1 INTRODUCTION

South Africa faces a most tragic and devastating challenge in the HIV/Aids epidemic.[1] The increasing phenomenon of child infections is a matter of the greatest concern.[2] It is estimated that 24% of pregnant women in this country are HIV positive, and approximately 70 000 children are infected each year through mother-to-child transmission (MTCT) of HIV.[3] MTCT of HIV occurs during pregnancy, during labour and at birth,[4] and through breast-feeding.[5]

However, MTCT of HIV can be significantly reduced and prevented. First, antenatal transmission of HIV can be reduced through the administration of anti-retroviral drugs such as Nevirapine.[6] Second, postnatal transmission of HIV can be prevented by avoiding breast-feeding and adopting exclusive formula feeding under safe and hygienic circumstances.[7] In undesirable or unfavourable circumstances, exclusive formula feeding is effective in preventing breast milk transmission of HIV but also poses other health hazards which can lead to infant mortality. In circumstances where the risks associated with formula milk are higher than the risks associated with postnatal transmission of HIV, exclusive breast-feeding is recommended. While the issue of antenatal transmission of HIV has been addressed in South Africa,[8] postnatal MTCT of HIV continues to pose a monumental challenge, with heated debates raging over the optimal form of feeding for infants whose mothers are HIV positive or who have Aids.[9]

Breast-feeding, although universally renowned as the best source of nutrition for infants in the early stages of life,[10] contributes to a

significant risk of HIV transmission. Although exact figures relating to the risk associated with breast milk transmission of HIV have not yet been established, it is estimated that at least a third to half of all MTCT of HIV is attributed to breast-feeding.[11] The risk of breast milk transmission of HIV becomes higher in situations such as early or advanced stages of the disease, if breast-feeding is of prolonged duration, and due to other maternal factors.[12] Breast milk transmission of HIV poses serious challenges to nutrition and enormous threats to the health care and survival of the child. However, besides its nutritional value, breast milk also provides immunological protection against childhood diseases such as diarrhoea, pneumonia, neonatal sepsis and acute otitis media.[13]

The risk of postnatal transmission undercuts the optimal nutritional status of breast milk. Research continues, but meanwhile two options for infant feeding have been recommended, namely exclusive breast-feeding and exclusive formula feeding. However, they are not without their limitations. Formula feeding is generally discouraged for producing lesser nutrition for infants when compared with breast-feeding.[14] Formula milk is commonly associated with high infant mortality and morbidity rates, especially in poorly resourced settings, thus raising an additional dilemma for the public health system. On the other hand, it has not been ascertained with precision whether these recommended feeding options override one another. Recent studies indicate that in many circumstances both options have produced relatively the same results in terms of child mortality rates.[15] Research is thus still needed to ascertain the benefits and dangers of exclusive breast-feeding.

Breast milk transmission of HIV presents a dilemma for infected mothers who do not have access to a safe and adequate water supply, who do not possess sufficient proper means to sterilise bottles and who cannot afford formula milk. It is restrictive for HIV-infected mothers to adopt formula milk as a breast-milk substitute in such circumstances. Critical in these poor circumstances is the development of policy guidelines aimed at providing directives on the measures that need to be taen to assist HIV-infected women in making a choice about infant feeding. In 1997, a collaborative policy statement[16] was issued which suggested a number of measures, *inter alia*, that an HIV positive mother should be informed of the risks of breast milk transmission and of the infections associated with formula milk in order to make a informed infant feeding choice. If an HIV positive mother has access

to adequate supplies of a breast milk substitute that can be safely prepared, then she should consider artificial (formula) feeding. However, '*assistance must be given to those mothers who choose not to breast-feed and cannot afford feeding alternatives*' (emphasis added).[17] Finally, the policy statement stressed that measures to prevent breast milk transmission should be part of an integrated strategy to reduce MTCT of HIV.

Subsequent policy guidelines further motivated for the provision of directives on infant feeding in HIV environments. In 2000, the conclusions and recommendations of the WHO Technical Consultation[18] reaffirmed the existing policy on supporting both feeding options. It issued a policy statement recommending, *inter alia*, that:

Measures to prevent breast milk transmission should be part of an integrated strategy to reduce mother-to-child transmission of HIV.

1. where formula feeding is acceptable, feasible, affordable, sustainable and safe, avoidance of all breast-feeding by HIV-infected women is recommended; otherwise exclusive breast-feeding is recommended during the first months of life; and
2. when HIV-infected mothers choose not to breast-feed from birth or stop breast-feeding later, they should be provided with specific guidance and support for at least the first two years of the child's life to ensure adequate replacement feeding.

The conclusions reaffirm the recognition of exclusivity in infant feeding and provide directives for assessing the personal circumstances of HIV-infected mothers before they make their decision. Thus, the yardstick for the adoption of one of these measures is that the risks of HIV transmission through breast-feeding must be weighed against the risks of exposure to infant mortality through formula feeding. For example, for HIV-infected women who choose to breast-feed exclusively, the benefits of this choice must outweigh the risks of HIV transmission through breast-feeding. The foregoing conclusion speaks to the counselling aspect of attending to infant feeding in the context of HIV. But beyond counselling, HIV-infected mothers who choose not to breast-feed need to be supported to ensure the sustainability of their choice through, for example, making formula milk available to them for a

reasonable period of time. It is argued that the second conclusion suggests the provision of such support, among other things.

