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After AIDS

Introduction

For a brief moment in time, the judicialization of HIV/AIDS treatment promised to transform the world. Between 1996 and 2005, AIDS activists, People Living with HIV and AIDS (PLWHA) and NGOs used diverse judicial processes to compel states to provide life-saving medications. In a thousand Brazilian *amparo* proceedings and in test cases before domestic, regional and international tribunals, courts and legislatures (many in Latin America) gave voice to the previously unthinkable – the direct implementation of one manifestation of social and economic rights.

How and why this intervention occurred is worth considering for it may have a bearing on whether rights to health – and positive rights more generally – are judicially enforceable. This paper examines the unique success of HIV treatment advocates while observing that the justiciable demand for access to AIDS medicines has not ushered in an era of enforceable claims to clean water, cultural preservation, education or a living wage.

In some respects, AIDS was an unlikely locus for a rights revolution. The early years of the pandemic were marked by fear and hatred of HIV-positive people and as a result, the field of HIV and the law was shaped by equality, destigmitization and privacy protection

efforts. The reasons for this fact are manifold and rooted in the history of the pandemic.[1] AIDS was initially understood by both epidemiologists and the general public as a disease of gay men, injecting drug users, prostitutes and their sexual partners – a frame of reference that is particularly strong in Latin America.[2] Outside of public health circles – and sometimes within the health sector – the disease was met with antipathy; PLWHA faced abject homophobia and discrimination.

Although scientists recognized the composition of the virus in 1984, there was no effective treatment available to people living with HIV/AIDS until 1996. To contain a disease for which there was neither a cure nor comprehensive treatment, most public health programs focused on prevention, care and the amelioration of opportunistic infections. The discovery of highly effective anti-retroviral drugs (described variously as HAART, ART or ARVs) catalyzed AIDS campaigners, particularly since the medicines were quickly available in developed countries and to wealthy individuals around the world. Predictably, AIDS activists demanded that states and public insurance companies cover the costs of life-saving ART. In a series of test cases and quasi-legal legislative crusades, courts and administrative organs – which are generally reluctant to adjudicate demands for social and economic rights much less dictate to legislatures how scarce resources should be allocated – were suddenly asked to rule on legal demands for treatment. Equally important, the demand came largely from the first generation of

[1] Noah Novogrodsky, *The Duty of Treatment: Human Rights and the HIV/AIDS Pandemic*, 12 YALE HUM. RTS. & DEV. L. J. 1 (2009).
[2] *See, e.g.*, RANDY SHILTS, AND THE BAND PLAYED ON: POLITICS, PEOPLE, AND THE AIDS EPIDEMIC (1987).

infected persons: transvestites in Brazil, prisoners in Colombia, sex workers and injecting drug users in a host of states – all marginalized populations.

Against all odds, treatment advocates prevailed. The Constitutional Court of Colombia was the first tribunal to hold that the state is required to provide AIDS treatment regardless of cost. In *Pedro Orlando Ubaque v. Director*,[3] the Colombian Court ordered ART for inmates unable to provide for their own healthcare.[4] Active lobbying in Colombia led to the subsequent addition of ART to the official medicines list.[5] The Constitutional Chamber of the Costa Rican Supreme Court of Justice reached the same conclusion in two cases, *Luis Guillermo Murillo Rodriguez et al. v. Caja Constarricense de Seguro Social* and *William Garcia Alvarez v. Caja Constarricense de Seguro Social*,[6] through which the Costa Rican Social Security Fund was ordered to supply the applicants with ART. In *Cruz Bermudez et al. v. Ministerio de Sanidad y Asistencia Social* too, the Venezuelan Supreme Court found that the Ministry of Health and Social Action had infringed health rights belonging to HIV-positive persons by failing to supply prescribed ART. *Cruz Bermudez* also established a number of specific steps required of the

[3] *Pedro Orlando Ubaque v. Director*, Constitutional Court of Colombia, Dec. No. T-502/94 (1994) (finding that conditions in a prison ward of HIV-positive prisoners violated the prisoners' right to health and dignity in view of their compromised immune systems).
[4] *See* Protection Writ, *Judgment of Fabio Moron Diaz, Magistrado Ponente*, Constitutional Court of Colombia, Dec. No. T-328/98 (1998) (holding denial of costly antiretroviral treatment prescribed for plaintiff under social security system violates constitutional fundamental right to life), http://bib.minjusticia.gov.co/jurisprudencia/CorteConstitucional/1998/Tutela/T-328-98.htm; *see* Alicia Yamin, *Not Just a Tragedy: Access to Medications as a Right under International Law*, 21 B.U. INT'L L.J. 325, 340 (2003).
[5] Decree No. 1543 (1997) (Colom.); *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?* 368 LANCET 309 (2006).
[6] *Luis Guillermo Murillo Rodriguez et al. v. Caja Constarricense de Seguro Social*, Constitutional Chamber of the Supreme Court of Justice, Decision No. 6096-97 (1997) (Costa Rica); *William Garcia Alvarez v. Caja Constarricense de Seguro Social*, Constitutional Chamber of the Supreme Court of Justice, Decision No. 5934-97 (1997) (Costa Rica).

government and ordered the Ministry to seek necessary budget allocations.[7] The *Cruz Bermudez* Court's holding also had profound procedural implications. "This ruling meant that the right to health, as interpreted by the Court, had the broadest possible application in Venezuela, giving every HIV positive person in the country the right to access ARV therapies."[8]

In Argentina,[9] Brazil,[10] Chile,[11] Ecuador,[12] Mexico[13] and Peru,[14] litigation resulted in judgments requiring affirmative action on the part of the state to uphold Constitutionally or statutorily protected rights.[15] As Tara Melish has written, the decisions "have generally been complied with by Latin American sates. Several of the leading cases led to national decrees or legislation giving meaning to the constitutional right to health and

[7] *Cruz Bermudez et al. v. Ministerio de Sanidad y Asistencia Social*, Supreme Court of Justice of Venezuela, Case No. 15.789, Decision No. 916 (1999) (Venez.). *See also Mrs. Glenda Lopez et al. v. Instituto Venezolano de Seguros Sociales*, Supreme Court, Expediente No. 15789 (1999) (Venez.).

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

[9] *AV &CM v. Ministerio de Slaud de la Nacion*, Federal Civil & Commercial Court No. 7 (Apr. 26, 2002) (Arg.).

[10] Tara J. Melish, *Rethinking the "Less as More" Thesis: Supranational Litigation of Economic, Social and Cultural Rights in the Americas*, 39 NYU J. INT'L L. & POL. 171, 281, fn. 305 (2006).

[11] *See, e.g.*, Court of Appeals of Santiago, petition for protection, no. 2,614-99, 14/6/99 (respondents had failed to provide essential medicines and therefore jeopardized claimants lives in violation of Article 1, section 4 and Article 19 of the Chilean Constitution and Article 6 of the ICCPR and that the cost of the drugs was "unacceptable"). On appeal, the Supreme Court reversed the Court of Appeal, finding that the issuance of medicines is a decision for health officials, not the courts. *See* SELA's own Rodolfo Figueroa, *Enforcing the Right to Health before the Courts: The case of HIV/AIDS in Chile*, HUM. SERVICES TODAY Spring 2005, Vol. 2, Issue 2; Jorge Contesse & Domingo Lovera Parmo, *Access to Medical Treatment for People Living with HIV/AIDS: Success Without Victory in Chile*, 8 SUR – INTERNATIONAL JOURNAL ON HUMAN RIGHTS 143 (2008).

