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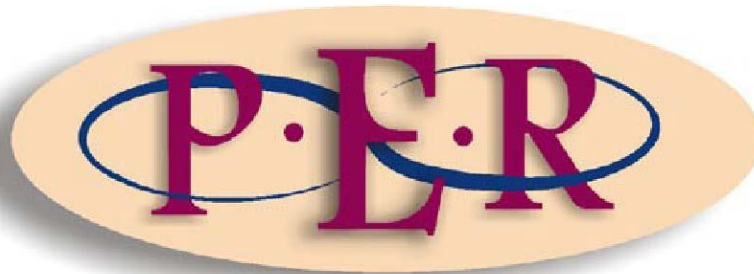

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A HUMAN RIGHTS-BASED APPROACH TO POVERTY REDUCTION: THE ROLE OF THE RIGHT OF ACCESS TO MEDICINE AS AN ELEMENT OF THE RIGHT OF ACCESS TO HEALTH CARE

Z Strauss*

D Horsten**

1 Introduction

> Poverty is the main reason [that] babies are not vaccinated, clean water and sanitation are not provided, curative drugs and other treatments are unavailable, and [that] mothers die in childbirth...[1]

The prevention and treatment of infectious diseases remain one of the greatest challenges faced by today's developing countries. Although they can be treated relatively easily, a significant portion of the world's population does not have sufficient or any access to the essential[2] and life-saving medicines that are necessary to do so.[3] The World Health Organisation (WHO) estimates that about one-third of the world's population lacks access to essential medicine[4] and that the HIV/AIDS pandemic has worsened this problem.[5] This is especially true for poor and otherwise vulnerable communities, where the lack of or inadequate access to these essential medicines compounds the effects of untreated infectious diseases, leading to preventable deaths and human suffering.[6] This, according to the United Nations (UN), directly contradicts the fundamental principle of health as a human right.[7]

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1 Spicker *et al Poverty* 91.

2 For a discussion on essential medicines, see s 3 below.

3 Leach and Paluzzi *et al* 2005 http://www.bit.ly/10WIxd9.

4 Especially in the poorest parts of Africa and Asia. See Bale *Consumption and Trade in Off-Patented Medicines* 2.

5 Chirwa 2003 *SAJHR* 542.

6 Leach and Paluzzi *et al* 2005 http://www.bit.ly/10WIxd9 24.

7 Leach and *Paluzzi et al* 2005 http://www.bit.ly/10WIxd9 24.

According to the World Summit for Social Development,[8] poor health and illness are factors that contribute to poverty while the adverse effects of illness are among the major reasons that the poor become poorer.[9] A lack of access to health care (including access to medicines), amongst other rights,[10] aggravates poverty, and because the financial resources of affected families are exhausted by the burden of HIV/AIDS and other infectious deceases[11] they inevitably slide even deeper into poverty.[12] Poverty is thus more than just the lack of that which is necessary for material welfare.[13] It also includes the refusal of the opportunities and choices essential to human development as well as the right to live a long and healthy life and to maintain a proper standard of living.[14]

In this article it will be argued that adequate access to essential medicines, as an element of the right of access to health care, can contribute to the reduction of poverty. This will be done firstly by discussing the human rights-based approach to poverty reduction,[15] whereafter attention will be turned to access to medicines as an element of the right to health. Lastly, the role of access to medicines in reducing poverty will be discussed, followed by the authors' conclusions.

2 A human rights-based approach to reducing poverty

If the internationally recognised human rights in their entirety had been fully implemented, poverty would not have existed.[16]

Section 1 above allows the inference to be drawn that there is a causal link between the lack of access to essential medicines and inadequate fulfilment or non-fulfilment

8 *Copenhagen Programme of Action* (1995) ch 2 para 19.
9 Benzeval *et al* "Relationships between Health, Income and Poverty" 78; *Spicker et al Poverty* 91; Van Genugten and Perez-Bustillo "Human Rights as a Source of Inspiration" 185.
10 A lack of access to sufficient housing, clean drinking water, food and education also contributes to poverty.
11 Such as tuberculosis, pneumonia, acute respiratory infections, malaria, diabetes and hypertension. See Leach and Paluzzi *et al* 2005 http://www.bit.ly/10WIxd9 24.
12 Watkinson *Right to Food* xv.
13 Gordon "Promotion of Economic, Social and Cultural Rights" 66.
14 Gordon "Promotion of Economic, Social and Cultural Rights" 66.
15 The fact that the right to health is a human right should be borne in mind throughout this discussion.
16 Eide "Human Rights and the Elimination of Poverty" 118.

of the right of access to health care.[17] What follows is a discussion, firstly clarifying the reason that the concept of poverty reduction is preferable to that of poverty alleviation, after which the multidimensional character of poverty and the human rights-based approach to poverty reduction will be set out. Finally, the link between poverty and human rights will be elaborated upon.

2.1 Poverty reduction versus poverty alleviation and poverty eradication

According to Mubangizi,[18] a variety of different concepts can be used to refer to activities aimed at fighting poverty: poverty reduction, poverty alleviation,[19] poverty relief[20] and the eradication of poverty.[21] However, in the light of the shortcomings of some of these concepts, poverty reduction is the most suitable concept to use.[22] Poverty reduction can be defined as the process through which the causes of deprivation and injustice are addressed by considering the level, degree, size and extent of the poverty and then attempting to reduce it.[23] Poverty reduction, which can be seen as the key to working towards the unattainable goal of eradicating poverty, stands in contraposition with poverty alleviation, which only temporarily addresses the symptoms of poverty. In this regard poverty reduction is not only a more realistic concept to which to subscribe, but is also more measurable and attainable.

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17 This link will be elaborated upon in s 3 below.

18 This distinction is based on Mubangizi 2005 *SAJHR* 34-35.

19 Poverty alleviation refers to public and private conduct aimed at addressing the lack of food, shelter, water and other basic necessities of life that enable people to function meaningfully in society. These basic necessities of life naturally include the right to health and consequently access to medicines. However, this term is immeasurable and implies that poverty can be made more tolerable or that the suffering of the poor can be made less serious. See Mubangizi 2005 *SAJHR* 34.

20 Poverty relief can be seen as a form of help and support afforded to the poor, when in urgent need, (usually after a natural disaster) and as such can be seen as an *ad hoc* measure falling under the ambit of disaster control. See Mubangizi 2005 *SAJHR* 34.

21 The eradication of poverty, on the other hand, creates the impression that poverty can be done away with in its entirety. Although this is the ideal goal of all activities aimed at the reduction of poverty, it is unrealistic, over ambitious and unattainable as it implies the total elimination of poverty by removing all of its causes. Mubangizi 2005 *SAJHR* 34-35 also points out that, although these terms do not have the same meaning, they are often used in the alternative and in a confusing manner.

22 The shortcomings referred to can be found in n 19-21 above.

23 Mubangizi 2005 *SAJHR* 35.

Poverty is so deeply rooted in most communities that it is unrealistic to assume that it can be utterly eradicated.[24] As is the case with the realisation of human rights, poverty reduction cannot be achieved immediately,[25] but is a progressive process that needs to go hand in hand with the setting of intermediary and final goals.[26] In order to understand the link between access to health care, including essential medicines, and poverty reduction, it is thus imperative to take cognisance of the progressive nature of both the realisation of human rights and poverty reduction. Both must be measurable in order to determine whether or not adequate access to medicines indeed has an impact on poverty reduction.

