

**IN THE HIGH COURT OF SOUTH AFRICA
DURBAN AND COAST LOCAL DIVISION**

Case No.: **4576/2006**

In the matter between:

EN	1 st Applicant
BM	2 nd Applicant
DM	3 rd Applicant
EJM	4 th Applicant
LMI	5 th Applicant
MAZ	6 th Applicant
MSM	7 th Applicant
N D	8 th Applicant
N S	9 th Applicant
SEM	10 th Applicant
TJX	11 th Applicant
T S	12 th Applicant
VPM	13 th Applicant
ZPM	14 th Applicant
LM2	15 th Applicant
TREATMENT ACTION CAMPAIGN	16 th Applicant

and

THE GOVERNMENT OF THE REPUBLIC OF SOUTH AFRICA	1 st Respondent
HEAD, WESTVILLE CORRECTIONAL CENTRE	2 nd Respondent
MINISTER OF CORRECTIONAL SERVICES	3 rd Respondent
AREA COMMISSIONER OF CORRECTIONAL SERVICES, KZN	4 th Respondent
MINISTER OF HEALTH	5 th Respondent
MEC FOR HEALTH, KZN	6 th Respondent

J U D G M E N T

PILLAY, J

THE PARTIES:

[1] The First to the Fifteenth Applicants, were at the launch of these proceedings, all serving prison sentences in the Medium B Section at the Westville Correctional Centre (WCC). The Sixteenth Applicant is the Treatment Action Campaign (TAC) a duly registered section 21 not for profit company. Its objectives *inter alia* and relevant for present purposes are the following:-

- “1. Campaign for equitable access to affordable treatment for all people with HIV/AIDS;
2. Campaign for and support the prevention and elimination of all new HIV infections;
3. Promote and sponsor legislation to ensure equal access to social services for equal treatment of all people with HIV/AIDS;
4. Challenge by means of litigation, lobbying, advocacy and all forms of legitimate social mobilization, of any barrier or obstacle, including unfair discrimination that limits access to treatment for HIV/AIDS in the private and public sector;
5. Educate, promote and develop an understanding and commitment within all communities of development in HIV/AIDS treatment;
6. Campaign for access to affordable and quality health care for all people in South Africa;
7. Train and develop a representative and effective leadership of people living with HIV/AIDS on the basis of equality and non-discrimination irrespective of race, gender, sexual orientation disability, religion, sex, socio-economic status, nationality, marital status or any other ground;
8. Campaign for an effective reasonable and global network comprising of organizations with similar aims and objectives.”

It is not disputed that ANNELINE MICHELLE GOVENDER is employed by the AIDS LAW PROJECT (ALP) and is authorized by them to depose to the affidavits on behalf of the Applicants. The ALP is a legal services provider with in-house attorneys and advocates.

The Government of the Republic of South Africa, nominally cited as the First Respondent, is the umbrella body of the various National and Provincial Governments responsible for the health and care of incarcerated persons. The Second, Third, Fourth, Fifth and Sixth Respondents are all cited in their official capacities as representatives of those State departments.

The First to the Fifteenth Applicants act in their personal capacities as persons infected by the HIV/AIDS virus and also in the interest of all prisoners with HIV/AIDS who need or will need to access antiretroviral (ARV) treatment as fellow inmates at the WCC. They also, as the Sixteenth Applicant does act in the public interest for the purposes of securing the effective enforcement on Constitutional rights. The Sixteenth Respondent also acts in the interest of its members who include persons with HIV/AIDS. The *locus standi* of the Applicants to act on behalf of all the inmates with HIV/AIDS at WCC and in the public interest, is disputed by the Respondents. I will return to that aspect later.

THE BACKGROUND:

[2] The application has its beginnings, it would seem, in a letter dated the 28th of October 2005 addressed by the ALP acting on behalf of approximately twenty offenders suffering from HIV/AIDS serving sentences at the WCC and unable to access proper treatment. This letter is annexed to the founding affidavit deposed to

by ANNELINE MICHELLE GOVENDER. The letter seeks answers from the WCC to the following questions:-

- “(a) What steps, if any have been taken to ensure that offenders at Westville Correctional Centre who need access to ARV treatment are indeed able to access it immediately? If no steps have been taken, why not?”*
- “(b) When and where will our clients and other offenders who are eligible for ARV treatment be able to access it?”*

The letter concludes with the following statement:

“We look forward to hearing from you by no later than Monday 7th November 2005, failing which we will assume that you are not taking any steps to ensure that offenders living with HIV/AIDS at Westville Correctional Centre and who are eligible for ARV treatment can access it immediately. In such a case we will have no option but to institute appropriate legal proceedings against the Minister of Correctional Services, the Westville Correctional Centre and any other relevant party. We sincerely hope that this is not necessary.”