[12] *See, e.g., Edgar Carpio Castro Joffe Mendoza & Ors v. Ministry of Public Health and the Director of the National HIV/AIDS Programme*, Amparo 28 (2004) (Ecuador).

[13] *See, e.g., Castro v. Instituto Mexicano del Seguro Socail*, Amparo Decision 2231/97 (Plenary Court of the Supreme Court of Justice, April 2000)

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

[15] In Panama, activists bypassed definitive judicial resolution and instead staged demonstrations and blockaded downtown streets until the Panamanian Social Security Fund announced that it would extend coverage under its health care plan to include ARVs. *See* Courting Rights: Case Studies in Litigating the Human Rights of People Living with HIV, UNAIDS and the Canadian HIV/AIDS Legal Network, pg. 57 (2006).

explicitly establishing the responsibility of the state to provide necessary medications to persons living with HIV/AIDS."[16] In Brazil, countless *amparo* proceedings for treatment of HIV based on the Constitution's right-to-health guarantee provided the preconditions for Law 9313 which today provides antiretroviral drugs free of charge in the public health system for all Brazilians living with HIV/AIDS.[17]

As if to underscore the revolutionary nature of the treatment jurisprudence, in *Minister of Health v. Treatment Action Campaign (TAC),*[18] the South African Constitutional Court cited *Brown v. Board of Education* to support its use of a structural injunction against the government. The legal recognition of an enforceable right to treatment soon extended beyond national courts. Between 2000 and 2002, the Inter-American Commission on Human Rights granted precautionary measures in cases involving care of HIV-positive people to more than four hundred claimants in cases from Bolivia, Chile, Colombia, the Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras and Peru.[19] In almost all of these cases, the Commission requested that the state provide the beneficiaries with the 'medical examination and treatment indispensable for their survival.'[20] In *Odir Miranda*, for example, the Commission specified that the government of El Salvador was to provide antiretroviral medication necessary to prevent death, as well as essential hospital, nutritional and pharmacological care to prevent the development of

[16] Melish, *supra* note 10 at 283.
[17] *See* Lei No. 9.313, de 13 Novembro de 1996 (Brazil).
[18] Minister of Health v Treatment Action Campaign, 2002 (10) BCLR 1033 (CC) (S. Afr.) ¶ 107.
[19] Since the end of 2002, the Commission has issued precautionary measures less frequently in cases of demands for ART by requiring additional information, including CD4 counts. *See* Tara Melish, The Inter-American Commission on Human Rights: Defending Social Rights Through Case-Based Petitions, 7.3 in SOCIAL RIGHTS JURISPRUDENCE: EMERGING TRENDS IN COMPARATIVE AND INTERNATIONAL LAW (Cambridge Univ. Press, M. Langford, ed. 2007).
[20] *See id.* at .

opportunistic infections.[21] In *Luis Rolando Cuscul Pivaral and Others Affected by HIV/AIDS v. Guatemala*,[22] the Commission cited Article 4 of the Convention (the right to life) in issuing precautionary measures against Guatemala in the case of HIV-positive persons requiring ART who were receiving inadequate medication through the Guatemalan public health system.[23]

The wellspring of legal support for HIV/AIDS treatment could have produced a paradigm shift with respect to the enforceability of social and economic rights. After all, the success of judicially 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."[24] However, with few exceptions, the revolution in social and economic rights enforcement has stalled. While the HIV/AIDS pandemic has served as the impetus for global concern and action about health "efforts to combat HIV/AIDS have so far managed to bring more money to the field but have not always

[21] *See, e.g.*, Jorge *Odir MirandaCortez v. El Salvador* Case 12.249, Inter-Am. C.H.R., Report No. 29/01 ¶ 32 (2001)..

[22] *Luis Rolando Cuscul Pivaral and Others Affected by HIV/AIDS v. Guatemala*, Petition 632/05, Report No. 32/05, Inter-Am. Comm. H.R., OEA/Ser.L./V/II.124, doc.5 ¶ 1 (2006).

[23] A similar dynamic is at work in the concluding observations of UN treaty bodies monitoring compliance by State Parties to international conventions. Thus, the Committee Interpreting the International Covenant on Economic, Social and Cultural Rights in its review of Honduras, urged the government "to undertake effective measures to address the high level of persons living with HIV/AIDS, and in particular facilitate access to essential drugs, and to seek international cooperation to this effect." E/C.12/1/Add.57. Similarly, the Committee on the Rights of the Child, which interpret state obligations under the Convention on the Rights of the Child recently chastised Mexico for failing to ensure access to ART. *See* Committee on the Rights of the Child concluding observations: Mexico, "The Committee recommends that the State party, taking into account the Committee's general comment no. 3 (2003) on HIV/AIDS and the rights of the child and the International Guidelines on HIV/AIDS and Human Rights:…(e) Ensure the free access to anti-retroviral treatment." CRC/C.MESX/CO/3, June 8, 2006.

[24] Paul Farmer, PATHOLOGIES OF POWER: HEALTH, HUMAN RIGHTS AND THE NEW WAR ON THE POOR 232 (2005). The implementation of economic, social and cultural rights is often focused on non-judicial remedies or directed toward a particular constitutional system (ie. South Africa). *See also*, Kristen Boon, *The Role of Courts in Enforcing Social and Economic Rights*, 39 GEO. WASH. INT'L L. REV. 449, 458 (2007).

had much beneficial impact on public health outside of their own niche."[25] To be sure, some of the legal achievements of the treatment movement, principally in the field of access to medicines, have been applied to other diseases amenable to pharmacological interventions. But the success of 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, water, housing or education. This is therefore a story of AIDS exceptionalism.

What accounts for the limited uptake of the treatment legacy? This paper offers three complementary explanations. The first recognizes that the treatment movement has grown overly specialized and has, in important ways, become a victim its own success. What was once a broad-based social movement demanding empathy, recognition and funding, has grown into a formidable and hyper-legal collection of experts focused on arcane intellectual property rules. The second reason for a failure to translate HIV treatment success into other arenas is the desystematization of AIDS. The unique attention and institutionalization of AIDS treatment has meant that the disease is increasingly disconnected from its roots as a mirror of poverty, public health and the subordination of women. The third account is rooted 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. Instead of a coherent expansion of socio-economic rights enforcement rooted in shared conceptions of human rights and dignity, we are witnessing a broad-based judicial retreat from the field, interrupted by occasional, disconnected progress. I conclude by

[25] Garrett, *The Challenge of Global Health*, *supra* note ___ at __(arguing that instead of directing so much attention to AIDS, the world health community should focus on increasing maternal survival and increasing overall life expectancy).

identifying some of the work that legal activists are doing to build on the global case law and related legislation and which may yet redeem the legacy of AIDS treatment.