2.2 A human rights-based approach to poverty

Defining poverty is no easy task.[27] The common denominator in most definitions is economic deprivation or a lack of income.[28] However, these economic definitions of poverty neglect to take into account the variety of social, cultural and political aspects thereof.[29] A successful definition must consider both aspects.[30] Such a definition must focus on the non-fulfilment of human rights without uncoupling it from a lack of economic resources.[31] Poverty is thus multidimensional in nature and for the purposes of this article cannot be defined as the mere lack of sufficient income. Consequently, a multidimensional approach to poverty will be followed. According to this approach, the non-fulfilment of human rights is inseparably part of a lack of command over economic resources, but is not exclusively limited thereto.[32]

24 UNHCHR 2002 http://www.bit.ly/13KMkyd guideline 4 para 62 (henceforth UNHCHR *Human Rights Approach to Poverty Reduction Strategies*).
25 UNHCHR *Human Rights Approach to Poverty Reduction Strategies* guideline 4 para 62.
26 UNHCHR *Human Rights Approach to Poverty Reduction Strategies* guideline 4 para 68.
27 In this regard see Spicker "Rights of the Poor" 3-6. See also UNCESCR 2001 http://bit.ly/14XesI1 (*Poverty and the ICESCR)* para 8 where it is stated that no universal definition for poverty exists. See also Matunhu 2008 *Tamara Journal* 201, who argues that poverty consists of experiencing scarcity and need at a specific time and place under specific circumstances.
28 UNHCHR Date Unknown http://bit.ly/13lG5t9. See also Osmani 2005 *Journal of Human Development* 207; Sen *Commodities and Capabilities* 1-3.
29 UNHCHR Date Unknown http://bit.ly/13lG5t9. See also Sen *Commodities and Capabilities* 1-3.
30 UNHCHR 2004 http://www.bit.ly/12QqIdr 6 (henceforth UNHCHR *Human Rights and Poverty Reduction: A Conceptual Framework*).
31 UNHCHR *Human Rights and Poverty Reduction: A Conceptual Framework* 6. In this regard see also Salomon *Global Responsibility for Human Rights* 48.
32 UNHCHR *Human Rights and Poverty Reduction: A Conceptual Framework* 8.

According to the UN, the aforementioned multidimensional character of poverty is satisfactorily contained in Sen's capability approach.[33] This approach defines poverty as the absence or inadequate fulfilment of the basic freedom to avoid illness, for instance.[34] The extent to which a person is free to pursue good health or is free to avoid ill-health indicates the person's level of well-being.[35] The poor, however, have limited opportunities to pursue well-being, making this the defining characteristic of poverty.[36] Capabilities in this regard, refer to a person's ability in the form of freedoms and opportunities to achieve such well-being,[37] making poverty a person's lack of ability to achieve well-being through the pursuit of good health or the avoidance of illness.[38]

According to the capability approach, poverty is indicative of extreme deprivation. Therefore, only a lack of those capabilities that can be classified as basic will amount to poverty.[39] However, communities have different priorities, resulting in different communities classifying different capabilities as basic.[40] The UN points out that it is possible to identify certain basic capabilities common to all communities. Amongst these are health and avoiding preventable morbidity, both of which can be assisted by the provision of access to essential medicines.[41]

33 UNHCHR *Human Rights and Poverty Reduction: A Conceptual Framework* 6.

34 In this regard, freedom is interpreted broadly and as such includes both positive and negative freedoms. UNHCHR *Human Rights and Poverty Reduction: A Conceptual Framework* 9. It is this aspect of the capability approach that makes it a suitable conceptual basis for human rights. Human rights need to be respected, protected and fulfilled, all of which implies respect for freedoms. Human rights obligations and the capabilities approach thus focus on the same freedoms. In this regard see Osmani 2005 *Journal of Human Development* 213-214.

35 UNHCHR *Human Rights and Poverty Reduction: A Conceptual Framework* 6.

36 UNHCHR *Human Rights and Poverty Reduction: A Conceptual Framework* 6-7.

37 UNHCHR *Human Rights and Poverty Reduction: A Conceptual Framework* 6.

38 UNHCHR *Human Rights and Poverty Reduction: A Conceptual Framework* 6

39 UNHCHR *Human Rights and Poverty Reduction: A Conceptual Framework* 7; UNHCHR *Human Rights Approach to Poverty Reduction Strategies* para 46. See also Osmani 2005 *Journal of Human Development* 214.

40 UNHCHR *Human Rights and Poverty Reduction: A Conceptual Framework* 7. See also Osmani 2005 *Journal of Human Development* 214; Sen 2004 *Feminist Economics* 77-80; Sen 2005 *Journal of Human Development* 158.

41 UNHCHR *Human Rights and Poverty Reduction: A Conceptual Framework* 7. See also Sen 2004 *Feminist Economics* 77-80; Sen 2005 *Journal of Human Development* 158-159.

Furthermore, according to the capability approach, a lack of command over economic resources plays an important role in defining poverty as it is helpful in distinguishing between poverty and a general low level of well-being.[42] Although poverty has an economic connotation, insufficient income is not the relevant concept. The broader concept of a lack of command over economic resources, however, is.[43] Insufficient income is only one possible cause of a lack of command over economic resources.[44] Other causes include a lack of command over public goods and services,[45] inadequate access to communally owned and managed resources and inadequate control over resources made available through formal and informal networks of mutual support.[46] Poverty will result if inadequate command over any of these resources plays a role in the deterioration of basic capabilities.[47]

Where the capabilities approach defines poverty as the absence or inadequate fulfilment of basic freedoms or basic capabilities enabling people to pursue well-being, the human rights-based approach to poverty argues that people have an inalienable right to these basic capabilities.[48] In the human rights-based approach, poverty is thus defined as the inadequate fulfilment of a person's human right to basic capabilities.[49] This approach interprets poverty broadly as the absence of the basic capabilities needed to live a dignified life.[50] Thus, poverty is not only a lack of income or economic and material resources; it is an infringement on human dignity and also on human rights.[51] A human rights-based definition of poverty can lead to a more suitable reaction to the many facets of poverty while paying attention to the

42 This distinction is of importance as poverty implies a low level of well-being, but not all low levels of well-being amount to poverty. UNHCHR *Human Rights and Poverty Reduction: A Conceptual Framework* 7. See also Osmani 2005 *Journal of Human Development* 214-215; Sen *Inequality Re-examined* 110-111.

43 UNHCHR *Human Rights and Poverty Reduction: A Conceptual Framework* 8.

44 UNHCHR *Human Rights and Poverty Reduction: A Conceptual Framework* 8.

45 Such as essential medicines.

46 UNHCHR *Human Rights and Poverty Reduction: A Conceptual Framework* 8. See also Osmani 2005 *Journal of Human Development* 214.

47 UNHCHR *Human Rights and Poverty Reduction: A Conceptual Framework* 8.

48 UNHCHR *Human Rights and Poverty Reduction: A Conceptual Framework* 6-7, 9. In this regard also see Salomon *Global Responsibility for Human Rights* 48.

49 UNHCHR *Human Rights and Poverty Reduction: A Conceptual Framework* 9-10.

50 UNCESCR *Poverty and the ICESCR* para 7.

51 UNHCHR Date Unknown http://www.bit.ly/13lG5t9.

vulnerability and daily infringements of human dignity that are coupled with poverty.[52]

The United Nations Committee on Economic, Social and Cultural Rights (CESCR)[53] defines poverty in the light of the International Bill of Rights[54] by stating that poverty may be defined as a human condition characterised by sustained or chronic deprivation of the resources, capabilities, choices, security, and power necessary for the enjoyment of an adequate standard of living and other civil, cultural, economic, political and social rights. This definition of poverty is also recognised by the European Union, the World Bank and the United Nations Development Programme.[55] This definition is regarded as the most comprehensive and rights-sensitive definition of poverty to date.[56]

Because poverty is the inadequate fulfilment of a person's human right to basic capabilities, this can be seen as the defining characteristic of poverty.[57] It has already been said above that health has been identified as a basic capability common to all communities.[58] Therefore, the conclusion can be drawn that if a person experiences inadequate or non-fulfilment of the right of access to health (and essential medicines as a component of this right), such a person will be classified as poor and experiencing a low level of well-being, in as far as these inadequacies have led to a lack of command over the necessary economic resources.[59]

52 UNHCHR Date Unknown http://www.bit.ly/13lG5t9.
53 The CESCR regards this definition as a multidimensional notion of poverty which reflects the indivisibility and interdependence of all human rights. See UNCESCR *Poverty and the ICESCR* para 8.
54 The *United Nations Universal Declaration of Human Rights* (1948) (UDHR), adopted by the General Assembly Resolution 217A (III) of 10 December 1948, the *United Nations International Covenant on Civil and Political Rights* (1966) (ICCPR), adopted by the General Assembly Resolution 2200A (XXI) and the *United Nations International Covenant on Economic, Social and Cultural Rights* (1966) (ICESCR), adopted by the General Assembly Resolution 2200A (XXI) of 16 December 1966, collectively make up the International Bill of Rights.
55 Kulindwa and Lein "Water and Poverty" 1-2.
56 Kulindwa and Lein "Water and Poverty" 1; and Mubangizi 2005 *SAJHR* 34.
57 UNHCHR *Human Rights Approach to Poverty Reduction Strategies* para 45.
58 See s 1 above.
59 It can be noted that the health of not all who receive health care and essential medicines will reach a level enabling them to pursue a higher level of well-being, thus reducing the level of poverty experienced. In this regard it is important to distinguish between people who are ill due to the non-fulfilment or inadequate fulfilment of their right of access to health care and essential

