of AIDS campaigning to related problems has generated a new vocabulary. Theorists in this arena now speak of the struggle for health justice, a phrase that encompasses the same moral, dialectical and flexible dimensions as the terms 'social justice' and 'environmental justice'.[158] Still, significant questions remain to be answered:

- are the rights in question collective or individual;
- does the wealth of the state modify the right;[159] and
- if the state in question fails to fulfil its responsibilities, do duties transfer to the international community as a whole?

Regardless of the answers, it is beyond debate that the global conversation has shifted toward the content and parameters of social and economic rights. As Jeremy Perelman and Lucie E White recognise, economic and social rights activists in a variety of contexts have begun to use human rights practice as redistributive politics and to mobilise constituencies to employ (but not privilege) litigation while prefiguring the structural change they seek.[160]

VI CONCLUSION

Most attempts to promote justice in environments of poverty and deprivation do not involve litigation.[161] In this light, the protracted struggle for HIV medicines and the use of courts as a tool to vindicate human rights offers one possible path to success. Despite the indirect invocation of the treatment precedent, the legacy of the effort to deliver scarce goods to people in need is present in the growing number of global cases concerning dignity and a measurable quality of life, international institutional responsiveness and the expanded theorising of human rights. It may be hubris to reconceive of social and economic rights-implementation in this fashion but it is consistent with the tradition of bringing previously unenforceable demands to the forefront of the legal imagination. For the next generation of rights promoters, it is a powerful symbol of what once was and what still could be.

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156 Ida Susser, 'Organic Intellectuals, Crossing Scales, and the Emergence of Social Movements with Respect to AIDS in South Africa: AES Presidential Address for 2008' (2011) 38 *American Ethnologist* 733, 736.

157 Ibid 733–42.

158 See generally David Schlosberg, *Defining Environmental Justice: Theories, Movements, and Nature* (Oxford University Press, 2007). See also Upendra Baxi, 'The Place of the Human Right to Health and Contemporary Approaches to Global Justice: Some Impertinent Interrogations' in John Harrington and Maria Stuttaford (eds), *Global Health and Human Rights: Legal and Philosophical Perspectives* (Routledge, 2010) 12, 20–1.

159 See Ooms and Hammonds, 'Taking Up Daniels' Challenge', above n 131, 34.

160 Perelman and White, above n 35. They note how diverse actors have fashioned integrative approaches that are both pragmatic and performative.

161 For a classic case of social and economic rights organising without litigation, consider the Cochabamba water controversy in which local villagers resisted privatisation efforts while foreign allies protested at shareholder meetings of multinational corporations: see William Finnegan, 'Leasing the Rain', *The New Yorker* (New York), 8 April 2002, 43.