Copies of this letter were faxed to:

1. Mr N Balfour, Minister of Correctional Services
2. Dr M E Tshabalala-Msimang, Minister of Health
3. Mr L Mti, National Commissioner of Correctional Services
4. Mr V Peterson, Area Commissioner of Correctional Services, KZN
5. Judge Fagan, Office of the Inspecting Judge

[3] No response was received either from the WCC or from any of the other parties to whom the letter was telefaxed. It is apparent from further correspondence that the assistance of the State Attorney was elicited in order to get a response.

The State Attorney, in response to the plea for his intervention, addressed a letter to the ALP dated 6 December 2005. It reads as follows:

*"The Aids Law Project
c/o Docex 197
JOHANNESBURG*

Dear Madam

OFFENCERS LIVING WITH HIV/AIDS AND ACCESS TO APPROPRIATE TREATMENT

I acknowledge receipt of your telefax of even date with enclosures. I also refer to my telephonic conversation with you and confirm that I have asked you to contact the Legal Services Official in Correctional Services based in Pietermaritzburg for the purposes of facilitating a meeting with you and your team with a view of finding a solution to the present impasse.

I do not believe that it is in the interest of all concerned to have this matter dealt with in the High Court.

Should any serious impediment arise in granting access to medication to HIV positive prisoners, then the need to approach the Courts may arise.

***K GOVENDER
STATE ATTORNEY (KWAZULU-NATAL)"***

This intervention by the State Attorney appears to have resulted in a round table meeting on the 15th of December 2005 at which a way forward was discussed. On the 11th January 2006 the ALP wrote to the Head of Legal services at the WCC, *inter alia*, seeking a progress report on the undertakings given and placing on record what was agreed to at the meeting on the 15th of December 2005.

With no progress being made, the ALP placed the WCC on terms. The Deputy Director of Legal Services of the Department of Correctional Services (RSA) (DCS), responded by letter dated the 20th of January 2006. Whilst disputing one aspect of

the agreement reached on the 11th of January 2006, he went on to state that for various reasons, the WCC was unable to give a feedback on progress. Further correspondence ensued between the ALP and Correctional Services, relating to the issue now before Court and difficulties experienced in arranging consultations with the affected prisoners. With still no progress in sight, the ALP gave notice on the 8th of March 2006 of its intention to launch these proceedings. The correspondence is not detailed here for the sake of brevity. Reference will be made, if need be, when dealing with the merits. Suffice it to say that from the view point of the Applicants, nothing significant was achieved through the negotiation process preceding the launch of this application. The application was launched on the 12th of April 2006.

RELIEF CLAIMED:

[4] The main relief claimed as set out in paragraphs 3, 4 and 5 of the Notice of Motion reads as follows:

- “3. *That the respondents are hereby ordered with immediate effect to remove the restrictions that prevent the First to the Fifteenth Applicants, and any and all other similarly situated prisoners at Westville Correctional Centre, who meet the criteria as set out in the National Department of Health’s Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa, from accessing antiretroviral treatments at an accredited public health facility.*

4. *That the respondents be and are hereby ordered with immediate effect to provide antiretroviral treatment in accordance with the foresaid Operational Plan, to the First to Fifteenth Applicants, and any and all other similarly situated prisoners at Westville Correctional Centre, at an accredited public health facility;*

5. *That the respondents are ordered on or before the _____ day of _____ 2006 to serve on the Applicants' attorneys and lodge with the Registrar of this Court, an affidavit setting out the manner in which it will comply with paragraph 4 of this order."*

The relief claimed in paragraph 5 (*supra*) has been referred to by Ms GABRIEL who appeared together with Ms HASSIM for the Applicants, as a 'structural interdict', in terms of which the Court is required to compel the Respondents to expedited time frames within which they will ensure that the Applicants receive ARV treatment. It is contemplated that, by virtue of the fact that the Applicants seek relief in a class action, and in the public interest, similarly situated offenders at WCC also receive ARV treatment.