Overspecialization

The struggle to treat infected persons began long before ART was readily available. In response to the opprobrium directed toward HIV-infected people in the first decades of the disease, AIDS activists around the world developed effective mobilization techniques to dispel the stigma associated with the virus.[26] North American and European activist groups including ACT-UP and the Gay Men's Health Crisis broke the silence surrounding AIDS by loudly and effectively championing the needs of infected people.[27] By staging performative die-ins and appearing in public bound and gagged, activists in the developed world generated a deep reservoir of sympathy for PLWHA.[28] The arrival of ART coincided with the emergence of a multifaceted movement – it includes South Africa's mass member Treatment Action Campaign, celebrities and guerilla activists – organized to advocate for research, prevention, care and treatment.[29]

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

[27] *See* JG Twomey Jr. *AIDS activism*, HASTINGS CENT. REP. 39 (1990). The President of the United States did not publicly mention the disease until the WHO had counted more than 38,000 cases in the U.S.. *See Gostin, supra* note ___, at xxv.

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

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

The movement's accomplishments are undeniable. Building on the work of Jonathan Mann, the first World Health Organization Global AIDS Director, HIV/AIDS campaigners have converted the international response to a disease once characterized by stigma and avoidance into defined structures, modalities and unprecedented levels of attention as measured by funding dollars. Today the combination of bilateral (mainly the U.S. President's Emergency Plan for AIDS Relief (PEPFAR),[30] multilateral and private philanthropic efforts (including the William J. Clinton Foundation[31] and the Bill and Melinda Gates Foundation[32]) ensures that vastly more money is directed to global AIDS than to any other international health or development problem.[33] Predictably, a growing number of critics now decry the disproportionate share of global health spending directed to HIV and AIDS.[34]

The development of ART and the justiciability of demands for essential medicines has spawned a protracted legal struggle to provide AIDS drugs at affordable prices.

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[30] *See* Unites States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003, 22 U.S.C. §§ 7601-82 (2003). PEPFAR was initially funded for 2003-2008 with $15 billion, at least $10 billion of which was new funding. PEPFAR's stated goal for this period was to avert seven million new HIV infections, begin two million people on ART and extend care to ten million HIV-positive people. http://www.state.gov/documents/organization/67502.pdf. In July 2008, Congress authorized an additional $41 billion for the program for the period 2009-2013. *See* President Bush Signs HR 5501, the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis and Malaria Reauthorization Act of 2008 [news release]. Washington, DC: Office of the Press Secretary; July 30, 2008. http://www.whitehouse.gov/news/releases/2008/07/20080730-12.html.

[31] Clinton Foundation Programs: HIV/AIDS Initiative, http://www.clintonfoundation.org/cf-pgm-hs-ai-home.htm. The Foundation has been instrumental in negotiating price reductions and bulk procurement opportunities from pharmaceutical companies.

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

[33] Laurie Garrett, *The Challenge of Global Health*, 86 FOREIGN AFFAIRS (2007)

[34] *See* David J. Casarett & John D. Lantos, *Have We Treated AIDS Too Well? Rationing and the Future of AIDS Exceptionalism*, 128 Annals of Internal Medicine 756-59 (1998); K. Morris, *The Effect of AIDS on International Health* ___THE LANCET August 2008; Roger England, *The Writing Is On The Wall for UNAIDS*, 336 BMJ 1072 (2008).

Specifically, the urgent need for treatment has pitted access to medicine campaigners against pharmaceutical patent holders. The conflict between AIDS patients and patent holders erupted in 1999 and 2000 when thirty-nine multinational pharmaceutical companies engaged in a short-lived challenge to a South African law that permits parallel importing and compulsory licensing while encouraging generic competition.[35] The civil society protests that followed spawned a movement. In 2001, treatment advocates working with negotiators from developing countries secured an amendment to TRIPS, the World Trade Organization's (WTO)[36] global compact on Trade-Related Aspects of Intellectual Property Rights.[37] The amendment permits Member States "to adopt measures necessary to protect the public health and nutrition, and to promote the public interest in sectors of vital importance to their socio-economic and technological development," including the issuance of compulsory licenses as a remedy for anticompetitive practices.[38] The amendment, promulgated as the Doha Ministerial Declaration, clarified that members may lift patent protections in a state of emergency and reaffirmed the understanding that Member States should not be prevented by WTO rules from taking measures to protect public health.[39] In 2003, a second Doha Accord[40] explicitly authorized the use of compulsory licensing to import essential medicines for

[35] *Pharmaceutical Manufacturers' Association and 41 Others v. President of South Africa and 9 Others*, High Court of South Africa, Transvaal Provincial Division, Case No. 4183/98 (2001).
[36] 149 states have joined the WTO. World Trade Organization, Members and Observers (Dec. 11, 2005).
[37] *See* Agreement on Trade-Related Aspects of Intellectual Property Rights, Annex 1C, Apr. 15, 1994, Marakesh Agreement Establishing the World Trade Organization, World Trade Organization, 1869 U.N.T.S. 299, 33 I.L.M. 1197 [hereinafter TRIPS].
[38] *Id.* at Art. 31.
[39] Declaration on the TRIPS Agreement and Public Health, WT/MIN(01)/DEC/W/2, Nov. 14, 2001 (01-5770) at ¶ 6 and 17. The Doha Declaration specifically recognized that "[e]ach Member has the right to determine what constitutes a national emergency or other circumstances of extreme urgency, it being understood that public health crises, including those related to HIV/AIDS, tuberculosis, malaria and other epidemics, can represent a national emergency…"
[40] Implementation of Paragraph 6 of the Doha Declaration on the TRIPS Agreement and Public Health, Decision of the General Council of 30 August 2003 WT/L/540 and Corr. 1.

states without manufacturing capacity, a move that was made permanent in 2005.[41]

As a condition of joining the WTO, Brazil and India amended their domestic patent acts (each state boasted a strong generic pharmaceutical industry) to become formally TRIPS-compliant but embedded procedural and substantive protections which have affected the price of medicines in developing countries around the world.[42] Brazil, Colombia and Ecuador among other states have also issued compulsory licenses for ARVs – often over intense criticism from patent-holding pharmaceutical companies and their political allies.[43] AIDS activists learned to advise poor states to use TRIPS flexibilities and became a consistent force advocating for alternatives to patent monopolies. The movement quickly coined the term, "access to essential medicines" to describe its agenda. Many of best organizations in the field dedicated themselves to challenging the pricing associated with research pharmaceutical products. Médecins Sans Frontières (MSF or Doctors Without Borders), for example, initiated a highly publicized campaign to track drug prices, to advocate for increased generic production of anti-retrovirals, and to expose the ways that the TRIPS Agreement contributes to the neglect of diseases afflicting the poor. Knowledge Ecology International has worked with delegations from Barbados and Bolivia to develop a global prize system to stimulate innovation. Yale's

[41] World Trade Org., Members OK Amendment to Make Health Flexibility Permanent, Press Release (Dec. 6, 2005), *at* http://www.wto.org/English/news_e/pres05_e/pr426_e.htm.
[42] *See, e.g.*, The Patents (Amendment) Act, 2005 (India), No. 15 of 2005.
[43] In October 2009, Ecuador's President Rafael Correa issued Decree 118 to improve access to medicines and support public health programs through a protocol that would reduce drug costs. Over the objections of the US Ambassador in Quito, the protocol established procedures for the compulsory licensing of pharmaceutical patents. Compulsory licensing authorizes 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 interagency cooperation to grant licenses on a case-by-case basis and pay royalties to patent holders.