South Africa's endorsement of the exclusivity approach in infant feeding assumes that – correctly so in some instances – HIV-infected women have a real choice to adopt one of the two recommended feeding options after being provided with the necessary information. However, this is not necessarily the case with all HIV-infected women. The right to exercise the choice of infant feeding is denied to those HIV-infected women who – in appropriate and feasible circumstances, and where medically indicated – cannot afford to sustain formula feeding due to their poor economic status. Similarly, those HIV-infected women who live in poor socio-economic conditions may be restricted from adopting the formula feeding route because of the associated spillovers.[19] Thus, it is arguable that only a small privileged group of HIV-infected women really have a choice.

In sum, the above background converges on three interrelated points. First, there are currently two universally recommended infant feeding options, namely exclusive formula milk and exclusive breast-feeding. Second, states should provide counselling and support to HIV-infected mothers to enable them to make an informed choice. Third, if HIV mothers choose not to breast-feed, states should provide support, including providing formula milk with the aim of ensuring the sustainability of breast milk substitutes. It is against these points that we critically assess whether the absence in South Africa of a policy to make formula milk available to all HIV-infected women is in compliance with these recommendations.

2 THE *TREATMENT ACTION CAMPAIGN* JUDGMENT

The case of *Minister of Health and Others v Treatment Action Campaign and Others* (*TAC*) presented a crucial opportunity to address the issue of combating MTCT of HIV. It particularly offered a platform for resolving the issue of whether government has an obligation to provide formula milk in order to prevent the postnatal transmission of HIV. While the *TAC* case's positive outcome – in holding government responsible for making Nevirapine widely accessible for the prevention of antenatal transmission – is welcomed,[20] the Court's failure to make a decision on the provision of formula milk at public

health institutions for preventing postnatal transmission of HIV is disappointing.[21] The Court's reason for not making such a decision was that:

1. the provision of formula feed is not a prerequisite for combating MTCT of HIV;
2. the provision of formula feed raises complex issues particularly where mothers concerned do not have access to clean water or the ability to adopt a bottle-feed regimen because of personal circumstances;
3. evidence presented before the Court was not sufficient to justify provision of formula feed by government on request and without charge in every case;
4. the information collected at the research and training sites would inform future policy development in this regard; and
5. therefore, health professionals should address this matter during counselling.[22]

The ruling does not make it clear whether government is obliged to make formula milk available in order to prevent breast milk transmission of HIV.

This aspect of the ruling not only represents a missed opportunity in maximising the efforts aimed at addressing the issue of MTCT of HIV, but it is also ambiguous in three respects. First, the ruling does not make it clear whether the government has an obligation to make formula milk available in order to prevent breast milk transmission of HIV. Second, even if such an obligation exists, it is not clear to what extent it should be met (immediately or progressively) in light of the fact that children's lives are at stake.[23] Third, if the obligation exists, it is not clear which constitutional provisions would form its basis. This ambiguity exists despite the fact that formula milk has been strongly recommended for preventing MTCT of HIV, while there is no obligation on the state to distribute formula milk to those poor HIV-infected women and their children that are in desperate need of it.

Currently, South Africa does not even have a policy on the provision of formula milk for the purpose of preventing postnatal transmission of HIV, except in relation to research and training sites.[24] Accordingly, people outside these sites do not have access to free formula milk. Given the crucial role it plays in preventing postnatal transmission of HIV, depriving HIV-infected women who opt for formula feed-

ing their babies of access to formula milk has serious implications for child nutrition as well as for the health and survival of affected children. Ironically, current policy guidelines on infant feeding do not dispute the crucial role of formula milk in preventing breast milk transmission of HIV,[25] but only express a concern over socio-economic circumstances under which the use of formula milk is favourable. Therefore, as point of departure, this paper submits that the decision to confine the provision of formula feed to the pilot sites, as well as the absence of a policy to extend its provision beyond the pilot sites, is constitutionally suspect. It is thus argued that the provision of formula milk will assist the state to fulfil its obligation to prevent MTCT of HIV and ensure children's right to survival and development.[26] This obligation is derived from children's right to basic nutrition[27] as read with the right of everyone to have access to health care, including reproductive health care,[28] as contained in the Constitution.[29]

It is important to note that the location of the state obligation to prevent postnatal transmission of HIV under the right to nutrition does not negate the broader implications of the issue on other rights. But this approach is premised on the fact that nutrition plays a pivotal role in infant development – the development and survival of infants largely depends on nutrition. The location of the obligation to prevent postnatal MTCT of HIV arises principally under the right to basic nutrition, and is informed by the critical impact of breast milk transmission on infant's nutrition.

Therefore, while acknowledging the inter-connectedness between the rights from which the obligation can be derived, this paper focuses on the obligation under the right to basic nutrition. It also provides an alternative argument for an obligation on the state to make formula milk available and suggests that the Court's decision in this regard in the *TAC* case is not consistent with the constitutional principles it established in *Grootboom*.

In setting out these obligations, the paper examines the relevant constitutional and international provisions (to the point to which South Africa is bound). It offers a critical analysis of the applicability of the interpretation accorded to children's socio-economic rights thus far in the context of the right to nutrition.