Mr MOERANE S. C. who appeared together with Ms T.S. NORMAN for all the Respondents, did not argue against the principle of a structural interdict. He did however oppose the granting of such an interdict.

That a Court can in suitable cases resort to the granting of such an interdict in appropriate cases to secure compliance with the Court Order has been accepted by our Courts. See ***CITY OF CAPE TOWN v RUDOLPH AND OTHERS 2004 (5) SA 39 (C)*** at page 88; ***MINISTER OF HEALTH AND OTHERS v TREATMENT ACTION CAMPAIGN AND OTHERS (No 2) 2002 (5) SA 721 (CC)***.

No relief is claimed in respect of the Fourth and Eighth Applicants because of events which have happened just before or subsequence to the launch of this application.

INTERLOCUTORY APPLICATIONS BY RESPONDENTS

[5] There were two interlocutory applications by the Respondents about which much need not be said. The First relates to the acceptance of a further affidavit on behalf of the Respondents to respond to new matters, so it is alleged, raised by the Applicants in their replying affidavit. The Second interlocutory applications seeks condonation for the late filing of the Respondents' heads of argument.

With regard to the filing of the further affidavit, no serious objection was raised by Ms GABRIEL save to place on record, as she put it, "*the so-called new matters were actually in response to the averments in the answering affidavit.*" I was not called upon to make a ruling on the application as the parties were *ad idem* that in the interests of justice, I should have before me a full a picture as possible of the dispute. On that basis a very short affidavit from the Applicants was also accepted dealing with the appointments made by WCC for certain of the Applicants at treatment centres. No issue was made either by the Court or Ms GABRIEL to the late filing of the Respondents' heads.

URGENCY

[6] Although the Respondents, on the papers, objected to the matter being heard as one of urgency in terms of Rule 6(12) of the Uniform Rules of Court, it was not pursued in argument. Mr MOERANE very correctly and rightly conceded that he was not pursuing that aspect. Argument on the merits therefore proceeded.

Before dealing with the merits of the case, it would be prudent and convenient to deal with two preliminary points raised by the Respondents. The First relates to the *locus*

standi of the Applicants and the other relates to what Mr MOERANE terms as the “defective founding papers”.

LOCUS STANDI

[7] The Respondents contest the *locus standi* of the Applicants to seek relief of behalf of all HIV positive prisoners at the WCC. They further deny that the Applicants act in the public interest. It is not in issue that the Applicants have the *locus standi* to bring the application in their own names. Mr MOERANE submitted that on the papers, no case has been made out for the Applicants to act in any capacity other than their own although in the notice of motion relief is claimed for other similarly situated prisoners.

To the extent that it is submitted on behalf of the Respondents that the Applicants had not identified a clearly defined group or class of persons who are not able to access ARV treatment and that no case has been made out on the papers entitling the Applicants to act in the public interest, two letters attached to the founding affidavit are both relevant and telling. The First is annexure “AMG 35” to the founding affidavit addressed by the Regional Commissioner of Correctional Services KZN to the ALP. Paragraph 4 of the letter dated 23 January 2006 reads as follows:

“Statistics required on the number of offenders in Medium-B with CD 4 count of less than 200 is 50 and the number of offenders who died with HIV/AIDS related conditions in Medium B last year were 78 (this number includes offenders who were transferred in Medium B 24 hour nursing facility from other management areas in the Region)”.

Attached to this letter is an earlier letter, once again by the Regional Commissioner, dated 20 December 2005 addressed to the ETHEKWINI HEALTH DISTRICT in

which he expresses the need to fast track the “whole ART issue at Westville”. Pertinent to the contention that the Applicants have not made out a case on the papers that they are acting in the public interest and in the interest of other prisoners similarly situated, are the following extracts from the same letter:

“2.1 It is basically only Westville Correctional Services which happen not to be participating in the Government ART program, and the reasons cited in this regard are that the surrounding Public Health Hospitals are not keen at all to render such services to offenders incarcerated at Westville Correctional Services:

and further on he says the following:

“2.4 The issue of HIV and AIDS at Westville Correctional is a reality with ± 110 HIV and AIDS related deaths since the beginning of 2005 ± 50 offenders whose CD 4 cell count of less than 200 etc.”

and at paragraph 6 he says:

“Looking at the seriousness of the whole exercise, which is a matter of life and/or death, and the urgency that it deserves this office deems it necessary to urge your office to fast track the ART issue at Westville Correctional Services on receipt of this communication.”