Thomas Pogge, who addressed SELA in Santiago last year, has been the intellectual driver behind the Health Impact Fund, a proposed alternative to the global patent registration regime protected by TRIPS. The combined efforts of AIDS activists, coupled with the steady supply of generic drugs, has dramatically lowered the cost of ART. The price of triple-combination HIV/AIDS therapy purchased from originator companies fell by 95%, and generics became widely available in many developing countries at a discount of 99%.[44] Drugs that cost $10,000 - $15,000 per patient per year in 2001 now cost $100 annually in generic form.[45]

Where significant price discrepancies between generic and brand products exist, the access community confronts would-be patent registrants and their efforts have meant that legally compelled price reductions for each new generation of AIDS drugs, are now commonplace. The right to treatment recognized in the AIDS cases has facilitated compulsory and voluntary licenses for generic competitors, bulk and advance purchase agreements and legally sanctioned parallel imports. Nowhere is the success more pointed than in Brazil which has a universal access law. But as World Bank economist Varun Gauri notes, even as Brazil has scaled up free ART, many basic antibiotics remain too expensive or inaccessible for millions of Brazilians.[46]

The problem with this dynamic is the over-attention to intellectual property concerns at

[44] It is Indian generic pharmaceutical companies that first bundled three-in-one drugs into a single pill, making ART adherence easier for People Living with HIV/AIDS (PLWHA). *See* www.avert.org/generic.htm.
[45] *See* MEDECINS SANS FRONTIERES, UNTANGLING THE WEB OF PRICE REDUCTIONS 5 (10th ed., July 2007).
[46] Varun Gauri, *Social Rights and Education: Claims to Health Care and Education in Developing Countries*, 32 WORLD DEVELOPMENT 465 (2003).

the expense of a broader understanding of human rights and the role of law. It is true that patents are legal constructs and a form of property, but increased access to ARVs alone is not enough to protect the dignity of PLWHA, much less vulnerable populations as a whole. As each new AIDS drug comes to market, access campaigners confront the manufacturer, insurers and government purchasers to ensure an interrupted supply of safe and affordable or free pills. No such process occurs for other diseases. Accordingly, the protracted struggle for access to ART represents the triumph of public law and human rights over private law interests for the production of a single class of goods.[47]

TRIPS, most commentators agree, is here to stay and the organized opposition to AIDS drug pricing has had little bearing on patent protection for other diseases and the reward structure provided by uniform intellectual property rules. There is scant evidence that the lessons of AIDS treatment have been applied outside the context of HIV and select other diseases and the hard truth is that more Brazilians die of hypertension than AIDS.[48] To date, right to health advocates have simply not asked judiciaries to provide ART-like remedies in other contexts and government agencies and insurers appear unwilling to assume expensive obligations unless pushed, particularly during a global recession. It is easy to imagine the extension of the treatment reasoning in cases demanding new anti-malarial drugs that derive from or synthetically copy artemisinin. These drugs are dramatically more effective than their predecessor therapies and would benefit millions

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

[48] AIDS is a disease of the developed and developing world alike which creates strong incentives for continued pharmaceutical innovation and profits in the global north.

of people in the developing world.[49] The same is true for drugs to treat sleeping sickness, diarrheal disease and many other ills of low and middle-income states but there appears to no constituency for diseases beyond AIDS.[50]

Even more problematic, the technical pharmaceutical pricing discourse has obscured other forms of rights-speak. Advising developing states on the meaning of Article 6(b) of TRIPS or designing a royalty scheme for a single voluntary license lacks the urgency and humanity that has been a hallmark of the international human rights movement's success. The more technical the conversation the farther 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 are frequently described as second generation rights, aspirational perhaps, but largely unrealizable. Because the International Covenant on Economic, Social and Cultural Rights (ICESCR) allows for the progressive realization of socio-economic rights by states and subjects implementation to an available resources limitation, the right to health means different things in different places. Some judges most notably in the U.S., have refused to entertain alleged violations of the ICESCR, reasoning that its "boundless and indeterminate principles" cannot be applied juridically.[51] An exclusive or excessive focus on pharmaceutical pricing runs the risk of rechanneling the conversation into the realm of resource allocation and of reinforcing the

[49] *See* Donald G McNeil Jr, *A cheaper, easier malaria pill,* International Herald Tribune, March 1, 2007 (describing how a new drug called ASAQ has entered the global market for less than $1 per day and requires only two pills per day for three days).
[50] *See* Gostin, *Basic Survival Needs, supra* note ___ at 4.
[51] *See, e.g. Flores v. Southern Peru Copper Corp.*, 414 F.3d 233 (2nd Cir. 2003). The United States has not ratified the ICESCR. In the analogous education context, *San Antonio Indep. Sch. Dist. V. Rodriguez*, 411 U.S. 1, 49 (1973), holds that because education is not a fundamental right under the Federal Constitution, Texas school financing plan did not violate rational basis review.

pre-treatment revolution view that courts are incapable of adjudicating economic, social and cultural rights because they lack the institutional capacity to make informed decisions about the methods of implementing such rights.[52] In this context, it is difficult to overstate the importance of rooting the access to medicines debate in the first principles – justiciability among them – provided by the treatment cases.

Desystemization

AIDS has always been associated with prejudice, discrimination and vulnerability. In the early 1990s, Jonathan Mann recognized that combating the disease required the linkage of human rights with public health, two fields that had not previously been connected.[53] Where international human rights are defined narrowly by reference to civil and political rights, individuals may enjoy privacy and protection against abuses of power by government authorities but have little recourse to affirmative goods.[54] "In contrast, public health has historically been defined by state efforts to ensure the conditions under which whole communities may be healthy but the discipline has traditionally diminished the significance of individual claims. While the dichotomy is obvious, one of the signal achievements of the World Health Organization was the reconceptualization of human rights and public health as complementary, not competing values."[55] This understanding emphasized the way that public health can respect the needs of individuals, promote trust

[52] YASH GHAI, Introduction, ECONOMIC, SOCIAL & CULTURAL RIGHTS IN PRACTICE: THE ROLE OF JUDGES IN IMPLEMENTING ECONOMIC, SOCIAL & CULTURAL RIGHTS (2003).
[53] Leonard S. Rubenstein, Foreward, PUBLIC HEALTH & HUMAN RIGHTS: EVIDENCE-BASED APPROACHES, eds. Chris Beyrer and H.F. Pizer (2007).
[54] Gerhard Erasmus, *Socio-Economic Rights and Their Implementation: The Impact of Domestic and International Instruments*, 32 INT'L J. LEGAL INFO 243 (2004).
[55] Novogrodsky, ___; GOSTIN, *supra* note __ , at 65.

between public health personnel and the community, foster conditions of nondiscrimination, and support access to health care and education.[56] As "political and economic forces have structured risk for AIDS, tuberculosis, and, indeed, most other infectious and parasitic diseases,"[57] holistic responses soon accounted for much more than biomedical outcomes.