3 THE INTERNATIONAL FRAMEWORK: THE RIGHT TO ADEQUATE NUTRITION

Numerous international instruments provide guidance on the promotion and fulfilment of the right to nutrition. These not only provide a framework for interpreting the right to nutrition, but are also useful in delineating the nature and extent of the obligations on the state in respect of this right. Since this paper focuses primarily on delineating the nature of the state's obligation under the right to nutrition, rather than mere interpretation, particular attention is paid to the relevant provisions encapsulated in selected international instruments to which South Africa is bound.[30]

The Convention on the Rights of the Child (hereafter the CRC) comprises a comprehensive catalogue of legal norms for the protection of the children's rights. The CRC entrenches a number of provisions that guarantee the right to nutrition. According to these provisions, South Africa is obliged to ensure, *inter alia*:

1. that the child enjoys the right *to survival and development* by, for example, taking positive steps to prolong the life of child, including steps *to reduce infant mortality;*[31]
2. that the child enjoys the highest attainable standard of health by taking measures to diminish infant and child mortality, to combat disease [and] malnutrition, including within its primary health care framework, through the provision of *adequate nutritious foods;*[32] and
3. the provision of, in case of need, material assistance and support programmes, particularly with regard to, *inter alia*, *nutrition*[33] (emphasis added).

These provisions exhibit a crosscutting interlinkage between the rights of the child to nutrition, health, survival and development. Article 24 elaborates on this by establishing that the provision of adequate nutritious food is but one means of preventing childhood diseases and child mortality. Article 27 implies that parents who are the primary caregivers for children should receive assistance from the state to, *inter alia*, nourish their children.

As the CRC's pre-eminent guiding principle, sound nutrition is a right because it is in the best interest of the child.[34] Although the CRC

does not expressly state that there is an obligation on the state to make formula milk widely available, it is submitted that formula feed is included in the package of adequate nutritious foods for infants facing possible postnatal transmission of HIV, alongside breast milk and other recommended infant feeds.

While an HIV positive mother is entrusted with the primary duty to determine what is in the best interest of her child, it is submitted that the international obligations converge to one point, namely that South Africa is bound to provide formula feed to prevent postnatal MTCT of HIV and to assist HIV positive mothers to make an informed infant feeding choice.

4 THE CONSTITUTIONAL FRAMEWORK: THE RIGHT TO BASIC NUTRITION

A child's right to basic nutrition is recognised in section 28(1)(c) of the Constitution, together with the rights to shelter, to basic health care and to social services. These rights are collectively known as children's socio-economic rights. The protection and realisation of the right to basic nutrition is fundamental to the enjoyment of many of the other socio-economic rights of children.

As has been indicated above, nutrition plays not only a dietary role in infants, but also it is critical for their health, growth and even survival.[35] Depriving infants of nutrition would necessarily mean violation of their right to health care, development and survival. Basic nutrition denotes a standard of quality and quantity of nourishing substances that are required for the health, survival and development of the child. In the context of infants, such substances include recommended forms of feeds such as breast milk, formula milk, heat treated/ expressed milk, and other complementary foods.

Despite the fundamental nature of the right and its widespread violation, the right to nutrition remains neglected terrain. To date, this right has not been given direct and substantive interpretation.

In delineating the scope of the obligation in respect of the right to nutrition, reference must be made to the existing interpretation of other socio-economic rights of children. Therefore, this paper examines the

obligation of the state under the right to nutrition drawing largely on the Constitutional Court's interpretation of the right of a child to shelter in the *Government of South Africa and Others v Grootboom and Others*[36] (*Grootboom*), which construction was subsequently followed in the *TAC* case.

Although *Grootboom* is highly acclaimed for providing a substantive and novel interpretation of the right of everyone to have access to adequate housing and the ensuing obligations, its children's rights aspect has not gone without criticism.[37] Prior to *Grootboom*, children's socio-economic rights were understood to constitute a direct claim against the state for the provision of services related to children.[38] This understanding was based on the textual reading of the Constitution, namely that children's rights are not qualified by, or subjected, to the progressive realisation and available resources principles set out in the general socio-economic rights provisions.[39] However, the interpretation accorded to children's rights in *Grootboom* implies that they are also subject to these principles.[40] This paper critically examines the applicability of this fledging jurisprudence and poses the following questions:

Prior to Grootboom, children's rights were understood to constitute a direct claim against the state for the provision of services related to children.

1. When does the state incur the responsibility in respect of the right to basic nutrition?
2. Is there a distinction between the right to shelter and basic nutrition in section 28?
3. Does the right to basic nutrition in this case present a freestanding obligation independent of the right of access to sufficient food? In other words, does the obligation to make formula milk available to infants arise from the right of children to basic nutrition or the rights of access to sufficient food and access to health care services?

The position of the Court in the *TAC* case is puzzling. As noted, the Court declined to make a decision, citing complex issues that should be addressed by health professionals. Therefore, in addition to the critical assessment of *Grootboom*, I also examine this question:

4. Should the Court have made a decision on the nature and scope of the state's obligation in respect of making formula milk available for the prevention of MTCT?