Now, if that does not constitute a reason to act in the public interest and in the interest of other similarly situated prisoners, I do not know what could be more compelling.

At paragraph 102 of the founding affidavit, the deponent makes the following point:

“I believe that it is clear from what has been set out in the paragraphs above that the Applicants have made every effort to resolve the issue with the DCS, WCC and DOH without resorting to litigation. At this stage, given the deterioration of the health of the First to the Fifteenth Applicants and other similarly situated prisoners, our only option is to ask this Honourable Court to intervene and order the WCC to meet its commitments.” (my emphasis)

There is therefore no merit in the submission that no case is made out in the papers for a class action or the Applicant’s right to act in the public interest. Incarcerated persons are wards of the State. There can be no doubt that from a reading of the letters emanating from the Regional Commissioner of Correctional Services, the group which could benefit from any order which the Court chooses to make is clearly identifiable. I associate myself with the submission made by counsel for the Applicants that the Applicants suffer a disadvantage in that they suffer physical and financial constraints and it would be unreasonable to expect that each prisoner with a similar case act individually.

[8] It is common cause that the Respondents are legally and constitutionally bound to provide adequate medical treatment to prisoners who need it.

Section 35(2)(e) of the Constitution provides:

“Everyone who is detained, including every sentenced prisoner, has the right to conditions of detention that are consistent with human dignity, including at least exercise and the provision at State expense, of adequate accommodation, nutrition, reading material and medical treatment.”

It is also common cause that the Applicants have a right to ARV treatment.

[9] Relevant to the issue of a class action or the right to act in the public interest in cases alleging infringement of Constitutional rights is clearly spelled out in section 38 of the Constitution. The grounds for *locus standi* in such cases include:

“anyone acting in their own interest;”

“anyone acting as a member of, or in the interest of, a group or class of persons;”

“anyone acting in the public interest;” and

“an association acting in the interests of its members.”

[10] There is ample authority for the proposition that *locus standi* requirements are meant to be expansively interpreted and should be read so as to avoid obstructions on its invocation. (see ***FERREIRA v LEVIN 1996 (2) SA 662 (CC)*** and ***BEUKES v KRUGERSDORP TRANSITIONAL LOCAL COUNCIL 1996 (3) SA 467 (W)*** at 474 C-H). Both these cases dealt with section 7(4) of the Interim Constitution which is similar in all material respects to section 38 of the Constitution.

More recently CAMERON JA dealing with the judgment of FRONEMAN J in ***PERMANENT SECRETARY, DEPARTMENT OF WELFARE v NGXUZA 2001 (4) SA 1184 (SCA)*** (upheld on appeal) held in relation to section 38 of the Constitution that:

“It is precisely because so many in our country are in a ‘poor position to seek legal redress’ and because the technicalities of legal procedure, including joinder, may unduly complicate the attainment of justice that both the interim Constitution and the Constitution created the express provision that ‘anyone’ asserting a right in the Bill of Rights could litigate ‘as a member of, or in the interest of a group or class of persons’”.

The Respondents' objections articulated by Mr MOERANE in his heads that:

- (i) the Applicants have not mentioned any inmate at the WCC who is not able to access ARV treatment;
- (ii) there is no evidence that such inmates were unable to join in this litigation;
- (iii) there is no evidence that any such inmates wish to join in this litigation;
- (iv) there is no evidence that any such inmates would wish to be bound by any order that this Honourable Court might make,

is met by what FRONEMAN J in the court a quo had to say in "**NGXUZA**" (supra) at page 629 E:

"- - - our common law was the poorer for not allowing the representative or class action. The Constitution seeks to rectify that deficiency in section 38 of the Constitution and there is no reason to interpret that section in a narrow and restrictive manner. A flexible approach is required. Making it easier for disadvantaged and poor people to approach the Court on public issues to ensure that the public administration adheres to the fundamental constitutional principle of legality in the exercise of public power serves our new democracy well."

I am respectfully in full agreement with the views as articulated by FRONEMAN J and CAMERON JA and consequently come to the conclusion that the objection to the *locus standi* of the Applicants in so far as they seek to act in the public interest and in the interests of other inmates at WCC who are similarly affected, is without merit.