2.3 Poverty and human rights

> ...Poverty reduction and human rights are not two projects, but two mutually reinforcing approaches to the same project.[60]

Vulnerability sets in when there is an absence of one or more of the capabilities needed for the fulfilment of basic obligations and the enjoyment of fundamental rights.[61] The lack of security that results from these circumstances will, with time, lead to chronic poverty, which will have a seriously detrimental effect on the ability to pursue these rights in the foreseeable future.[62] One of the central ideas behind the human rights-based approach to poverty reduction is that:

> ...poverty reduction no longer derives merely from the fact that the poor have needs but also from the fact that they have rights – entitlements that give rise to legal obligations on the part of others. Poverty reduction then becomes more than charity, more than a moral obligation – it becomes a legal obligation.[63]

As the social phenomenon that probably has the largest detrimental effect on human rights, poverty will not be eradicated without the fulfilment of human rights.[64] There exists a further dual theoretical justification behind the link between human rights and poverty.[65] Poverty in itself is seen as a denial of human rights, while the inadequate or non-fulfilment of human rights causes poverty.[66] According to the

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medicines, and those who are ill due to an incurable disease. Although both categories experience a low level of well-being, only the first category will be classified as poor, if a lack of command over economic resources played a role in the causal chain of events leading up to the low level of well-being. The second category of people will remain ill, irrespective of the fulfilment or non-fulfilment of their right to access to health care and essential medicines. Furthermore, factors such as training, education and the economic climate, also play a role in a person's ability to pursue a higher level of well-being. If any one of these factors has a detrimental effect on a person's capabilities, poverty will result, irrespective of whether or not their right of access to health care and essential medicines has been fulfilled. UNHCHR *Human Rights and Poverty Reduction: A Conceptual Framework* 7-8; UNHCHR *Human Rights Approach to Poverty Reduction Strategies* guideline 7 para 114.

60 UNHCHR *Human Rights and Poverty Reduction: A Conceptual Framework* 3.

61 Ochoa "Poverty and Human Rights" 59.

62 Ochoa "Poverty and Human Rights" 59.

63 Spicker *et al Poverty* 95.

64 Mubangizi 2005 *SAJHR* 32. See also Van Genugten and Perez-Bustillo "Human Rights as a Source of Inspiration" 201; Ochoa "Poverty and Human Rights" 60; UNHCHR *Human Rights Approach to Poverty Reduction Strategies,* in terms of which the denial of human rights is inherent in poverty. See also Pieterse 2008 *Journal of Law and Society* 379 where it is argued that socio-economic rights give the poor an opportunity to insist that the state pay attention to their needs.

65 Osmani 2005 *Journal of Human Development* 206. See also Mubangizi 2005 *SAJHR* 36.

66 Osmani 2005 *Journal of Human Development* 206. See also Mubangizi 2005 *SAJHR* 36.

CESCR,[67] anti-poverty policies will be more effective, sustainable and meaningful to the poor if they are based on international human rights. Furthermore, the International Bill of Rights contains provisions that are directly relevant to the reduction of poverty.[68] Various articles contained in the ICESCR are relevant to poverty and can even be seen as synonymous with aspects of poverty.[69] Similar provisions can also be found in the *United Nations Convention on the Elimination of All Forms of Racial Discrimination* (CERD),[70] the *United Nations Convention on the Elimination of all forms of Discrimination Against Women* (CEDAW),[71] the *United Nations Convention on the Rights of the Child* (CRC)[72] and the *United Nations International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families*.[73]

The development of concepts that link poverty to a lack of rights, has led to more attention being paid to human rights-based approaches as a means to ensure basic security and poverty reduction.[74] By viewing poverty as the denial of human rights, the focus is moved away from poverty reduction as an issue exclusive to economic development towards the rights and obligations entrenched within the formal legal system.[75] In the context of human rights, poverty is thus no longer seen as a social problem but rather as an infringement on human rights, where relationships

67 See UNCESCR *Poverty and the ICESCR* para 13.

68 In this regard see for example aa 16, 25 and 26 of the ICCPR, a 12 of the ICESCR and a 25 of the UDHR.

69 Van Genugten "Use of Human Rights Instruments" 102. See also Salomon *Global Responsibility for Human Rights* 48.

70 See the *United Nations Convention on the Elimination of All Forms of Racial Discrimination* (1969) (CERD) adopted by the General Assembly Resolution 2106 (XX) of 21 December 1965, a 5(e)(iv) which protects the right to public health.

71 See the *Convention on the Elimination of All Forms of Discrimination Against Women* (1981) (CEDAW) adopted by the General Assembly Resolution 34/180 UN Doc A/34/46, aa 10(h), 11(f), 14(2)(b) and particularly a 12, which requires of States Parties to take all appropriate measures to eliminate discrimination against women in the field of health care.

72 See the *Convention on the Rights of the Child* (1990) (CRC) adopted by the General Assembly Resolution 44/25 of 20 November 1989, aa 3(3), 17, 23, 25, 32, 39 and particularly a 24, which places States Parties under an obligation to strive to ensure that no child is deprived of his or her right of access to health care services.

73 See *United Nations International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families* (2003) adopted by the General Assembly Resolution 45/158 of 18 December 1990 aa 25(1)(a), 28, 43(1)(e), 45(1)(c) and 70.

74 Spicker *et al Poverty* 94-95.

75 Spicker *et al Poverty* 95.

characterised by dominance and control deprive people of the fulfilment of their basic human rights.[76]

This link between poverty and human rights has been acknowledged and promoted by the UN by it granting the High Commissioner for Human Rights the mandate to formulate guidelines for the integration of human rights into poverty reduction strategies.[77] These guidelines acknowledge that a human rights-based approach to poverty reduction entails that policies and institutions attempting to reduce poverty are based on the norms and values of international human rights.[78] This approach links poverty reduction to rights and obligations.

The eighteen guidelines can be divided into three sections: section one sets out the basic principles that need to be considered when formulating poverty reduction strategies in terms of a human rights-based approach.[79] Section two sets out the human rights approach according to which the content of a poverty reduction strategy can be determined.[80] In this section, the main elements that ought to be included into strategies aimed at fulfilling each human right relevant to poverty reduction are identified.[81] Lastly, section three explains how the human rights approach can lead to monitoring and accountability as aspects of poverty reduction strategies.[82]

There is no doubt that these guidelines address complex issues which are of the utmost importance for the relationship between poverty and human rights.[83]

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76 Spicker *et al Poverty* 95.

77 UNHCHR *Human Rights and Poverty Reduction: A Conceptual Framework* 35; UNHCHR *Human Rights Approach to Poverty Reduction Strategies* para 1.

78 UNHCHR *Human Rights Approach to Poverty Reduction Strategies* para 3.

79 UNHCHR *Human Rights and Poverty Reduction: A Conceptual Framework* 36; UNHCHR *Human Rights Approach to Poverty Reduction Strategies* guidelines 1-5.

80 UNHCHR *Human Rights and Poverty Reduction: A Conceptual Framework* 36; UNHCHR *Human Rights Approach to Poverty Reduction Strategies* 18.

81 UNHCHR *Human Rights and Poverty Reduction: A Conceptual Framework* 36; UNHCHR *Human Rights Approach to Poverty Reduction Strategies* guidelines 6-15.

82 UNHCHR *Human Rights and Poverty Reduction: A Conceptual Framework* 36; UNHCHR *Human Rights Approach to Poverty Reduction Strategies* guidelines 16-18.

83 Including the right to health. Mubangizi 2005 *SAJHR* 38; UNHCHR *Human Rights Approach to Poverty Reduction Strategies* para 42.