4.1 Analysing the applicability of the constitutional jurisprudence on the right to basic nutrition

4.1.1 When does the state incur responsibility in respect of the right to basic nutrition?

In *Grootboom*, the Constitutional Court adopted an interpretive approach to children's socio-economic rights that conflated sections 28(1)(c) and 28(1)(b). According to the Court, these sections must be read together because while the latter:

> *encapsulates the conception of the scope of care that children should receive, the former provides a list of various aspects of care entitlements.*[41]

Following this approach, the Court said that the responsibility to provide services in section 28(1)(c) lies primarily with those parents who can afford them.[42] This does not mean, the Court noted further, that the state incurs no obligation in relation to children who are cared for by their parents. The state is not only enjoined with an obligation to provide services to those children that are abandoned, or removed, or in alternative care away from their families. In addition, the Court mentioned a catalogue of administrative, legislative and programmatic measures that the state could take to meet its responsibility for children who are in the care of their parents, including measures to provide families with food in terms of the general socio-economic rights provisions.[43]

This approach to children's rights was criticised for reducing the rights of children into programmatic and policy measures, and subjecting them to the availability of resources.[44] The approach is confusing in relation to the question of when the state incurs the responsibility in respect of children's rights to, for example, basic nutrition. However, in the *TAC* case, the Court drew back from this approach by emphasising that while the primary obligation to provide basic health care services no doubt rests on those parents who can afford to pay for them, the state is not free from an obligation to those children whose

parents cannot afford health care treatment. The reason is that, the Court noted, these children (and their parents) are mainly dependent on the state to provide access health care services.[45]

As already suggested, the *Grootboom* approach to children's rights is restrictive and ambiguous, and thus problematic in the context of nutrition. First, children would not have to be abandoned, or removed, or be put into an alternative care away from their parents for the state to incur a responsibility in relation to providing nutrition. Second, not even the fulfilment of the right of access to sufficient food would ensure the advancement of the right to nutrition for children in the context of MTCT of HIV.[46] However, as noted above, the *TAC* approach seems to have removed the restrictions and cleared the ambiguity created in *Grootboom*. In applying the *TAC* approach to the present case, it is contended that while the responsibility to provide basic nutrition to the children of HIV-infected parents lies with those parents who can afford to do so, the state is under an obligation to provide basic nutrition to those children whose HIV-infected parents do not have sufficient means to do so. The *TAC* judgment is hailed as a step in the right direction for the realisation of children's socio-economic rights.

The *Grootboom* approach to children's rights is restrictive and ambiguous and this problematic in the context of nutrition.

4.1.2 Where does the state obligation to provide formula milk for the prevention of MTCT of HIV arise?

There is a distinction between the formulation of the right to shelter and the right to basic nutrition. In *Grootboom*, the Court said that the formulation of the right to shelter in the absence of the adjective 'basic' suggests that something more than simple shelter is meant by section 28. In elaborating on this, it said that section 28 'embraces shelter in all its manifestations'.[47] The Court held that the obligation created under section 28(1)(c) can be ascertained only in the context of the rights and obligations created under sections 25(5), 26 and 27 of the Constitution. These provisions impose an obligation to take reasonable legislative and other measures, within the available resources, to

achieve the realisation of the rights entailed in these provisions. There is therefore is an overlap between these provisions and the children's rights clause in section 28. As a result, children's rights do not create separate and independent obligations from their parents' rights.[48]

It is worth noting that the Court took this view based on a concern for the ramifications of holding in favour of the right to shelter of homeless parents with children. This, according to the Court, would have meant that people with children would have a direct and enforceable claim to housing under section 28(1)(c), whereas people without children, but in similar or worse living circumstances, would not have such a claim. In other words, as the Court noted further, 'children will become stepping stones to housing for their parents instead of being valued for who they are' – a situation that would make little sense of 'a carefully constructed constitutional scheme for progressive realisation of the right to adequate housing.'[49]

The undesirable results contemplated in *Grootboom* in enforcing the right to shelter for children and their parents cannot be similarly produced in enforcing the right to basic nutrition.

It is contended that the undesirable results contemplated in *Grootboom* in enforcing the right to shelter for children and their parents cannot be similarly produced in enforcing the right to basic nutrition. The right to nutrition suggests that a child's caregiver must ensure the bare minimum level of nutrition necessary for the child's health, development and survival. In the present case, where infants are at risk of contracting HIV, the relevant nutritional measure in the form of formula milk is intended to provide a nourishing substance for infants only, thereby preventing postnatal MTCT of HIV. Such children would not become stepping-stones to sufficient food for their parents. A carefully constructed constitutional scheme in terms of access to sufficient food would not be affected by realising the right to nutrition, as such a scheme would focus on providing, for example, food security to the population at large, and not necessarily just to infants.

It is concluded that, in the light of *Grootboom* interpretation, there is a distinction between the right to shelter and the right to basic nutrition. The measures to fulfil the right to nutrition exist independently

and separately from those that are intended to fulfil access to sufficient food. Thus, the state's obligation to make formula milk available arises from the right to basic nutrition as read with the right of access to health care services.

4.1.3 Should the Court in TAC *have made a decision on the nature and scope of the state's obligation in respect of the providing formula milk?*

It is contended that the Court should have made a decision on the provision of formula milk. This decision should have followed similar lines to those followed by the Pretoria High Court in the same matter. The lower court ordered government to devise an effective, comprehensive programme to reduce MTCT of HIV, including the provision of voluntary counselling and testing, and where appropriate, Nevirapine or other appropriate medicine and formula milk for feeding, and ordered that the programme be progressively extended to the whole country.[50]

The Court is constitutionally mandated to determine the scope of the obligation that government has in realising the right to basic nutrition.