The Sixteenth Applicant acts in the interests of its members, some of whom are HIV positive and incarcerated at WCC. The relief sought is consistent with its aims and

objectives as set out in its constitution. Its *locus standi* has been accepted by our Courts in similar matters. (see **MINISTER OF HEALTH v TAC AND OTHERS (NO 2)** supra). I see no reason why its *locus standi* should, in a like manner, not be accepted by this Court.

DEFECTIVE FOUNDING PAPERS

[11] The Respondents attack the founding affidavit as being irregular on account of the fact that ANNELINE MICHELLE GOVENDER deposed to it on the 10th of April 2006, and much of which she says about the case of the First to the Fifteenth Applicants could not possibly have been confirmed by them because the confirmatory affidavits are all dated the 16th of March 2006.

Each of the Applicants in the confirmatory affidavits, make the following averment on oath:

"I have read the affidavit of ANNELINE MICHELLE GOVENDER and as far as it pertains to me, confirm the contents of the affidavit."

This statement, Mr MOERANE submitted, is patently incorrect because GOVENDER's affidavit was only produced a month later. Therefore the papers are fatally defective.

He wished to place on record however, that this point is taken not because of the Respondents' predilection for being technical, but because they raise important issues regarding motion proceedings and duties owed to the Court by practitioners. By the latter, I assume that the complaint is because the defect in the papers was not brought to the attention of LEVINSOHN J on the 3rd of May 2006 when preference

was sought for the matter to be heard as one of urgency and the rules dispensed in accordance with Rule 6(12) of the Uniform Rules of Court.

The complete answer to Mr MOERANE's objection to the acceptance of the founding affidavit is to be found at paragraphs 9 to 11 of the founding affidavit itself, which reads as follows:

- "9. *As a result of obstruction by the DCS (as set out in paragraphs 80 – 83 below) in allowing us access to our clients we have not been able to bring the necessary amendments to this affidavit to their attention. These amendments were made to take into account recent events as well as correspondence between the AIDS Law Project and both the DoH and DCS (referred to from paragraph 76 onwards)*
- '10. *Due to the urgency of this matter and to ensure availability of counsel at the hearing we believe that it is necessary to set this matter down without further delay.*
- "11. *Supplementary affidavits from the First to the Fifteenth Applicants will be filed with this Honourable Court as soon as we are provided with an opportunity to consult with them.*' (my emphasis)

The supplementary confirmatory affidavits were indeed filed and form part of the papers from page 214 to 243. They were filed on the 10th of May 2006.

I accept Ms GABRIEL's submission that if counsel for the Respondents who was present when the approach was made to LEVINSOHN J for an expedited hearing in terms of Rule 6(12), had read the papers, he or she would have seen in the opening

paragraphs that there was a problem which the Applicants undertook to put right – as indeed they did. The problem was foreshadowed in the founding affidavit.

I have a discretion in such matters and having regard to the problems encountered by the legal representatives of the Applicants in arranging consultations with their clients at WCC, as is apparent from a reading of the correspondence attached to the founding papers, the so-called ‘defect’ is understandable. To the extent that condonation is required, the ‘defect’ if it is that, is accordingly condoned in the interest of fairness and justice. To be charitable to counsel for the Respondents, I would like to believe that he had overlooked paragraphs 9 to 11 of the founding affidavit and took the point not knowing that when LEVINSOHN J was approached, both counsel for the Applicants and Respondents were present, and the order taken by consent.

In the ensuing paragraphs, I deal with terminology, as understood by me, used frequently in the papers and in argument and about which there is consensus, unless otherwise indicated.

HIV AND HIV/AIDS AND THE CD 4 COUNT:

[12] There is no dispute about what HIV and HIV/AIDS is all about. Dr WILLEM DANIEL FRANCOIS VENTER who deposed to an affidavit forming part of the founding papers and whose expertise is impressive and not challenged, states that:

“11. Infection with Human Immunodeficiency Virus (HIV) ultimately results in a condition known as Acquired Immune Deficiency Syndrome (AIDS). This is an invariably fatal condition that is marked by the development of largely predictable set of

opportunistic illnesses that lead over time to a deterioration of the immune function and the premature death of people with HIV.

“12. ARV medicines target either a particular step in the life cycle of HIV or its interaction with host cells. They arrest the progression of HIV and allow the immune system to recover in the majority of treated patients, and thereby keep patients both alive and productive.