At the same time, AIDS researchers developed an understanding of the social determinants of health that spread the disease. Experts concluded that the HIV/AIDS pandemic thrives when economic conditions force workers to migrate in search of employment, bringing forms of social fragmentation that loosen family ties and encourage abandonment of traditional sexual mores and taboos.[58] Under Mann's leadership, the WHO publicly identified AIDS as a disease of global poverty because the vast majority of infections are in developing countries. Writing in 1997, Mann noted that, "it [had become] clear that those populations who, before AIDS arrived, were already socially marginalized or stigmatized, became at greatest risk of HIV infection."[59] Mann's conclusions have only been reinforced in subsequent years.[60]

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[56] *Id.* at 43.
[57] Farmer, PATHOLOGIES OF POWER at 30.
[58] EPSTEIN, THE INVISIBLE CURE, *supra* note ___. *See also* Nanu Poku and Fantu Cheru, *The Politics of Poverty and Debt in Africa's AIDS crisis*, XV (6) INT'L REL. 3 (2001).
[59] Jonathan Mann, Afterward to LAWRENCE O. GOSTIN & ZITA LAZZARINI, HUMAN RIGHTS AND PUBLIC HEALTH IN THE AIDS PANDEMIC (1997). *See also* Peter Piot, Executive Director of UNAIDS, "Message from Peter Piot on International Women's Day, March 8, 2003," available at http://data.unaids.org (recognizing that inequality between the sexes and women's lack of power to challenge these inequalities lie at the heart of women's vulnerabilities to HIV).
[60] *See* WHO, Commission on Social Determinants of Health Final Report, available at: http://www.who.int/social_determinants/en/

Of course, HIV poses unique challenges. Other diseases target the very young or old but HIV/AIDS is an equal opportunity killer and has attenuated the class of skilled labor including teachers, doctors, nurses, small business owners, and other members of the urban, managerial and professional elite. Heavily AIDS-impacted countries have lost up to 15 years of life expectancy at birth and have reversed decades of progress.[61] AIDS is also different because of the remarkable efficacy of anti-retroviral drugs.[62] Many observers describe the "Lazarus" effect of ART, which has dramatically reduced rates of morbidity and mortality of infected persons.[63] ART has converted the disease from a death sentence to a manageable, chronic illness.[64]

The collective AIDS jurisprudence is focused on the exceptional aspects of HIV, principally the life-saving capability of ART, not the ways in which the disease functions as a symbol of poverty and deprivation. Predictably, the global case law pivots on the ability of judges to forestall death by ordering treatment, a dynamic which has led to the legal conclusion that interrupting ART constitutes an affront to human dignity. As Lord Nicholls declared in the House of Lords' decision in *N (FC) v. Secretary of State for the Home Department*, "Antiretroviral treatment can be likened to a life support system.

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[61] Alex de Waal, *HIV/AIDS: The Security Issue of a Lifetime*, *in* GLOBAL HEALTH CHALLENGES FOR HUMAN SECURITY 121, 127 (Lincoln Chen, Jennifer Leaning & Vasant Narasimhan eds., 2003).

[62] For the HIV Outpatient Study Investigations, *see* F.J. Palella et al., *Declining morbidity and mortality among patients with advanced human immunodeficiency virus infection*, 338 NEW ENG. J. MED. 853 (1998). Treatment of HIV is therefore biomedically and conceptually different than interventions for many other diseases. There is no single cure for AIDS and scientists have not yet developed a vaccine to guard against infection. Although children cannot be inoculated against AIDS as they are for meningitis, diphtheria and yellow fever, treatment for HIV is highly effective and can lower viral loads to almost undetectable levels.

[63] Laura Bush, Speech at the National Press Club (July 25, 2007), http://www.pepfar.gov/press/89420.htm.

[64] WHO, "Scaling UP Antiretroviral Therapy in Resource-Limited Settings: Treatment Guidelines for a Public Health Approach, 2003 Revision", (WHO Geneva 2004), available at http://www.who.int/3by5/publications/documents/arv_guidelines/en/, at 5. [hereinafter WHO Treatment Guidelines].

Although the effects of terminating treatment are not so immediate, in the longer term they are just as fatal."[65] This reasoning is echoed in *D. v. United Kingdom*, in which the European Court of Human Rights (ECHR) prohibited 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. The ECHR found that deporting D. would amount to inhuman or degrading treatment contrary to Article 3 of the European Convention on Human Rights.[66] Judges, no doubt, are empowered by the ability to save a life with the stroke of a pen. But compelling the clinical provision of ART does little to advance the right to health beyond the recipient of the drugs. While this targeted intervention generates results appropriate for combating HIV it is an individuated achievement and may warp the priorities of health officials in states and communities grappling with multiple challenges.

The institutional response to the threat of AIDS has also been framed by the power of ARVs and a desire on the part of donors and AIDS activists to deliver measurable results. The United Nations has devoted an entire bureau, UNAIDS, to tracking the virus – the only such division of the organization dedicated to a single disease. Total funding for AIDS, most of which goes to treatment, now dwarfs other diseases. In addition, the creation of dedicated funding vehicles, principally the Global Fund to Fight AIDS, Tuberculosis and Malaria ("the Global Fund") and the RED campaign, have focused

[65] *N (FC) v. Secretary of State for the Home Department* [2005] UKHL 31 ¶4.
[66] *D. v. United Kingdom*, Eur. Ct. H.R., 24 E.H.R.R. 423 (1997); *see also, B.B. v. France*, App. No. 30930/96, Eur. Ct. H.R. (1998), in which 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 Article 3.

billions of dollars on turning the tide against the virus.[67] The World Bank, for its part, has begun to fund programs in AIDS-affected communities and has shifted its position from the belief that health improves in tandem with general economic development to the realization that AIDS impedes economic development in the first place.[68]

Sustained attention to HIV is laudable but the fact that funding exists for AIDS but not other diseases produces peculiar distortions. MSF reports that at some HIV clinics in Africa, the organization is seeing people who want healthcare but aren't HIV-positive; plainly uninfected people know that AIDS is their ticket to doctors and medical care. AIDS treatment, it is apparent, is increasingly characterized by institutionalization, not systematization. The infusion of dollars from the Global Fund and PEPFAR to poorer countries has reduced the budgetary burden on states to provide treatment but it may not have made societies appreciably healthier.[69] Moreover, outside of Africa, it is questionable whether AIDS treatment has improved health systems. As Brazil illustrates, public health workers have had difficulty connecting judicially-ordered treatment of HIV with poverty alleviation, maternal health and other solvable health challenges. "AIDS is not a disease living in splendid isolation. AIDS is inextricably tied to other diseases and predicaments. Well over a million people with tuberculosis are also infected with

[67] The Global Fund is a public-private partnership to attract, manage and disburse resources to fight infectious disease. *See* How the Global Fund Works, http://www.theglobalfund.org/en/about/how/. The Global Fund has spent in excess of $7 billion on prevention, care and treatment.

[68] Since 2006, the Bank has also been engaged in a review of its programs to ensure compliance with international human rights law. *See* Ana Palacio, *The Way Forward: Human Rights and the World Bank* DEV. OUTREACH (Oct. 2006 at 35); Robert Danino, *The Legal Aspects of the World Bank's Work on Human Rights: Some Preliminary Thoughts*, HUMAN RIGHTS AND DEVELOPMENT: TOWARD MUTUAL REINFORCEMENT, eds. Philip Alston and Mary Robinson (2005) at 509.

[69] It is important to note that many of the Latin American cases, including the Brazil and El Salvador cases, were decided at a time when ART was prohibitively expensive and required significant budgetary allotments. *See* Hogerzeil et al., *Access to Essential Medicines*, 368 THE LANCET at 306.