By simply leaving the matter to the health professionals, the Court confused the medical and legal issues. The Court is constitutionally mandated to determine the scope of the obligation that government has in realising the right to basic nutrition.[51] This is clearly a legal question. For example, the Court declared that Nevirapine should be made available to all HIV-infected women. However, it is not entitled to decide that all HIV positive women *must* receive Nevirapine. Whether a particular woman receives Nevirapine or not depends both on her own choice and on whether it is medically indicated for her specifically. Similarly, the pronouncement that the state should make formula milk available for the purpose of the preventing MTCT of HIV does not necessarily mean that all HIV-infected mothers *must receive* it. Rather, it should be *available* at public institutions for those HIV-infected mothers who choose it after counselling and who cannot afford it through their own means, and also if it is medically indicated for them.[52] Approached in this way, the Court would have avoided meddling in the mothers' choice and also refrained from prescribing to doctors what to give to specific patients.

5 ASSESSING THE STATE'S OBLIGATION TO PROVIDE FORMULA MILK UNDER THE RIGHT OF ACCESS TO HEALTH CARE SERVICES AND AGAINST THE CONSTITUTIONAL PRINCIPLES

Alternatively, providing formula milk for the prevention of postnatal MTCT of HIV would assist the state to comply with its obligation under section 27 of the Constitution – the right to have access to health care services. It could be argued that the Court in the *TAC* case was mistaken in holding for the provision of Nevirapine only, and not formula milk, for the prevention of MTCT of HIV. This is of particular concern in the light of constitutional principles that the Court established in *Grootboom* for determining whether measures taken are reasonable. These principles are as follows:

- there must be a coordinated and comprehensive programme that is capable of facilitating the realisation of the right;[53]
- such a reasonable programme must clearly allocate responsibilities and tasks to the different spheres of government and ensure the availability of financial and human resources;[54]
- a reasonable programme must respond to the urgent needs of those in desperate situations;[55]
- the programme must be reasonable both in formulation and implementation;[56]
- the programme must provide for the progressive realisation of the right – meaning it must allow access to a larger and wider section of the society;[57] and
- in assessing the reasonableness of a measure, the availability of resources will be an important factor.[58]

5.1 Applying the constitutional principles

It is evident that the recommendation of providing formula milk in the HIV feeding environment suggests that it is effective in preventing postnatal MTCT of HIV and is thus appropriate for fulfilling the state's obligation to prevent MTCT of HIV under the right of access to health care services.

5.1.1 A coherent, comprehensive and coordinated policy

The absence of a government policy and the failure of the Court to require government to make formula milk available for the prevention of MTCT of HIV are not consistent with the principle of policy coherence[59] and comprehensiveness, which require that the problem is addressed holistically. As noted, Nevirapine only concerns the prevention of antenatal transmission of HIV, thus leaving the equally important issue of postnatal transmission unresolved. It is submitted that the provision of formula milk for the purpose of preventing postnatal MTCT of HIV should not have been divorced from the measures to address antenatal transmission. Even the international recommendations suggest that measures to prevent breast milk transmission should be part of an integrated strategy to combat MTCT of HIV.[60] Nevirapine and formula milk complement one another in addressing MTCT of HIV.[61] Separating these measures undermines the maximum impact that could be achieved through implementing both measures in favourable circumstances. But even more importantly, separating them simply means that MTCT of HIV will be addressed in a fragmented manner, which is not consistent with the principle of a comprehensive and coherent policy.

The provision of formula milk for preventing postnatal MTCT of HIV should not have been divorced from the measures to address antenatal transmission.

Moreover, the principle of coordination should not be narrowly construed so as just to refer to one department, for example, the Department of Health, and the allocation of responsibilities therein. Rather, it should be extended to encompass integration between all affected government departments. Realising the infant's right to nutrition is impacted on, to a great extent, by poor HIV-infected mothers' lack of access to such other rights as clean and adequate water, sanitation, and other factors related to the hygienic preparation of bottle-feeds.[62] The prevalence of poor socio-economic conditions influenced a political decision not to provide formula milk at state expense and resulted in a delay in developing a policy focusing on the feeding of infants born to HIV-infected mothers. The crosscutting nature of this problem strongly demands coordinated efforts between different departments with the aim of comprehensively addressing MTCT of HIV.

5.1.2 Access by those most desperate and in crisis

The absence of a policy requiring government to make formula milk available is also not consistent with the principle of responding to the urgent needs of those in desperate circumstances. As noted above, recommending formula milk in HIV feeding environments does not necessarily mean that mothers can effectively exercise their right to choose between exclusive breast-feeding and exclusive formula feeding. An HIV positive mother who would like to choose formula feed, whose physical environment is favourable, and for whom formula milk is medically indicated, but who cannot sustain formula feeding through her own means, is effectively denied the right to exercise such a choice and her child is denied the nutrition that could save its life.

A reasonable policy could create a feasible and flexible environment for accessing formula milk by HIV-infected mothers who, after being provided with all the necessary information, finally make an informed choice.