“13. A marked called the CD 4 count measures the deterioration of immune function. A CD 4 count, which is commonly used as an indicator of immune strength, is a measure of white blood cells. It is used to determine how seriously a person’s immune system has been damaged by HIV. It is a rough although very useful measure, as it can vary by 10/15% in a short period, both due to internal physiology and due to laboratory variation. It is therefore used as a guide in conjunction with clinical and other considerations, specifically the risk of developing opportunistic infections.”

Further relevant is the following paragraph:

“16. There is a broad international and local scientific consensus on when to commence ARV treatment. A person living with HIV/AIDS who has demonstrated the requisite commitment to taking ARV medicines should commence ARV treatment no later than the point when his or her CD 4 count is below 200 cells/ml and/or he or she has already contracted a stage IV illness, as defined in the internationally accepted World Health Organisation (WHO) staging system. The only debate on the initiation of ARV treatment is whether or not this should begin earlier, and if so at what point.”
(my emphasis)

He goes on to say at paragraph 17:

“17. *The approach to the initiation to ARV treatment has been adopted by the Department of Health ARV Treatment Guidelines, which in turn confirm the approach to ARV treatment that is included in the Operational Plan for Comprehensive HIV and AIDS Care Management and Treatment for South Africa (the plan).* - - -“

I will make further reference to Dr VENTER’s evidence later in this judgment. In ***HOFFMAN v S A AIRWAYS 2001 (1) SA 1 (CC)*** at paragraph 11 there is a useful analysis of the four stages of untreated HIV infection. About the fourth stage, (on which there is consensus) the following appears:

“AIDS (Acquired Immune Deficiency Syndrome) stage – this is the end stage of the gradual deterioration of the immune system. The immune system is so profoundly depleted that the individual becomes prone to opportunistic infections that may prove fatal because of the inability of the body to fight them.”

THE OPERATIONAL PLAN

[13] It is not disputed that the Operational Plan was put in place by the Cabinet of the First Respondent on the 19th of November 2003 and contains a comprehensive strategy for the management of HIV/AIDS, the care and treatment of patients living with HIV/AIDS described as a “National Pandemic”. The Operational Plan recognizes the critical role of ARV medicines in the treatment of the virus and the need to make it progressively available especially to those less fortunate than others in the private sector who can afford it and to whom it is readily available. Importantly, the Operational Plan acknowledges that patients with a CD 4 count of below 200 need to commence ARV treatment as well as those patients who present with certain particularly serious illnesses designated as WORLD HEALTH ORGANISATION (WHO) Stage IV illnesses. In the case of the latter illnesses, ARV treatment should

commence regardless of the DC 4 count. It is accepted that the lower the CD 4 count the higher the risk of AIDS and consequently more the urgency for treatment. It is further recognized that an important precondition before starting ARV treatment is a patient's readiness and commitment to adhere to the treatment over the long term. This assessment is tasked to the MULTI DISCIPLINARY TEAM.

THE NATIONAL ANTIRETROVIRAL TREATMENT "GUIDELINES":

[14] The guideline was published by the National Department of Health in 2004 and deals, *inter alia*, with patient selection criteria and "psycho-social considerations" which are expressly stated to be non-exclusionary criteria. It is to be noted that the only instance contemplated in the Guidelines where treatment will not commence is when a patient is found not to meet the readiness criteria. The suitability and readiness for the initiation of treatment is taken by a **Multi Disciplinary Team** at the applicable ARV treatment centre. It is to be further noted that not all hospitals or clinics are accredited centres. Only those designated as such can initiate treatment. Relevant for present purposes is that the guidelines list the following criteria for ARV initiation in Adults, Adolescents and Pregnant Woman:

- CD 4 < 200 cells/mm³ irrespective of stage,
or
- WHO stage IV AIDS defining illness, irrespective of CD 4 count,
or
- Patient expresses willingness and readiness to take ARV adherently.
(my emphasis)

MULTI-DISCIPLINARY TEAM:

[15] The Multi – Disciplinary Team as described by the Respondents is a team which consists of doctors, social workers, nutritionists, professional nurses etc. They assess social support of the patient and his readiness to take the ARV treatment. The first decision to treat the patient with ARV's at an accredited site is taken by this team.