HIV."[70] Notwithstanding the rich proposal of Larry Gostin for a Framework Convention on Global Health, the treatment revolution has not been replicated for other diseases.[71]

Ironically, although ART has bettered health outcomes for individuals, AIDS treatment has not improved most public health metrics.[72] Even as AIDS campaigners lobby for more money and decry recession-driven cutbacks, there has been virtually no commonality of purpose with health advocates tackling neglected diseases of the developing world.[73] The Obama Administration has been heavily criticized by AIDS activists for its attempt to broaden PEPFAR's mandate and reallocate funding to other global health concerns.[74] Insofar as vulnerable populations require food security, clean water, education, and economic opportunities – in addition to ART – the global architecture for AIDS addresses only some of those needs.

Incoherence in the case law

A third explanation for the failure to translate the legal success of AIDS may be found in the treatment cases themselves. Several courts have focused on the hybrid quality of rights to life and health implicated by the treatment jurisprudence. Invoking the

[70] Richard Horton, "Among the Orphans," Times Literary Supplement, January 7, 2011.
[71] Gostin conceives of a flexible international health instrument along the lines of the Framework Convention on Tobacco Control that would be augmented over time by specific protocols reflecting more detailed norms, structures and processes. *See* Lawrence O. Gostin, *Meeting Basic Survival Needs of the World's Least Healthy People – Toward a Framework Convention on Global Health*, JAMA, July 11, 2007.
[72] Proponents of sustained funding respond that combating HIV is not an either/or proposition and that the virus has served as an important catalyst for increased health systems support. *See* "Dead Wrong," Speech by Stephen Lewis, 25 January 2008, *available at* http://www.aids-freeworld.org/content/view/107/153/.
[73] *See* Gostin, *Basic Survival Needs*, *supra* note ___ at 4.
[74] *See* Te-Ping Chen, "How Obama Backed Away From the Global War on AIDS," Change.org, July 16, 2010.

constitutionally protected right to life, the Colombian Constitutional Court recognized that receipt of ART can preserve human dignity.[75] The *Ubaque* Court emphasized the fundamental nature of the right to health as a predicate to the rights to life and dignity.[76] The Costa Rican Supreme Court's decision in *Alvarez v. Caja Costarricense de Seguro Social* echoes the sentiment. "In a state of law," the Court reasoned, "the right to life, and in consequence the right to health, receives particular protection. . . . without the right to life all of the other rights are useless. . . ."[77] Even in the direct right to health context presented by *Cruz Bermudez et al. v. Ministerio de Sanidad y Asistencia Social*, the Venezuelan Supreme Court found that the Ministry of Health and Social Action had infringed rights belonging to HIV-positive persons by failing to supply prescribed ART. The Court's decision relied on unspecified international human rights instruments related to rights to health and life as well as the right to health guarantee in the Venezuelan Constitution expressed as a crucial element in the protection of human dignity.[78]

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[75] *See* Protection Writ, *Judgment of Fabio Moron Diaz, Magistrado Ponente*, Constitutional Court of Colombia, Dec. No. T-328/98 (1998) (holding denial of costly antiretroviral treatment prescribed for plaintiff under social security system violates constitutional fundamental right to life), http://bib.minjusticia.gov.co/jurisprudencia/CorteConstitucional/1998/Tutela/T-328-98.htm; *see also Yakye Axa Case*, finding that Paraguay had violated the indigenous community's right to a dignified life and imputing 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.

[76] *Pedro Orlando Ubaque v. Director*, Constitutional Court of Colombia, Dec. No. T-502/94 (1994) (finding that conditions in a prison ward of HIV-positive prisoners violated the prisoners' right to health and dignity in view of their compromised immune systems).

[77] *Alvarez*, *supra* note ___ at Exp. 5778-V-97, No. 5934-97, cited in Yamin, *Not Just a Tragedy*, *supra* note___ at fn.68.

[78] The *Cruz Bermudez* Court's holding also had profound procedural implications. "This ruling meant that the right to health, as interpreted by the Court, had the broadest possible application in Venezuela, giving every HIV positive person in the country the right to access ARV therapies." Mary Ann Torres, *The Human Right to Health, National Courts, and Access to HIV/AIDS Treatment: A Case Study from Venezuela*, 3 CHI. J. INT'L L. 105 (2002).

In the U.S. too, hardly a bastion of judicially recognized health rights,[79] the treatment jurisprudence extends to American prisons in a series of cases alleging inadequate care for HIV-positive inmates in violation of the constitutional prohibition on cruel and unusual punishment.[80] *Montgomery v. Pinchak*, 294 F.3d 492 (3rd Cir. 2002) and *Smith v. Carpenter*, 316 F.3d 178 (2nd Cir. 2003),[81] hold that HIV-positive prisoners have a right to ART and that treatment has become the enforced norm. A recent survey demonstrates that virtually all county, state and federal correctional facilities provide ART as outlined in guidelines set by the National Institute for Health.[82] Thus, in *Brown v. Johnson*, 387 F.3d 1344, 1352 (11th Cir. 2004), the Eleventh Circuit upheld an injunction compelling prison officials to provide proper medical care of HIV-positive inmates based on the finding that defendants were deliberately indifferent to a prisoner's needs, had stopped providing prescribed medications and threatened his life and safety.

Taken together, the treatment cases appear to be grounded in hybrid rights to health and rights to life,[83] individual and collective remedies, and positive and negative rights claims.

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

[80] 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 the South African case of *N and Others v. Government of Republic of South Africa and Others* (No 1) 2006 (6) SA 543 (D) (Westville Prison case) in which the Court found respondents legally and Constitutionally bound to provide adequate medical care to prisoners, including the provision of ART to HIV-positive inmates under Section 35(2)(e) of the Constitution.

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

[82] *See* National Survey of Infectious Diseases in Correctional Facilities: HIV and Sexually Transmitted Diseases at 26, Theodore M. Hammett, Sofia Kennedy and Sarah Kruk, January 19, 2007. *See also Gates v. Fordice*, No. CIV.A. 4:71CV6-JAD, 1999 WL 33537206, at *4 (N.D. Ms. July 19, 1999).

[83] *See e.g.*, *Ceballos v. Instituto de Seguros Sociales*, Constitutional Court of Colombia, Dec. No. T-484 (1992) (requiring the social security institute to provide treatment under principles of non-discrimination and solidarity), http:// bib.minjusticia.gov.co/jurisprudencia/CorteConstitucional/1992/Tutela/T-48492.htm

Like the right to due process, the treatment cases give rise to positive governmental obligations to protect and to fulfill as well as negative obligations to respect,[84]all within a wholly justiciable framework. While acknowledging the significance of the treatment legacy, it is nonetheless possible to identify three case-specific reasons why the jurisprudence has not been invoked in other contexts.

First, the conceptual joinder of the right to life and the right to health represents the blurring of traditional civil and political rights with socio-economic rights. In several discrete contexts, human rights advocates have learned to privilege civil and political rights claims over alternative arguments,[85] a practice that is particularly common in the realm of health law.[86] Some large human rights organizations have adopted the same strategy in the area of social, economic and cultural rights promotion and have self-consciously focused their documentary and shaming efforts on the arbitrary or

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and *Alvarez v. Caja Costarricense de Seguro Social*, Constitutional Court of Costa Rica, Exp. 5778-V-97, no. 5934-97 (1997) ("In a state of law, the right to life, and in consequence the right to health, receives particular protection. . . . without the right to life all of the other rights are useless. . . ."). *See* Yamin, *Not Just a Tragedy*, *supra* note ___ at 341.