5.1.3 Reasonable formulation and implementation of a policy

In the present case, developing a policy that is reasonable in both its formulation and implementation is important. Reasonableness is a yardstick against which the state would have to measure its action towards realising a right. This principle means that a policy on HIV/Aids and infant feeding should be carefully and reasonably designed and implemented. It should create a feasible and flexible environment for accessing formula milk by HIV-infected mothers who, after being provided with all the necessary information, finally make an informed choice. It must, for example, be made easily accessible to those who choose this form of feeding for a period of at least six months.[63]

However, the reasonable formulation and implementation principle also suggests that a policy should provide preventive safeguards against certain spillovers, such as an increased general use of formula feeding, particularly in non-HIV communities or by women of unknown HIV status, which undermines breast-feeding. Attention should be paid to prevent a range of negative effects associated with the provisioning of free formula milk, such as corruption among nurses, and the recycling and selling of formula milk to increase general food security in households.[64] Thus, the policy must ensure that formula milk is dis-

tributed to the most needy HIV-infected and affected individuals for the purpose of further reducing the likelihood of MTCT of HIV through breast-feeding.[65] At a tertiary level, measures to address the broader socio-economic conditions that limit the choice of formula milk need to be developed. These measures, as pointed out elsewhere, should be aimed at 'responding to household food insecurity, alleviation of poverty, access to social welfare grants care systems for orphans and the provision of clean water to all households'.[66] The adoption of such measures would facilitate an environment in which HIV-infected mothers can effectively exercise a choice between exclusive breast-feeding and exclusive formula feeding.

Though considerable attention has been paid to the side effects of formula milk, little has been revealed on the limitations of exclusive breast-feeding.

Considerable attention has been paid to the side effects of formula milk (even when it is used exclusively). Very little has been revealed on the limitations of exclusive breast-feeding. The extent to which exclusive breast-feeding is more beneficial in preventing postnatal MTCT of HIV is currently not clear. The dilemma presented by breast milk transmission of HIV is twofold. On one hand, breast-feeding is associated with a risk of HIV transmission; on the other, formula milk is associated with a risk of infant mortality and morbidity. Both risks have serious implications for the infant's right to survival. The absence of a policy on the provision of free formula milk seems to suggest that it is preferable to expose an infant to the former risk (MTCT of HIV) than the latter. This point is critical for developing a reasonable policy that will sufficiently deal with infant feeding in the context of HIV.

5.1.4 Availability of resources

As noted above, the provision of free formula at public health institutions raises complex issues, especially in relation to operational costs. Acknowledging this complexity, the Court in *TAC* also pointed out that information collected at the research and training sites will inform policy development.[67] Such information should inform the government of the cost implications of extending access to formula milk beyond these sites.

However, determining the availability of resources should also take into account a number of other factors. First, the significant role and

efficacy of formula milk in favourable HIV feeding environments should be considered.[68] Second, it should consider the resources currently available for providing formula milk. In the *TAC* case it was revealed that there are stocks of formula milk available in some public health institutions but these are not expressly designated for distribution to prevent MTCT of HIV. Third, formula milk is already provided as part of a comprehensive package at the research and training sites in poor resource settings, such as the Eastern Cape. It is unthinkable that government would provide formula milk at these sites if it were concerned with the side effects associated with formula feeding.

Admittedly the distribution of formula is not as simple as the administration of Nevirapine, but nor does it require substantial additional human and institutional capacity. It requires counselling facilities, trained counsellors, provision of ongoing counselling and follow up or monitoring sessions, which the Court pointed out must in any event be in place for the administration of Nevirapine.[69] Once a choice is made to use formula feed, counselling would specifically entail, *inter alia*, providing information on sterilisation and bottle-feeding regimens, and on methods of formula mixing. The prerequisite in this regard is to provide access to formula milk in such a way that it is sufficiently available to those who most need it and who have access to such related resources as adequate water, sanitation, facilities to sterilise bottles and so on. The operational cost of formula milk relates to its provision to the most needy groups, whose living conditions may otherwise be unfavourable for the adoption of bottle-feeding. [70]

While the distribution of formula milk is not as simple as the administration of Nevirapine, nor does it require substantial additional human and institutional capacity.

6 CONCLUSION

The scourge of HIV infection of children through breast-feeding poses serious threats to the universal policy that promotes and protects a culture of breast-feeding. But even more importantly, it has serious implications for the affected children's right to basic nutrition, health care services, development and survival. An urgent policy decision has to be made to curb this scourge and save the children. Cur-

rently, there are two policy options that have been recommended for infant feeding of HIV-infected mothers, namely exclusive breast-feeding and exclusive formula feeding. However, they are not on the same footing in the extent to which all HIV positive mothers can realistically choose to adopt one or other option. While exclusive breast-feeding can be adopted with a fairly minimal support from the state, unfortunately the same cannot be said with regard to exclusive formula feeding. Without a policy intervention that seeks to make formula milk available to HIV positive mothers who choose not to breast-feed, there is effectively no choice to be exercised at all.

As argued in this paper, the absence of such a policy is constitutionally suspect. The provision of formula milk in HIV feeding environments to those who choose not to breast-feed would assist the state to comply with its constitutional obligation to comprehensively prevent MTCT of HIV. Given the effect of breast milk transmission of HIV primarily on child nutrition, this paper has argued that the state's obligation to make formula milk available should be delineated under the right to basic nutrition. Alternatively, this obligation can be derived under the right to have access to health care, taking into account the constitutional principles established in *Grootboom*. The absence of a policy on providing formula milk is disastrous for those infants whose HIV positive mothers choose not to breast-feed, but who cannot afford formula milk without assistance.