The six psycho-social criteria to be considered by the Multi-Disciplinary team are not exclusionary. The list is as follows:

- (i) demonstrated reliability, meaning the attendance at three or more scheduled visits to an HIV clinic;
- (ii) disclosure of HIV status to at least one friend or family member, or joining a HIV/Aids support group;
- (iii) acceptance of HIV status, and insight into the consequences of HIV infection and the role of ARV treatment;
- (iv) ability to attend the ARV treatment centre on a regular basis or access to services for maintaining the treatment chain;
- (v) no active alcohol or other substance abuse; and finally
- (vi) no untreated active depression.

It is worth observing that not all can be applied in the prison context.

ARV TREATMENT / ART (THERAPY):

[16] There does not appear to be unanimity between the Applicants and Respondents as to whether ARV treatment and Anti-Retroviral Therapy are one and the same thing. The terminology is not defined as being a reference to two separate

procedures in either the Operational Plan or the Guidelines. They are used interchangeably. Mr MOERANE submitted however that they are distinct terms – the Treatment with ARV medicines follows the Therapy. What is not in dispute however, whether you use the term ARV Therapy or ARV Treatment, the actual administering of medication has to be preceded by a clinical assessment by a qualified medical practitioner. It is common cause that treatment must take place as soon as possible once the CD 4 Count has reached 200.

WHAT IS THIS CASE ALL ABOUT?

[17] We have two divergent views on what this case is all about. From the Applicants' viewpoint, two constitutional issues are involved. The one is that the Respondents have failed to discharge their constitutional obligation to the Applicants and others similarly affected by the HI-Virus. The First of these obligations is set out in section 27 of the Constitution, the relevant portions of which read as follows:

- “(1) Everyone has the right to have access to –
 - (a) health care services, including reproductive healthcare;
 - (b) - - -
 - (c) - - -
- (2) The State must take reasonable legislative and other measures within its available resources to achieve the progressive realization of each of these rights.”

The Second of these obligations, directly applicable to the class of persons such as the First to the Fifteenth Applicants is section 35(2)(e) of the Constitution which at the risk of repeating myself, reads as follows:

“Everyone who is detained, including every sentenced prisoner has the right to conditions of detention that are consistent with dignity, including at

least exercise, and the provision, at State expense, of adequate accommodation, nutrition, reading material and medical treatment.

It is not an issue that the Applicants have these rights and that the Respondents bear a corresponding obligation to fulfill these rights.

[18] Counsel for the Applicants was at pains to point out that what the Applicants want is a declarator ordering the Respondents to remove such restrictions as there are that prevent the First to the Fifteenth Applicants and all other similarly situated prisoners, from benefiting from treatment in accordance with the Operational Plan and Guidelines. Pursuant upon removal of these restrictions the Applicants seek a declarator that the Respondents be ordered to provide ARV treatment to the fifteen Applicants and all other similarly situated prisoners, again in accordance with the Operational Plan and Guidelines.

There is in my view, a fundamental misconception on the part of the Respondents on the interpretation of the relief claimed by way of the declarator. Mr MOERANE submitted that what the Applicants seek to do is to ask the Court to override the Operational Plan and Guidelines and prescribe ARV treatment. His submission is that the Respondents are bound by the Operational Plan and Guidelines and that is what in fact the Respondents are doing.

I accept without hesitation that the Court cannot prescribe treatment. That is the function of the medical fraternity. My understanding of the relief claimed, and what the Applicants seek to do, is to remove impediments and to fast track the procedures because it is a matter of urgency that the First to Fifteenth Applicants and other

similarly situated prisoners be assessed for ARV treatment in accordance with the Operational Plan and Guidelines. I do not see the Applicants as seeking an order that the Court write out a medical prescription as Mr MOERANE has suggested. My understanding is that what the Applicants seek to do is to avoid unnecessary delays in treatment of prisoners because such delays, especially in the context of their incarceration and vulnerability, compromise their already serious health status, which Ms GABRIEL has stated, in her heads of argument are, "*a matter of life and death*".

Justification that the matter is a "life and death one" is to be seen from an examination of Dr VENTER's evidence and annexure "AMG 19" attached to the founding affidavit which shows that the Applicants are seriously ill. All fifteen applicants have CD 4 cell counts of below 200. Eight have CD 4 cell counts of below 100 and of these, five Applicants have CD 4 cell counts of below 50.