[84] *See* Lisa Forman, *Ensuring Reasonable Health: Health Rights, the Judiciary, and South African HIV/AIDS Policy*, 33 J.L. Med. & Ethics 711, 7713 (2005) ("Drawn from international human rights law this typology [in section 27 of the South African Constitution] implies both positive and negative duties with respect to each right…" In Canada, Arbour J. echoed this view by noting that "…any claim that only negative rights are constitutionally recognized is of course patently defective. The rights to vote (section 3), to trial within a reasonable time (s11(b)), to be presumed innocent (s 11(d)), to trial by jury in certain cases (s11(f)), to an interpreter in penal proceedings (s14), and minority language education rights (s 23) to name but some, all impose positive obligations of performance on the state and are therefore best viewed as positive rights (at least in part)." *Gosselin v. Quebec (Attorney General)* [2002] 4 S.C.R. 429. 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. *See* Todres, *supra* note ___at 440.

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

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

discriminatory nature of socio-economic rights deprivations rather than on violations alone.[87] But this tactic only works with some demands. Because the treatment cases rely so heavily on highly effective pills to ensure survival and a minimum quality of life, application to right to health claims that merely alleviate suffering is problematic since it is difficult to equate sustained misery with a clear and present threat to life.[88] In the absence of the health-life admixture of the treatment cases, courts and legislatures may be reluctant to address similar claims on the basis of health protection or demands for education alone. That dynamic also runs the risk of defining socio-economic rights necessary to secure life as hierarchically superior to other socio-economic rights.

The scale of the threat posed by HIV constitutes another point of distinction vis-à-vis other social and economic rights claims. At least two of the leading treatment cases have recognized the risk to human security posed by the HIV/AIDS pandemic. The South African Constitutional Court in *TAC* prefaces its order for the nationwide expansion of PMTCT treatment with the observation that the AIDS pandemic "has claimed millions of lives, inflicting pain and grief, causing fear and uncertainty, and threatening the economy."[89] The same human security consequences are apparent in the Costa Rican Supreme Court judgment in *Alvarez*:

> [I]f it is necessary to put the problem in the cold light of financial imperatives, this Court believes that it would be no less appropriate to ask ourselves how many millions of *colones* [the national currency of

[87] Kenneth Roth, *Defending Economic, Social and Cultural Rights: Practical Considerations Faced by an International Human Rights Organization*, 26 HUM. RTS. Q. 63 (2004).
[88] *See Auton (Guardian ad litem of) v. British Columbia (Attorney General)*, [2004] 3 S.C.R. 657, 2004 SCC 78 (refusing to order the province of British Columbia to fund specialized ABA/IBI treatment within the meaning of "core, physician-funded services" covered by the Canada Health Act).
[89] *TAC*, *supra* note ___ at para. 1.

> Costa Rica] are wasted because ill persons have no possibility of reintegrating themselves into the labor force and contributing, even if in a very small way, to the national wealth. … it seems reasonable to postulate that the country loses more in direct and indirect costs due to the state of incapacity of those who are prostrated by a disease, which alternatively could be invested providing treatment that would permit them to return to a productive life. [90]

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

The greatest strength of the treatment cases – their resolution in domestic courts – provides a third reason why judicial enforcement of non-AIDS cases has been so 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 is governed by a diluted reporting mechanism that lacks any meaningful sanctions, domestic courts addressing health rights and other socioeconomic cases have largely rejected the inclusion of international obligations that might provide a template for the resolution of comparable issues.

In order to develop a concrete legal standard by which to measure state performance in this arena, some socio-economic rights proponents have attempted to locate a "minimum core"[91] content for economic and social rights. Yet what is meant by a minimum core is debatable and several scholars have asked whether the idea is universal or whether it

[90] *Alvarez v. Caja Costarricense de Seguro Social*, Exp. 5778-V-97, No. 5934-97, (Sala Constitucional de la Corte Suprema de Justicia de Costa Rica 1997), *cited in* Yamin, *supra* note __.
[91] *See* U.N. Econ. & Soc. Council [ECOSOC], Comm. On Econ., Soc. & Cultural rights, *Report of the Fifth Session, Supp. No. 3*, Annex III, ¶ 10, U.N. Doc. E/1991/23 (1991) [hereinafter *General Comment No. 3*).

contemplates resource limitations.[92] The Committee on Economic Social and Cultural Rights (the "Committee" or "CESCR"), the group of experts that interprets the ICESCR and issues general comments to guide States Parties, has muddied the waters by "variously equat[ing] the minimum with a presumptive legal entitlement, a nonderogable obligation, and an obligation of strict liability."[93] As a consequence, even the South African Constitutional Court's decision in *TAC* has been condemned for its refusal to embrace the minimum core obligations standard contained in General Comments No. 3 and 14.[94]

How might the international legal regime provide content to social and economic rights fulfillment? One way would be for the CESCR to announce clearly articulated rights for which any violation would amount to a breach of customary international law. Rather than the tepid criticism found in most Committee reports, an unqualified statement that a given state has violated it's citizens human right to inoculations or an elementary school education would offer a useful benchmark.[95] Alternatively, the Committee could provide an economic definition of *available resources* against which state fulfillment of under-enforced rights might be judged. With several notable exceptions, the vast majority of states have ratified the ICESCR which means they are bound by the interpretive

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

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

[94] *See* David Bilchitz, *Towards a Reasonable Approach to the Minimum Core: Laying a Foundation for Future Socio-Economic Rights Jurisprudence*, 19 S. AFR. J. ON HUM. RTS. 1 (2003).

[95] *See* Sital Kalantry, Jocelyn E. Getgen and Steven Arriggh Koh, *Enhancing Enforcement of Economic, Social and Cultural Rights Using Indicators: A Focus on the Right to Education in the ICESCR*, 32 HUMAN RTS. Q. 253 (2010).

comments of the Committee.[96] General Comment No. 14 instructs States Parties to the ICESCR to allocate sufficient budgetary resources to fulfilling the right to health, an admonition that applies equally to other rights.[97] Specifically, States Parties must make "every effort" using "all" available resources to ensure fulfillment of the right.[98] Human rights advocates would benefit from the ability to ask domestic courts and legislatures (whose authority is beyond dispute) to hold states to international standards.

Conclusion

Intuitively, legal actions modeled on the ART jurisprudence are recognizable in a full range of social and economics rights cases including claims to literacy[99] and the right to education, [100] to social services that protect against child abuse, [101] to satisfactory housing[102] and to the redress of degrading working conditions. To the extent that very little of the conceptual translation work has occurred, I submit that overspecialization of the AIDS advocacy community, desystematization and the internal frailties of the treatment cases explain why that is so. There are, however, pockets of progress that point