Notes

1 Although statistics are in dispute, it is generally estimated that between 4 and 6 million people in South Africa are living with HIV or Aids.

2 It is estimated that approximately 800 000 children under the age of 15 are newly infected with HIV each year. See WHO (1997).

3 See *Treatment Action Campaign and Others v Minister of Health and Others* 2002 (4) BCLR 356 (T) at 359.

4 MTCT of HIV during pregnancy, labour and at birth are referred to as 'antenatal transmission'.

5 Breast milk transmission is interchangeably referred to as 'postnatal transmission'.

6 Nevirapine is described as a fast-acting and widely recommended antiretroviral drug, long used worldwide to reduce MTCT of HIV. It is included in the World Health Organisation Model List of Essential Drugs (as revised in December 1999, s6.4.2). The Medical Control Council

registered it in South Africa in 1998. This registration confirmed its safety and efficacy. For the description of Nevirapine see *Minister of Health and Others v Treatment Action Campaign and Others* (*TAC*), 2002 (10) BLCR 1033 (CC) at 1035 footnote 3. Also see *TAC* para. 12 for an elaborative account of the registration of Nevirapine.

7 In 1997, a joint policy statement on HIV and infant feeding was released which recommended both feeding options, while stressing the importance of breast-feeding in HIV-free feeding environments. See UNAIDS (1997). Following this the United Nations developed two policy guidelines that endorsed the recommendations. See WHO/FRH/NUT/CHD (1998a and 1998b). These policy guidelines emanated from a catalogue of research studies undertaken to elicit the impact of HIV on infant feeding, and seek to influence policy development at the national level. Thus, while South Africa has not developed its own policy, these UN policy guidelines have been incorporated in the existing HIV/Aids policy documents, including Department of Health, 2000a, *HIV/Aids and STDs: Strategic plan for South Africa 2000–2005*, available at <www.gov.za/documents/2000/aidsplan2000.pdf> (accessed: 13 January 2003).

8 In the *TAC* case, *supra* note 6, the Constitutional Court ordered government to extend the provision of Nevirapine to public health hospitals and clinics to give HIV-infected pregnant women access to the drug. This order settled the dispute around whether government had an obligation, under the right of access to health care, to provide Nevirapine to all pregnant HIV-infected women and their babies, and not to confine it to the research and training sites.

9 The Court's failure in *TAC* to reach a decision on government's obligation in providing formula milk to prevent postnatal transmission of HIV has left this component of MTCT unresolved. The details of this aspect of the judgment form the basis of this paper.

10 The general policy directive on infant feeding strongly recommends the promotion and protection of breast-feeding for all women in HIV free environments. See the policy documents referred to in note 7 above. A UNICEF report (1998: 22–23) states that 'breast-feeding combines three fundamentals of sound nutrition – food, health and care – and is the next critical window of nutritional opportunity after pregnancy. Breast milk contains all the nutrients, antibodies, hormones and antioxidants that are pivotal in the promotion of mental and physical development of the child. It is a bulwark against malnutrition and infant mortality' The value of breast-feeding is also set out in WHO/FRH/NUT/CHD (1998a: 8).

11 This estimation is revealed in the South African policy guidelines on HIV and infant feeding. See Department of Health, 2000b, *HIV/Aids policy guideline on feeding of infants of HIV positive mothers*, Pretoria: Government Printer. An African study referred to in the guidelines (p7) indicates that breast-feeding increases the risk of MTCT of HIV by

12–43%. The UN policy guidelines reveal that breast milk transmission increases the risk of HIV infection by at least 15%, and a third of HIV transmissions are attributed to breast-feeding. The duration of breast-feeding is an important factor in determining the risk. See WHO/FRH/NUT/CHD (1998a: 5).

12 WHO/FRH/NUT/CHD (1998a 5–6).

13 Ibid. p9.

14 Breast milk contains all the nutrients, antibodies, hormones and antioxidants an infant needs for mental and physical development (UNICEF 1998: 22).

15 For example, see Rosenburg (2002:129–130).

16 WHO. 1997.

17 I elaborate on this point later when I critically examine the *TAC* judgment against the *Grootboom* principles of an obligation to adopt a comprehensive and coherent policy to reduce or prevent MTCT.

18 See UNFPA/UNICEF/WHO/UNAIDS (2000: 6).

19 Research studies indicate that there are a number of spillover effects associated with the provision of free formula milk. These include the decline in efforts to promote breast-feeding as a result of formula feeding intervention in HIV environments. Also, at some sites where free formula milk is provided, nurses have reported that women are giving some of the formula to their babies' siblings and to other family members. Some free formula is also being sold off in the community. See McCoy (2002: 29–30).

20 The Court declared, *inter alia*, that the government policy was unreasonable and constituted a violation of the obligation engendered by sections 27(1)(a) and 27(2) of the Constitution. According to these sections the state is required to devise and implement, within its available resources, a comprehensive and coordinated programme to realise progressively the rights of pregnant women and their newborn babies to have access to health care services to combat MTCT of HIV. It therefore ordered government to remove the restrictions that prevent Nevirapine from being made widely available at public hospitals and clinics other than the research and training sites. See *TAC, supra* note 6, para. 135. This finding of the Court represents a critical step in addressing the issue of MTCT of HIV in this country. However, it is not the final step: provision of formula milk is also necessary for the prevention of MTCT of HIV.