3 Access to essential medicines as an element of the right to health

3.1 The ICESCR

Article 12 of the ICESCR is considered the most important international law provision relating to the right to health.[84] The rights contained in this document have been the subject of several high-profile and authoritative attempts at norm clarification.[85] The UNCESCR, in *General Comment 14*[86] on the content of the right to health as enshrined in article 12 of the ICESCR, emphasises that the phrase "right to health" should not be read as implying a right to be healthy, since one's health status is influenced by various personal and environmental factors. Instead, the right may best be understood as encompassing a package of interrelated and mutually supporting rights that operate jointly to enable the achievement of the highest attainable standard of physical and mental health.[87]

While article 12(1)[88] of the ICESCR provides a broad formulation of the right to health in international law, article 12(2)[89] proceeds to prescribe a non-exhaustive list of steps to be taken in pursuit of the highest attainable standard of physical and mental health.[90] It is article 12(2), in particular, that illustrates how medication comes into play in the right of access to healthcare.[91]

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84 Alston 1998 *ESR Review* 2; Pieterse *Benefit-Focused Analysis of Constitutional Health Rights* 26.

85 For instance the *Limburg Principles on the Implementation of the ICESCR* (1987) (henceforth the *Limburg Principles*); the *Maastricht Guidelines on Violations of Economic, Social and Cultural Rights* (1997) (henceforth the *Maastricht Guidelines*) and the various General Comments by the CESCR. See Chirwa 2003 *SAJHR* 546; Pieterse *Benefit-Focused Analysis of Constitutional Health Rights* 26.

86 *UNCESCR General Comment No 14: The Right to the Highest Attainable Standard of Health* (2000) (henceforth *General Comment 14*).

87 *General Comment 14* paras 1, 3-4, 7-9. See also Bueno de Mesquita, Hunt and Khosla *International Assistance and Cooperation in Health* 114.

88 Article 12(1) of the ICESCR provides that "[t]he States Parties…recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health".

89 A 12(2) of the ICESCR provides that "[t]he steps to be taken by the States Parties…to achieve the full realisation of this right shall include (a) [t]he provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child; (b) [t]he improvement of all aspects of environmental and industrial hygiene; (c) [t]he prevention, treatment and control of epidemic, endemic, occupational and other diseases; (d) [t]he creation of conditions which would assure to all medical service and medical attention in the event of sickness".

90 *General Comment 14* para 7.

91 See Hestermeyer *Human Rights and the WTO* 104.

The first of these rights, as contained in article 12(2)(a), can be interpreted as a right to adequate maternal, child and reproductive health services and information. This right entitles pregnant women and new-born children to the context-specific care necessitated by their particular health-related vulnerabilities.[92] The right of access to anti-retroviral drugs to prevent MTCT of HIV can, for example, be seen as a constituent element of this right.

Article 12(2)(b) implies two broad entitlements, firstly, a right to occupational health, safety and hygiene[93] and secondly a right to environmental determinants of health.[94]

Of particular importance to the topic at hand are subarticles 12(2)(c) and 12(2)(d). Article 12(2)(c) implies the right to the prevention, treatment and control of epidemic, endemic, occupational and other diseases.[95] The right requires the establishment of prevention and education programmes for behaviour-related health concerns such as sexually transmitted diseases, in particular HIV/AIDS, the creation of a system of urgent medical care in cases of accidents, epidemics and similar health hazards, and the provision of disaster and humanitarian relief in emergency situations. The control of diseases refers to States' individual and joint efforts *inter alia* to implement or enhance immunisation programmes.[96] The reference to

92 This right may, according to Pieterse *Benefit-Focused Analysis of Constitutional Health Rights* 31 be further justified by virtue of the fact that such access is essential for the achievement of substantive gender equality.

93 *General Comment 14* para 15. This right includes the right to the improvement of all aspects of environmental and industrial hygiene, *inter alia* "preventive measures in respect of occupational accidents and diseases; the requirement to ensure an adequate supply of safe and potable water and basic sanitation; the prevention and reduction of the population's exposure to harmful substances such as radiation and harmful chemicals or other detrimental environmental conditions that directly or indirectly impact upon human health" and "the minimisation, so far as reasonably practicable, of the causes of health hazards inherent in the working environment".

94 *General Comment 14* para 15. Such environmental determinants of health include "adequate housing and safe and hygienic working conditions, an adequate supply of food and proper nutrition, and [discouragement of] the abuse of alcohol, and the use of tobacco, drugs and other harmful substances". These environmental determinants of the right to health are important in relation to access to medicines too. In relation to the HIV/AIDS pandemic, for example, access to medicines alone has been proven insufficient to ensure good health. Access to adequate nutrition is also critical to the success of anti-retrovirals in reducing MTCT of the virus. See Chirwa 2003 *SAJHR* 547.

95 *General Comment 14* para 16.

96 *General Comment 14* para 16. A 12(2)(c) of the ICESCR further encompasses the promotion of social determinants of good health such as environmental safety, education, economic development and gender equity. Disease control further encompasses making available relevant

treatment presupposes an obligation to take measures aimed at ensuring access to medicines.[97] This right can be interpreted to include the right of access to certain medicines, namely medicines necessary for immunisation and medicines specifically required to combat particular epidemics (such as anti-retrovirals which, although they do not combat the epidemic, are essential in the management and control thereof).

Probably the most important of the rights in the ICESCR relating to access to medicines is contained in article 12(2)(d), which implies the right to have access to health care facilities, goods and services.[98] General Comment 14 understands this article to require "the provision of equal and timely access to basic preventative, curative, rehabilitative health services and health education; regular screening programmes; appropriate treatment of prevalent diseases, illnesses, injuries and disabilities, preferably at community level; the provision of essential drugs; and appropriate mental health treatment and care".[99] By explicitly including "the provision of essential drugs" as a component of this right, the CESCR underlines the importance of access to medicines (at the very least, essential medicines) as one of the components of the right to health. The WHO estimates that about one-third of the world's population lacks access to essential medicine[100] and that the HIV/AIDS pandemic has worsened this problem.[101] Although there is currently no cure for HIV/AIDS, anti-retrovirals have proven to be effective in reducing AIDS-related death rates in high-income countries. Access to medication, treatment and care is

technologies, using and improving epidemiological surveillance and data collection on a disaggregated basis.

97 According to Hestermeyer *Human Rights and the WTO* 104, prevention, treatment and control of most diseases rely on medicine as an integral, vital and indispensable part of the therapy. The treatment of serious infections without antibiotics, of fungal infections without antifungal agents, and increasingly, of viral infections without viral agents is unthinkable and could even constitute malpractice. Access to medicine is thus necessary for the prevention and treatment of most diseases as well as the control of communicable diseases. Medical service and medical attention in the event of sickness equally necessitate the provision of drugs. See Chirwa 2003 *SAJHR* 547; Drews *In Quest of Tomorrow's Medicines* 3; Yamin 2003 *B U Int'l LJ* 327.

98 *General Comment 14* para 17.

99 *General Comment 14* para 17.

100 Especially in the poorest parts of Africa and Asia. See Bale *Consumption and Trade in Off-Patented Medicines* 2; Mok 2010 *Health and Human Rights* 73.

101 Chirwa 2003 *SAJHR* 542.

thus an essential element of an effective response to such pandemics. It is also critical in respecting the rights of those affected.[102]

3.2 Essential medicines

The first attempt at defining "essential drugs" was made in 1977 by the Expert Committee on the Selection of Essential Medicines,[103] which defined essential drugs as those drugs that "are of the utmost importance, basic, indispensable and necessary for the health needs of the population".[104] The Expert Committee then, without motivation, amended this definition by describing essential medicines as "those that satisfy the needs of the majority of the population; they should therefore be available at all times in adequate amounts in appropriate dosage forms".[105] All subsequent Committees endorsed this definition until 1999 when the element of affordability was incorporated.[106] According to this definition, therefore, essential medicines had not only to satisfy the health care needs of the majority of the population and be available in adequate amounts and appropriate dosage forms, but they also had to be available "at a price that individuals and the community [could] afford".[107]

This 1983 definition, as revised in 1999, raises several concerns. Firstly, what is meant by the phrase the "majority of the population" is unclear. Secondly, although

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102 Whereas AIDS is almost 100% terminal if left untreated, anti-retroviral treatment may convert it into a chronic yet controllable disease similar to diabetes or high blood pressure. While these drugs have been widely available in the United States, they have because of their cost been out of reach of those living with HIV/AIDS in the developing world. See Chirwa 2003 *SAJHR* 542; Chung 2006 *Southwestern Journal of Law and Trade in the Americas* 172-173; De Vos 2003 *Law, Democracy and Development* 88; Hestermeyer *Human Rights and the WTO* 8.