[96] There are 151 States Parties to the ICESCR.
[97] MATTHEW CRAVEN, THE INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS 114 (1995).
[98] *TAC*, *supra* note ___.
[99] *See Mohini Jain v. State of Karnataka*, (1992) 3 SCC 666; AIR (1992) SC 1858 (India).
[100] *See* Robynn K. Sturm and Julia A. Simon-Kerr, "Justiciability and the Role of Courts in Adequacy Litigation: Preserving the Constitutional Right to Education" (December 6, 2008). *Yale Law School. Yale Law School Student Scholarship Series.* Paper 78, *available at* http://lsr.nellco.org/yale/student/papers/78 (recognizing that while many U.S. state courts have interpreted the education clauses of their state constitutions to guarantee an "adequate" education for all students, since 2005, separation of powers concerns regarding budgetary allotment have drives state courts from this avenue for education reform.)
[101] Claims for the preservation of human dignity could have a future bearing on cases such as *Deshaney v. Winnebago County Social Services Department*, 489 U.S. 189 (1989), in which the United States Supreme Court held that a state's failure to protect a boy who was violently abused by his father over a long period of time did not violate the Due Process Clause of the Fourteenth Amendment of the U.S. Constitution.
[102] This issue was famously explored by Frank Michelman in *The Advent of a Right To Housing: A Current Appraisal*, 5 HARV. CIV. RTS. & CIV. LIB. L. REV. 207 (1970)

to alternative means of enforcing economic, social and cultural rights. Citing Article 13 of the ICESCR and acknowledging that the country was a regional outlier, Colombia's Constitutional Court recently outlawed student tuition fees in public primary schools. In the 2008 Matanz-Riachuelo River Basin Case, the Argentine Supreme Court found the federal government, the Province of Buenos Aires and the City of Buenos Aires liable for environmental damage in the river basin and responsible for restoration and future prevention of additional harm.[103] And in Bolivia, the mass mobilization over the privatization of water sources in Cochabamba demonstrated the power of citizen action in defense of social and economic rights.

To the best of my knowledge, none of these cases or controversies has directly invoked the sociolegal campaign for universal ART. But each of these struggles adopts the discursive framing provided by the treatment legacy and imbues courts and legislatures with the confidence to declare that economic, social and cultural rights are fully enforceable human rights. This task has been aided by the Inter-American Court of Human Rights exercise of jurisdiction over economic, social and cultural rights claims in the form of landmark indigenous rights, social security and human development cases.[104]

Latin America is fertile ground for giving specific content to a category of rights that have frequently been denigrated as mere "hortatory goals, programmatic objectives [and]

[103] In an innovate step, the Supreme Court further instructed the National Ombudsman and the NGOs that participated in the case to form a Chartered Body to exercise control over the clean-up plan.
[104] *See Yakye Axa Indigenous Community v. Paraguay*, Judgment of June 17, 2005, Inter-Am. Ct. H. R. (Ser. C) No. 125, *Five Pensioners v. Peru*, Judgment of Feb. 28, 2003, Inter-Am. Ct. H.R. (Ser C) No. 98 (2003), *Street Children* case ____.

utopian ideals."[105] Notwithstanding the fact that civil law countries are less likely to cite analogous proceedings from other jurisdictions, no region is better situated to begin incorporating the language or standard of international human rights into socioeconomic rights cases because in many Latin American countries, the Constitution enshrines certain social, economic or cultural rights and contains a provision that international treaties enjoy constitutional rank.[106] International human rights instruments, specifically "the American Declaration, the San Salvador Protocol, and the ICESCR—which are viewed as creating binding, legally-enforceable commitments for Latin American states"[107]may then be marshaled as additional support for the normative values contained in domestic Constitutional and statutory law. There is evidence of this practice from Ecuador, where the Court strengthened its interpretation of domestic law by invoking the American Declaration and the San Salvador Protocol. In Costa Rica too, the *Alvarez* Court cited directly to the country's commitments under the ICESCR.[108] In Argentina (despite the fact that there is no right to health in the Constitution) the Constitutional Court invoked the ICESCR in a case involving a threat to the treatment of a child with a potentially fatal

[105] *See* Michael J. Dennis & David P. Stewart, *Justiciability of Economic, Social and Cultural Rights: Should There be an International Complaints Mechanism to Adjudicate the rights to Food, Water, Housing, and Health?*, 98 AM. J. INT'L L. 462 (2004).
[106] *See, e.g.*, *Cruz Bermudez*, *supra* note ___.
[107] Melish, *supra* note __ at n.317.
[108] Courting Rights, *supra* note ___ at __. *See also, N (FC) v. Secretary of State for the Home Department* [2005] UKHL 31(interpreting the United Kingdom's obligations under the European Convention on Human Rights).

blood disease.[109] Lastly, Colombia's *tutela* system provides the continent with a model for challenging social and economic rights deprivation in direct legal actions.[110]

What remains is to galvanize social movements around critical rights demands and to expand the legacy of treatment to protect and promote human rights beyond AIDS.[111] In this respect, the organizing efforts, if not actual litigation, by advocates for effective tuberculosis, malaria and cancer treatment hold the promise of successful future action. The same logic applies to the right to food. Globally, national courts have decided public interest cases in which litigants have asserted the right to adequate nutrition. Indian judges, for example, have ordered the government to provide petitioners with food stocks containing prescribed minimum quantities of protein and daily calories to vulnerable individuals[112]in order to prevent starvation. Like the treatment cases, right to food claims benefit from discrete and effective interventions, domestic law reinforced by international declarations, as well as the institutional assistance of the World Food Programme and the aid policies of donor states.[113] From this perspective, right to water[114] and emergency

[109] *See Campodonico v. Beviacqua, Ana Carina v. Ministerio de Salud Accion Social*, Constitutional Court, File C.823.xxxv (Oct. 24, 2000) (Arg.). *See also* Vicki Jackson, "Engagement with the Transnational" (forthcoming)(observing that the constitutions of Argentina and Colombia seek to achieve convergence between the interpretation of constitutional rights and international human rights law; Argentina does so directly by incorporating human rights treaties into the Constitution).
[110] *See* Julieta Lemaitre and Katherine Young, *The Comparative Fortunes of the Right to Health: Notes from Colombia and South Africa* (on file with author).
[111] See Florian F. Hoffman and Fernando R.N.M. Bentes, *Accountability for Social and Economic Rights in Brazil*, COURTING SOCIAL JUSTICE: JUDICIAL ENFORCEMENT OF SOCIAL AND ECONOMIC RIGHTS IN THE DEVELOPING WORLD (Varun Gauri & Daniel M. Brinks (eds)(2008) 144 (observing that the organized HIV/AIDS movement in Brazil often files demands for new AIDS drugs as they are developed and sometimes before they are certified for distribution in Brazil).
[112] *See People's Union for Civil Liberties v. Union of India* (2001) 5 SCALE 303 and *People's Union for Civil Liberties v. Union of India* (2001) 7 SCALE 484.
[113] Smita Narula, *The Right to Food: Holding Global Actors Accountable Under International Law*, 44 COLUM. J. OF TRANSNAT'L L. 691 (2006)
[114] Ramin Pejan, *The Right to Water: The Road to Justiciability*, 36 GEO. WASH. INT'L L. R. 1181 (2004).

shelter claims, without which millions of lives are immediately imperiled, should also be justiciable.

If nothing else, 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 fulfillment of social and economic rights. The justiciability of demands for ARVs also reflects the power of law to adapt to calamitous realities while providing a principled alternative to charity. Over time, rights observance begets funding and the creation of institutions capable of effecting systemic change. Gorik Ooms' and Rachel Hammonds' have theorized the global response to the HIV/AIDS pandemic as a new paradigm of international health assistance.[115] I read Ooms and Hammonds to argue that the Global Fund is helping to delineate global and national responsibilities for global health challenges while simultaneously developing a framework for social and economic justice.

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 into the legal imagination. For the next generation of rights promoters, it's also a powerful symbol of what once was and still could be.

[115] Gorik Ooms and Rachel Hammonds, *Taking up Daniels' Challenge: The Case for Global Health Justice*, 12 HEALTH & HUMAN RTS, 1 (2010).