21 I also critique this aspect of the *TAC* judgment elsewhere. See Khoza (2002: 5–6). Also see Proudlock (2002: 8) who provides an elaborate critique of this aspect of the judgment and analyses its implications for the children's socio-economic rights in general.

22 *TAC, supra* note 6, para. 128.

23 The question is whether the Court's interpretation of the provisions on children's socio-economic rights means that children's rights to basic

nutrition must be progressively realised through reasonable legislative and other measures, within available resources. Other children's rights activists have similarly found the children's right interpretation thus far uncertain. For example, see Proudlock (2002: 8).

24 The government programme on the prevention of MTCT of HIV is implemented in accordance with the *Protocol for providing a comprehensive package of care for the prevention of mother-to-child transmission of HIV in South Africa* (draft version 4) issued by the Department of Health in April 2001. Cf *TAC, supra* note 6, para. 42.

25 Formula milk is recommended as a breast milk substitute in various policy and related documents. These include:
Department of Health (2000a) *supra* note 7.
Department of Health (2000b) *supra* note 11.
Department of Health. 2000c. *HIV/Aids policy guideline on the prevention of mother-to-child HIV transmission and management of HIV positive pregnant women.* Pretoria: Government printer.
Department of Health (2001) *supra* note 24.

26 The right to survival and development is one of the pillars of Convention on the Right of the Child (1989), which South Africa ratified in 1995.

27 Section 28(1)(c).

28 Section 27(1)(a) and 27(2).

29 Constitution of the Republic of South Africa, Act 108 of 1996.

30 The CRC (1989), the African Charter on the Rights and Welfare of the Child (1990), the International Covenant on Economic, Social and Cultural Rights (1966), the Convention on the Elimination of All Forms of Discrimination Against Women (1979). Given its binding nature and leading protective legal norms in respect of children, this paper particularly focuses on the CRC.

31 Article 6.

32 Article 24.

33 Article 27.

34 UNICEF (1998: 21).

35 See note 10 above.

36 *Government of South Africa and Others v Grootboom and Others* 2000 (11) BCLR 1169 (CC) *(Grootboom).*

37 See Sloth-Nielsen (2001: 229–230). In criticizing the judgment, Sloth-Neilsen observes that what is left for children's socio-economic rights post-*Grootboom* 'could be a fallback position premised on the role of the state as primary providers to children without families'.

38 See Brand (2000: 9–10).

39 Sections that embody qualifications are 25(5), 26(2), 27(2) and 29(2).

40 See *Grootboom*, *supra* note 36, paras. 74 and 78.

41 *Ibid.* para. 76.

42 *Ibid.* para. 77.

43 *Ibid.* para. 78.

44 See note 39 above.
45 *TAC, supra* note 6, paras. 77–79.
46 The Court pointed out that the state is obliged to fulfil children's rights under the general socio-economic rights provisions. According to these provisions, the state would be obliged to provide families with, *inter alia*, access to sufficient food on a programmatic and coordinated basis, subject to available resources. See *Grootboom, supra* note 36, para. 78. I distinguish below between the right to basic nutrition and the right to sufficient food.
47 *Grootboom, supra* note 36, para. 73.
48 *Ibid*. para. 74.
49 *Ibid*. para. 71.
50 For an order granted by a lower court, see *Treatment Action Campaign and Other v Minister of Health and Others,* 2002 (4) BCLR 356, at 386–387.
51 Even the Court itself confirms this mandate in the *TAC* judgment. See *TAC, supra* note 6, para. 99.
52 As mentioned above, such a measure is in conformity with the international policy on HIV and infant feeding as developed by the United Nations.
53 *Grootboom, supra* note 36, para. 40.
54 *Ibid*. para. 39.
55 *Ibid*. para. 43–44.
56 *Ibid*. para. 42.
57 *Ibid*. para. 45.
58 *Ibid*. para. 46.
59 *Ibid*. para. 41.
60 UNICEF (1998: 30).
61 Formula milk is strongly recommended if the anti-retroviral therapy is given during pregnancy for the prevention of MTCT of HIV. See Department of Health, 2000b: 21 *supra* note 11.
62 Given the multi-sectoral dimension of the problem, the Department of Health is not solely responsible for developing measures for infant feeding in the context of HIV. The Departments of Water Affairs, Social Developments, Agriculture and Finance, to mention a few, could well be enjoined with the responsibility to assist in resolving the issue.
63 This point is made in McCoy (2002: 41).
64 *Ibid*. p30.
65 Although provision of Nevirapine would be the primary means of reducing MTCT of HIV, if the ultimate objective is to save the lives of children by whatever means then the distribution of formula milk, where medically and socio-economically appropriate, should include both those who received Nevirapine and those who, for whatever reason, did not receive the drug.
66 McCoy (2002:21).

67 *TAC, supra* note 6, para. 128.

68 Essentially, the recommendation that formula milk should be used in HIV feeding environments is evident of its efficacy. See the discussion above on the recommendations.

69 *TAC, supra* note 6, para. 135 at 3(c) and (d).

70 This contention does not intend to perpetuate discrimination in the provision of health care services on the grounds of socio-economic status. However, it emphasises that the primary issue is to open access to one of the tools most needed for saving lives. Access to others should be progressively realised, as a matter of urgency. This should not bar less advantaged groups, whose access would still be dealt with on a case-by-case basis.

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