103 The WHO Committee on the Selection and Use of Essential Medicines is a committee comprised of international experts that provide the WHO with scientific and technical advice. They serve without remuneration in their personal capacities rather than as representatives of governments or other bodies and their views do not necessarily reflect the decisions or stated policy of the WHO. The Committee meets every two years to review the latest scientific evidence on the efficacy, safety and cost effectiveness of medicines in order to revise and update the WHO Model List of Essential Medicines for both adults and children. The first Committee met in 1977. There have to date been 18 such Committee meetings and the next Committee meeting is expected to take place early in 2013. WHO Date Unkown http://www.bit.ly/13lLKPX.

104 WHO *Technical Report Series 615* (1997) 9. See Chirwa 2003 *SAJHR* 554.

105 SHARED Inc 2003 http://bit.ly/18YvnkY.

106 Chirwa 2003 *SAJHR* 554.

107 WHO *Technical Report Series 895* (2000) 1. See Chirwa 2003 *SAJHR* 554.

the elements of availability and accessibility are included in the definition, those of adequate quality and acceptability are omitted.[108] In recognition of these concerns the WHO has adopted a new definition of the term "essential medicines", comprising three components, namely, definition, selection criteria and purpose. Essential medicines are, according to this definition, medicines that satisfy the priority health care needs of the population.[109] Such medicines are selected "with due regard to disease prevalence, evidence on efficacy and safety, and comparative cost-effectiveness" and the purpose of these medicines is that they should be "available within the functioning health systems at all times in adequate amounts, in the appropriate dosage forms, with assured quality, and at a price the individual and the community can afford".[110] Through the classification of certain drugs as essential medicines the WHO thus prioritises a limited list of vital and essential drugs that are supposed to be effective, safe, of a good quality and affordable for the treatment of the priority health care needs of the population.[111] This list is updated by the WHO every two years.[112]

While the importance of the medicines listed on the WHO's Essential Drugs List[113] should not be underestimated, cognisance should be taken of the fact that many medicines that are essential to the lives of many people, for example contraceptives, which are crucial to women's health and well-being, are not included on the list. Such exclusion should, according to Yamin,[114] not be interpreted as meaning that the drugs are not needed and that the state should not work aggressively to promote their access.

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108 As required by *General Comment 14* para 12. See Chirwa 2003 *SAJHR* 554-555.

109 See WHO Date Unknown http://www.bit.ly/13lLKPX. See also Chirwa 2003 *SAJHR* 555; Perenhudoff "Health, Human Rights and National Constitutions" 1.

110 See WHO Date Unknown http://www.bit.ly/13lLKPX.

111 Mushayavanhu "Realisation of Access to HIV and AIDS-Related Medicines" 127. The list of essential medicines can be accessed at http://www.bit.ly/12DZfKI.

112 In its list of essential medicines the WHO does recognise different national health needs providing that the concept of essential medicines should be flexible and adaptable to many situations. Exactly which medicines are regarded as essential medicines, according to the WHO, remains a national responsibility. See De Vos 2003 *Law, Democracy and Development* 103; Mok 2010 *Health and Human Rights* 75; WHO Date Unknown http://bit.ly/13lLKPX.

113 The Essential Drugs List merely constitutes an advisory opinion by a panel of experts as to the baseline for their own lists of essential drugs

114 Yamin 2003 *B U Int'l LJ* 358.

General Comment 14 determines that compliance with the right to have access to health care facilities, goods and services should be assessed with reference to the availability, accessibility, acceptability and quality of such facilities, goods and services.[115] Availability, while dependent on numerous factors, including a State Party's development level, entails that functioning public health and health-care facilities, goods and services and programmes must be available in sufficient quantity within such State Party.[116] Paragraph 12(a) of *General Comment 14* specifically includes essential drugs, as defined by the WHO Action Programme on Essential Drugs, in its definition of health-care goods and services that need to meet the requirement of availability.[117]

The requirement of accessibility has four components with which health facilities, goods and services must comply, namely non-discrimination, physical accessibility, economic accessibility and information accessibility.[118] The elements of non-discrimination and physical accessibility both require that the health-care goods and services (for purposes of this topic, medicines) must be accessible to all, especially vulnerable and marginalised groups, including persons with HIV/AIDS.[119] Information accessibility includes the right to seek, receive and impart information concerning health issues but should not impair the right to have personal health data treated with confidentiality.[120]

Economic accessibility, or affordability, deals with the issue of drug pricing.[121] This element requires that health facilities, goods and services must be affordable to all, including socially disadvantaged groups. According to *General Comment 14*, equity

115 *General Comment 14* para 12. See Pieterse *Benefit-Focused Analysis of Constitutional Health Rights* 33.
116 *General Comment 14* para 12(a).
117 Other health-care facilities, goods and services and programmes identified by *General Comment 14* para 12 include the underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries.
118 *General Comment 14* para 12(b)(i)-(iv).
119 Other groups listed as vulnerable or marginalised include ethnic minorities and indigenous populations, women, children, adolescents, older persons and persons with disabilities. See *General Comment 14* para 12(b)(ii).
120 *General Comment 14* para 12 (b)(iv).
121 Hestermeyer *Human Rights and the WTO* 105.

demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.[122] While primary medical care (including the first and second-line HIV/AIDS medication) is generally available free of charge or at a minimal cost in the public health sector, secondary and tertiary care (including third-generation medication, which becomes necessary once resistance has been built up against first and second-generation medication) is often not. Whether or not this infringes upon the requirement of economic accessibility is an issue of much debate.

Acceptability requires that health care facilities, goods and services are culturally appropriate[123] and adhere to relevant medical ethics and standards,[124] while the requirement of quality requires that such facilities, goods and services are "scientifically and medically appropriate and of good quality", which includes the provision of scientifically proven and unexpired drugs.[125]

From the above, it is clear that the four elements of accessibility of medicine can, at times, come into conflict.[126] The requirement of appropriate quality can, for example, conflict with the requirements of accessibility and availability.

3.3 Limitations on the right of adequate access to essential medicines

The international community has recognised the reality that, due to the great extent of the prevailing socio-economic need as well as the significant resource implications

122 *General Comment 14* para 12(b)(iii).

123 Here, the issue of universal as opposed to relative acceptability comes into play. In a 2012 study by Rice *et al* 2012 *HIV/AIDS – Research and Palliative Care* 79 on cultural differences in the acceptability of a vaginal microbicide, for example, it was found that the use of this a vaginal microbicide as a measure in the prevention of the transmission of HIV does not enjoy the same acceptance among African-American women in America and African women in Zambia. Despite the fact that this medical intervention meets acceptable medical standards, it was found to be less culturally appropriate among the participants in Zambia than in America for various reasons, including lack of knowledge as to the product, not having full control of their sexual health because of social demands on their accepted behaviour in a marriage setting, and low adherence to the use of the product.

124 *General Comment 14* para 12 (c).

125 As well as skilled medical personnel, hospital equipment, safe and potable drinking water and adequate sanitation. *General Comment 14* para 12(2)(d).

126 Hestermeyer *Human Rights and the WTO* 105.

of realising socio-economic rights, states cannot immediately be expected to comply with all of the obligations imposed on them by the said socio-economic rights.[127] For this reason the ICESCR, as well as several other international and regional human rights instruments, affirms that there are limits to the extent to which socio-economic rights may be enforced at any given time.[128] Article 2(1) of the Covenant determines that states must take deliberate steps, to the maximum of their available resources, in order to achieve progressively the full enjoyment of all socio-economic rights. This article has been criticised for failing to provide sufficiently concrete standards against which to measure compliance by states with their obligations, thereby perpetuating the perception that socio-economic rights amount to unachievable ideals rather than enforceable rights.[129] The bold and innovative comments of the CESCR have, to a large extent, addressed this problem. [130]

The CESCR, in *General Comment 3*,[131] states that:[132]

> The fact that realisation over time, or in other words progressively is foreseen under the Covenant should not be misinterpreted as depriving the obligation of all meaningful content. It is on the one hand a necessary flexibility device, reflecting the realities of the real world and the difficulties involved for any country in ensuring full realisation of economic, social and cultural rights. On the other hand, the phrase must be read in the light of the overall objective, indeed the *raison d'etre,* of the Covenant which is to establish clear obligations for State Parties in respect of the full realisation of the rights in question.

This provision makes it clear that, while it may not be possible to realise the right to health immediately, a State Party may not simply ignore its obligations in respect of this right, but has to take deliberate, concrete and targeted steps towards

127 See De Vos 1997 *SAJHR* 96; Pieterse *Benefit-Focused Analysis of Constitutional Health Rights* 38.
128 Chirwa 2003 *SAJHR* 548; Pieterse *Benefit-Focused Analysis of Constitutional Health Rights* 38.
129 See Chapman 1996 *Hum Rts Q* 31-39; Pieterse *Benefit-Focused Analysis of Constitutional Health Rights* 38; Robertson 1994 *Hum Rts Q* 694; Van Bueren 1999 *SAJHR* 60.
130 See Blake *Normative Instruments in Human Rights Law* 10.
131 *UNCESCR General Comment No 3: The Nature of States Parties Obligations* (1990) (henceforth *General Comment 3*).
132 *General Comment 3* para 9.

expeditious and effective full realisation thereof.[133] In this regard the UN Human Rights Commission states:[134]

> access to medication in the context of pandemics such as HIV/AIDS is one fundamental element for achieving progressively the full realisation of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

General Comment 14 recognises the tripartite typology of interdependent duties with regards to the right to health.[135] According to this typology, the right to health imposes three levels of obligations on State Parties, namely the obligations to respect, protect and fulfil the right to health.[136]

The duty to respect requires State Parties to refrain from interfering directly or indirectly with the enjoyment of the right to health. This duty includes but is not limited to the obligation to refrain from denying or limiting equal access for all persons to preventive, curative and palliative health services; from marketing unsafe drugs and from limiting access to contraceptives.[137] Denial of access to essential medicine or medical products would thus constitute a violation of this duty, as would any discriminatory allocation of medicines or funding for medicines. [138] The UNHRC *Access to Medication in the Context of Pandemics Resolution*[139] calls upon states at national level to "refrain from taking measures which would deny or limit equal access for all persons to preventive, curative or palliative pharmaceuticals or medical technologies used to treat pandemics such as HIV/AIDS or the most common opportunistic infections that accompany them".[140]

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133 See *General Comment 14* paras 30 and 31.

134 *Access to Medication in the Context of Pandemics such as HIV/AIDS* (2002) (Hum Rts Comm Res 2002/32, UN ESCOR 58th Sess UN Doc E/CN/4/2002/200) para 3(a) (henceforth UNHRC *Access to Medication in the Context of Pandemics Resolution).*

135 See Hestermeyer *Human Rights and the WTO* 108; Yamin 2003 *B U Int'l LJ* 350.

136 *General Comment 14* para 33. The *Constitution of the Republic of South Africa*, 1996 in s 7(2), places the state under the obligation to "respect, protect, promote and fulfil" the rights in the Bill of Rights.

137 See *General Comment 14* paras 33 and 34. See Chirwa 2003 *SAJHR* 558; Hestermeyer *Human Rights and the WTO* 108-109; Liebenberg 2011 *SAPL* 38.

138 Chirwa 2003 *SAJHR* 558; Yamin 2003 *B U Int'l LJ* 351.

139 *Human Rights Resolution 2005/23: Access to Medication in the Context of Pandemics such as HIV/AIDS, Tuberculosis and Malaria* (2005).

140 UNHRC *Access to Medication in the Context of Pandemics Resolution* para 3(a).

The duty to protect requires State Parties to take measures that prevent third parties, including pharmaceutical companies, third-party states and international institutions such as the WTO, from interfering with article 12 guarantees.[141] The importance of the duty to protect is even greater in respect of access to medicines, as pharmaceuticals are almost entirely manufactured and marketed by the private sector.[142] This places the state under an obligation to ensure that pharmaceutical manufacturers do not limit the accessibility of essential drugs.[143]

The duty to fulfil, which encompasses the duty to promote, entails an obligation to act positively in facilitating the actual realisation of the right to health.[144] According to *General Comment 14*, this duty requires State Parties to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realisation of the right to health. This duty places obligations on States Parties which include, but are not limited to, giving sufficient recognition to the right to health in the national political and legal systems, preferably by way of legislative implementation; adopting a national health policy with a detailed plan for realising the right to health (including a policy on generics);[145] ensuring the provision of health care, including immunisation programmes against major infectious diseases; and providing a public, private or mixed health insurance system which is affordable for all.[146] Additionally, the duty to fulfil includes an obligation to provide the right when individuals or groups are unable to realise the right by their own means.[147] This duty forbids policies or acts, even under pressure from other actors,

141 See Chirwa 2003 *SAJHR* 559; Hestermeyer *Human Rights and the WTO* 109; Mok 2010 *Health and Human Rights* 76; Yamin 2003 *B U Int'l LJ* 328-329, 353.

142 Hestermeyer *Human Rights and the WTO* 109.

143 Where a state acquires the drugs for the patients or contributes to a comprehensive health insurance system that provides the drugs to all patients who need them, high prices do not limit economic accessibility. However, even developed nations are finding it increasingly difficult to finance such a system. See Hestermeyer *Human Rights and the WTO* 109.

144 For example by building and equipping clinics and by providing medication. See Chirwa 2003 *SAJHR* 560; Hestermeyer *Human Rights and the WTO* 110; Viljoen *International Human Rights Law in Africa* 7.

145 Yamin 2003 *B U Int'l LJ* 358-359.

146 See *General Comment 14* paras 33 and 36. See Chirwa 2003 *SAJHR* 560-561; Hestermeyer *Human Rights and the WTO* 110; Yamin 2003 *B U Int'l LJ* 355-356.

147 *General Comment 14* para 37.

which would entail regression in terms of the availability or affordability of medications.[148]

According to the *Maastricht Guidelines*,[149] both the obligations to respect and to protect are immediately enforceable, while the obligation to fulfil requires the adoption of "appropriate legislative, administrative, budgetary, judicial and other measures towards the full realisation of [socio-economic] rights".[150] Despite the obligation to fulfil being recognised as being realisable over time, *General Comment 3* embraces the concept of the minimum core obligation approach to socio-economic rights by stating that:[151]

> a minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights is incumbent upon every State Party. Thus, for example, a State Party in which any significant number of individuals is deprived of...essential primary health care...is, *prima facie,* failing to discharge its obligations under the Covenant.

As is evident from the above article, the "minimum core approach" to socio-economic rights serves not only to clarify the content of these rights but also to prioritise certain basic needs over others (indicating a starting point and general framework for progressive realisation).[152] While *General Comment 3* provides that the resources of a particular State Party must be taken into account in determining whether or not it has met its minimum core obligations, it requires that states give priority to the meeting of people's basic needs.[153] The minimum core approach, which is aimed at protecting the most vulnerable members of society, entails that there are minimum levels of socio-economic subsistence below which nobody should be allowed to exist regardless of state-resource constraints. This approach aims to identify such subsistence levels, which represent a "floor" of immediately enforceable

148 Yamin 2003 *B U Int'l LJ* 329.
149 The *Maastricht Guidelines* constitute a non-binding interpretive instrument which resulted from a workshop between the International Commission of Jurists, the Maastricht Centre for Human Rights and the Urban Morgan Institute for Human Rights in 1997. See Dankwa, Flinterman and Leckie 1998 *Hum Rts Q* 706-707; Viljoen *International Human Rights Law in Africa* 30.
150 *Maastricht Guidelines* 6.
151 *General Comment 3* para 10. See also *Maastricht Guidelines* 15(i).
152 Pieterse *Benefit-Focused Analysis of Constitutional Health Rights* 42.
153 *General Comment 3* para 10.

entitlements from which progressive realisation should proceed.[154] It does not require the division of rights according to their priority, but rather that each right be realised to the extent that provides for the basic needs of everyone.[155]

Failure to meet these basic standards for a dignified human existence *prima facie* amounts to a breach of the obligations of the ICESCR.[156] Only when a state can convincingly show that resources are "demonstrably inadequate" can its failure to fulfil these duties be justified.[157] Such a minimum threshold is, however, country specific. In other words, the ways in which economic and social rights can be realised will vary with the nature of the national situation and the conditions applying there.[158] The CESCR has, however, indicated that a state party is still under the obligation to strive to ensure the widest possible enjoyment of the relevant rights under the prevailing circumstances.[159] In relying on a lack of available resources as a defence for not meeting such a minimum core, states must demonstrate that they have made every effort to use all of the resources at their disposition in an effort to satisfy, as a matter of priority, those minimum obligations.[160] In this regard the CESCR has noted that it is important to distinguish inability from unwillingness.[161]

Article 43 of *General Comment 14* confirms that State Parties have core obligations to ensure at the very least the satisfaction of minimum essential levels of each of the

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154 See Alston 1998 *ESR Review* 4; Bilchitz 2003 *SAJHR* 11-18; Bollyky 2002 *SAJHR* 184; Chirwa 2003 *SAJHR* 549-550; Chirwa 2003 *East African Journal of Peace and Human Rights* 174; Dankwa, Flinterman and Leckie 1998 *Hum Rts Q* 717; De Vos 1995 *SAPL* 251; Jansen van Rensburg and Olivier "International and Supra-national Law" 638-640; Lehmann 2006/2007 *Am U Int'l L Rev* 183-184; Mbazira 2009 *Litigating Socio-Economic Rights* 61-64; Ngwena and Cook "Rights Concerning Health" 117; Nicholson 2002 *CILSA* 360; Pieterse *Benefit-Focused Analysis of Constitutional Health Rights* 43; Scott and Alston 2000 *SAJHR* 250; Tveiten 2003 *Nordic Journal of International Law* 60.

155 Mbazira *Litigating Socio-Economic Rights* 61.

156 A state which fails to satisfy such obligations is placed under an increased justificatory burden to demonstrate that every effort has been made to make use of all resources available to it to satisfy, as a matter of priority, these minimum core obligations. *General Comment 3* para 10. See Hestermeyer *Human Rights and the WTO* 220; Mbazira *Litigating Socio-Economic Rights* 61; Yamin 2003 *B U Int'l LJ* 358.

157 Alston 1998 *ESR Review* 4; Bilchitz 2003 *ESR Review* 3; Chirwa 2003 *SAJHR* 550.

158 Eide "Strategies for the Realisation of the Right to Food" 468.

159 Alston 1998 *ESR Review* 4; Bilchitz 2003 *SAJHR* 1; Chirwa 2003 *SAJHR* 549.

160 Hestermeyer *Human Rights and the WTO* 110-111; Yamin 2003 *B U Int'l LJ* 358.

161 *General Comment 14* para 47.

rights enunciated in the Covenant, including essential primary health care, and refers to the *Alma-Ata Declaration*[162] to provide guidance on the core obligations arising from article 12. These core obligations include *inter alia* the obligation to ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalised groups;[163] to provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;[164] to ensure equitable distribution of all health facilities, goods and services;[165] to adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population;[166] to ensure reproductive, maternal (pre-natal as well as post-natal) and child health care;[167] to provide immunisation against the major infectious diseases occurring in the community;[168] and to take measures to prevent, treat and control epidemic and endemic diseases.[169]

4 The role of access to essential medicines in poverty reduction

According to Thekaekara,[170] poverty can be alleviated only if there is an even and rapid spread of healthcare. The link between poverty and health is clear when one considers that the poor are generally not as healthy as the rich and that people in lower social classes are more prone to contracting infectious deceases.[171] This is especially true for third-world countries, where the HIV/AIDS pandemic makes the impoverished more prone to contracting HIV-related illnesses such as tuberculosis. Furthermore, ill health not only causes poverty but also contributes to it by destroying livelihoods, reducing productivity and educational achievements and

162 *Alma-Ata Declaration* (1978) adopted by the International Conference on Primary Health Care, held at Alma-Ata, USSR 6-12 September 1978. The *Alma-Ata Declaration* is a non-binding declaration which expresses the need for urgent action by all governments, health and development workers and the world community to protect and promote the health of all people.
163 *General Comment 14* para 43(a).
164 *General Comment 14* para 43(d).
165 *General Comment 14* para 43(e).
166 *General Comment 14* para 43(f).
167 *General Comment 14* para 44(a).
168 *General Comment 14* para 44(b).
169 *General Comment 14* para 44(c).
170 Thekaekara 2006 http://www.bit.ly/13dZQax.
171 Benzeval et al "Relationships between Health, Income and Poverty" 78; Spicker *et al Poverty* 91.

limiting opportunities.[172] The adequate fulfilment of these peoples' right of access to essential medicines will inevitably enable them to achieve a higher level of well-being, thereby reducing the level of poverty experienced. However, as poverty leads to an increased exposure to environmental risks, malnutrition and ill health due to a reduction in access to health care and essential medicines and a lack amongst other goods of sufficient food, clean drinking water and housing, ill health is also considered to be a consequence of poverty.[173]

Despite the fact that ill health is considered to be both a cause and a consequence of poverty, access to health care and essential medicines is still deemed a key element in achieving good health, enabling the impoverished to achieve a higher level of well-being through an increased livelihood, ultimately resulting in a reduction of poverty.[174] As good health can contribute to economic security by safeguarding other rights such as the right to education and the right to work, the UN accordingly holds good health as essential for the creation and sustainability of those basic capabilities needed to escape the vicious cycle of poverty.[175]

Thus, the right of access to health care and essential medicines has a crucial role to play in poverty reduction strategies. Guideline number seven sets out the following targets for the fulfilment of the right to health as part of a poverty reduction strategy:[176] the universal enjoyment of access to adequate and affordable primary health care; the elimination of preventable deaths amongst women and children; universal access to safe and effective birth control; the elimination of HIV/AIDS; the elimination of infectious diseases; and lastly the ensuring of gender equality in

172 UNHCHR *Human Rights Approach to Poverty Reduction Strategies* para 112; Weil 2007 *Future of Children* 98-99; Salomon *Global Responsibility for Human Rights* 49. See also Benzeval et al "Relationships between Health, Income and Poverty" 78 where it is argued that various reasons exist for the link between income and poverty. Low income causes ill health due to a lack of basic capabilities. On the other hand ill health causes a reduction in income, but ill health and a low income can also both be the result of the same preceding circumstances, for instance a lack of access to education.

173 UNHCHR *Human Rights Approach to Poverty Reduction Strategies* para 112; Spicker *et al Poverty* 91.

174 Weil 2007 *Future of Children* 99.

175 UNHCHR *Human Rights Approach to Poverty Reduction Strategies* para 114.

176 UNHCHR *Human Rights Approach to Poverty Reduction Strategies* 24-25.

access to health care. Adequate access to essential medicines plays a role in each of these targets.

The UN has also identified some key features for the fulfilment of the right to health as part of a poverty reduction strategy.[177] Amongst these is the obligation on states to improve the provision of and access to personal health services for those who live in poverty. This can be done by targeting service delivery to the poor and by ensuring that the division of resources favours poorer geographical areas. By ensuring that the division of resources favours primary health care which respects culture and gender and is of a good quality, access to these services will inevitably also improve. Essential medicines as prescribed by the WHO must be provided, prioritising reproductive and mother-and-child health care. Illnesses that specifically impact on the poor, like malaria, tuberculosis and HIV/AIDS, must be identified and programmes must be specifically developed and launched to help the poor.[178] Furthermore, states must reduce the financial burden placed by health care and health protection on the poor by reducing or removing user fees, for instance.[179]

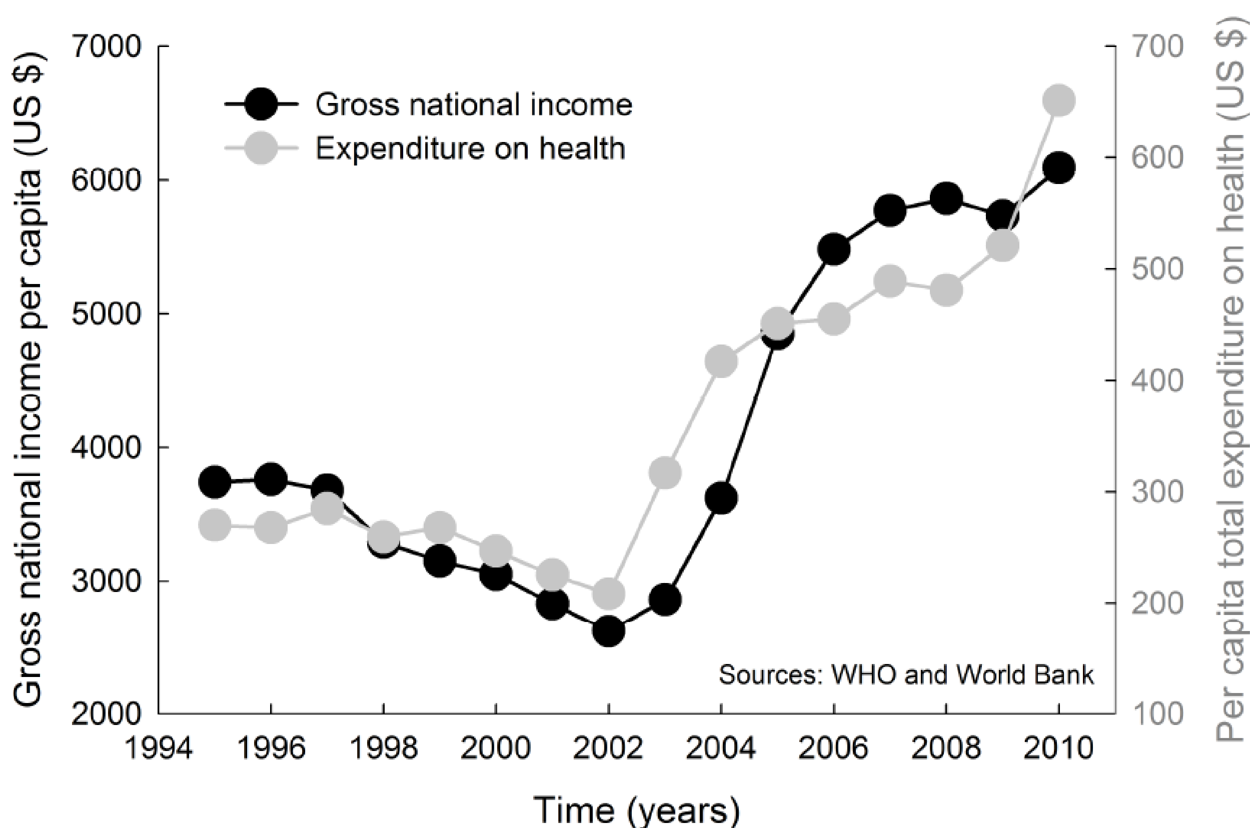
In order to eradicate poverty and promote human dignity and equality, the Millennium Development Goals (MDGs) emanating from the *United Nations Millennium Declaration* of 2000 (*Millennium Declaration*) specify eight commitments aimed at development, poverty reduction and a worldwide partnership.[180] These goals serve as benchmarks for the assessment of progress and each goal is linked to socio-economic rights, making the achievement of these goals a step towards poverty reduction as well as towards the fulfilment of socio-economic rights.[181]

177 UNHCHR *Human Rights Approach to Poverty Reduction Strategies* paras 120-124.
178 UNHCHR *Human Rights Approach to Poverty Reduction Strategies* para 120 i-vii.
179 UNHCHR *Human Rights Approach to Poverty Reduction Strategies* para 122.
180 *United Nations Millennium Declaration* (2000) resolution adopted by the General Assembly, 18 September 2000, A/RES/55/2 (henceforth *United Nations Millennium Declaration*). This declaration is non-binding, falling under the category of soft law, which is intended to guide states in their conduct. In this regard see Jansen van Rensburg "Human Rights-based Approach to Poverty" 15. See also UNHCHR 2002 http://bit.ly/174DPMZ 2-3.
181 Jansen van Rensburg "Human Rights-Based Approach to Poverty" 16.

A wide range of health targets are included in the MDGs.[182] MDG number four, for instance, requires a two thirds reduction in the mortality of children under the age of five, and MDG number five a three quarter reduction in maternal mortality. Furthermore, MDG number six states that the spread of HIV/AIDS, malaria and other illnesses must be combated. The *Millennium Declaration* also emphasises other important health issues, such as the increased universal availability of affordable essential medicines in developing countries.[183] The emphasis that the *Millennium Declaration* places on health targets and health issues further stresses their importance in poverty reduction strategies.[184]

The following graph[185] visually illustrates the authors' arguments in this article. It shows South Africa's gross national income *versus* the total *per capita* expenditure on health care by the state over a fifteen-year period and illustrates the clear correlation between the two. The example is indicative of the way in which a government's increased expenditure on health care can in principle increase the general well-being of its citizens, thereby reducing the level of poverty experienced. Good health can be seen as being not only a consequence of economic development, but also a means for achieving economic development.[186]

182 UNHCHR *Human Rights Approach to Poverty Reduction Strategies* para 115.
183 *United Nations Millennium Declaration* para 20.
184 UNHCHR *Human Rights Approach to Poverty Reduction Strategies* para 115.
185 This graph is based on statistics released by the WHO and the World Bank. The statistics can be accessed at www.who.org and www.indexmundi.com.
186 UNHCHR *Human Rights Approach to Poverty Reduction Strategies* para 113.



5 Conclusion

The human rights-based approach to poverty defines poverty as the inadequate fulfilment of a person's human right to basic capabilities, an approach which interprets poverty, very broadly, as the absence of the capabilities needed to live a dignified life.[187] As such, poverty constitutes an infringement on human rights[188] and will not be eradicated without the fulfilment of human rights, including the right to health.[189]

The most important international law provision relating to the right to health is article 12 of the ICESCR. Article 12(1) of this document provides a broad formulation of the right to health in international law, while article 12(2) prescribes a non-exhaustive list of steps to be taken in pursuit of the highest attainable standard of

187 See s 2.2.
188 See s 2.2.
189 See s 2.3.

health.[190] Article 12(2), in particular, illustrates the role that adequate access to medication plays in the right of access to healthcare.[191] The CESCR, has explicitly included the provision of essential drugs as a component of the right to healthcare,[192] thereby emphasising the causal link between the lack of access to essential medicines and the non-fulfilment of the right of access to healthcare.[193]

As with all socio-economic rights, the resource implications of the realisation of the right to health are such that states cannot be expected to immediately comply with their obligations in respect thereof.[194] Instead, article 2(1) of the ICESCR and the General Comments of the CESCR place obligations on states to take deliberate, concrete and targeted steps towards expeditious and effective full realisation of the right to health, including access to medication.[195] The measures taken to do so must, according to *General Comment 3*, embrace the concept of the minimum core obligation (the minimum core in relation to medicines being access to essential medicines, at the very least).[196]

The spread of access to healthcare will, as is illustrated by the graph above, contribute to poverty reduction. The adequate fulfilment of peoples' rights of adequate access to essential medicines will enable them to achieve a higher level of well-being, thereby reducing the level of poverty which they experience.[197] Both the right to access healthcare and the right to access essential medicines – the latter being a crucial component of the former – therefore have significant roles to play in a state's poverty reduction strategies.[198]

190 See s 3.1.
191 See s 3.1.
192 See s 3.1.
193 See s 1.1.
194 See s 3.3.
195 See s 3.3.
196 See s 3.3.
197 See s 4.
198 See s 4.

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List of abbreviations

Am U Int'l L Rev	American University International Law Review
B U Int'l LJ	Boston University International Law Journal
CEDAW	United Nations Convention on the Elimination of all forms of Discrimination Against Women

CERD	United Nations Convention on the Elimination of all forms of Racial Discrimination
CILSA	Comparative and International Law Journal of Southern Africa
CRC	United Nations Convention on the Rights of the Child
HIV/AIDS	Human immunodeficiency virus / Acquired immunodeficiency syndrome
Hum Rts Q	Human Rights Quarterly
ICCPR	United Nations International Covenant on Civil and Political Rights
ICESCR	United Nations International Covenant on Economic, Social and Cultural Rights
MDGs	Millennium Development Goals
Millennium Declaration	United Nations Millennium Declaration of 2000
MTCT	Mother to child transmission
SAJHR	South African Journal on Human Rights
SAPL	South African Public Law
UDHR	United Nations Universal Declaration of Human Rights
UN	United Nations
UNCESCR	United Nations Committee on Economic, Social and Cultural Rights
UNHCHR	United Nations High Commissioner for Human Rights
UNHRC	United Nations Human Rights Committee
WHO	World Health Organisation
WTO	World Trade Organisation