[19] It is not disputed that VENTER was one of a group of expert clinicians who contributed to the development of the ARV Treatment Guidelines for the public sector that was adopted by the Government in March 2004. He says that people with CD 4 counts of below 200 cells/ml are by definition severely ill and require immediate assessment for ARV treatment. He qualifies this by saying that this is not a rigid requirement and would depend on other circumstances of the particular patient, for example, whether the patient is showing symptoms of opportunistic infections and the CD 4 cell count. What he makes clear is that they need to be immediately assessed. He comes to the conclusion that if ARV medicines are not made available to offenders at WCC immediately, many of them will suffer irreparable harm and in all likelihood premature death.

ARE THE RESPONDENTS COMPLYING WITH THEIR CONSTITUTIONAL OBLIGATIONS?

[20] The Respondents say that they are complying with their constitutional and legislative obligations and have taken the Court through the medical history of each of the fifteen Applicants to illustrate this. I will return to this later.

The Courts have, as far back as 1912 and possibly even earlier upheld the rights of prisoners to have access to health care despite their incarceration. In **WHITAKER v ROOS and BATEMAN; MORANT v ROOS and BATEMAN 1912 AD 92** at 122, INNES CJ said the following:

“True, the plaintiffs’ freedom had been greatly impaired by the legal process of imprisonment; but they were entitled to demand respect for what remained. The fact that their liberty had been curtailed could afford no excuse for a further illegal encroachment upon it.”

More recently the sentiments of INNES CJ were echoed by HOEXTER JA in **MINISTER OF JUSTICE v HOFMEYER 1993 (3) SA 131 (A)** at 141 C-D. More to the point, the right of a prisoner to ARV treatment where it was medically prescribed, was enforced in **VAN BILJON v MINISTER OF CORRECTIONAL SERVICES 1997 (4) SA 441 (C)**.

To emphasise the seriousness of the issue before me it is worth reiterating what was said by the Constitutional Court in relation to the HIV/AIDS Pandemic at paragraph 1 in **MINISTER OF HEALTH v TAC AND OTHERS (No 2)** (supra):

“The HIV/AIDS Pandemic in South Africa has been described as ‘an incomprehensible calamity’ and ‘the most important challenge facing

South Africa since the birth of our new democracy’ and Government’s fight against ‘this scourge’ as ‘a top priority’. It has claimed millions of lives, inflicting pain and grief, causing fear and uncertainty, and threatening the economy. These are not the works of alarmists but are taken from a Department of Health publication and a Ministerial foreword to an earlier Departmental publication.”

[21] The Respondents do not dispute their obligation both in terms of the Constitution and in terms of section 12 of the Correctional Services Act No 111 of 1998 – the relevant part of which reads as follows:

“(1) The Department must provide, within its available resources, adequate health care services, based on the principles of primary health care, in order to allow every prisoner to lead a health life.

(2)

(a) every prisoner has a right to adequate medical treatment.

(b) - - -

(3) - - - -

(4)

(a) every prisoner should be encouraged to undergo medical treatment necessary for the maintenance or recovery of his/her health.

(b) - - - -“

The Fifth and Sixth Respondents are joined in the application because they too share a responsibility for health care of convicted and awaiting trial prisoners. Section 21(2)(b)(iv) of the National Health Act 61 of 2003 provides:

“The Director-General [of Health] must, in accordance with the national health policy - - - issue and promote - - - health services for convicted persons awaiting trial.”

[22] A good starting point is whether there is any evidence that prior to the first intervention by the ALP the Respondents had acted reasonably in the implementation of their constitutional statutory and policy obligations. The first intervention by the ALP is by way of the letter of the 28th of October 2005. As at that day we know that each of the fifteen Applicants had a CD 4 count of less than 200 – the date of the count being taken in each case, save for the Sixth, Seventh, Tenth and Eleventh Applicants, in March 2005. The Sixth and Eleventh Applicants' count was taken in April 2005 and that of the Tenth Applicant in August 2005. The Seventh Applicant's count was taken in November 2004. In March 2006 all of them with the exception of the Fifteenth Applicant showed a CD 4 cell count of less than 200. It is common cause that by March 2005, the Operational Plan and Guidelines were already in place.

JABULILE ELIZABETH SISHUBA deposing to the answering affidavit on behalf of the Respondents, admits that all the Applicants meet the criteria for ARV Therapy, but in dealing with each of the Applicants she does not say when the therapy started. Even in referring to the “**Wellness Programme**”, she makes no mention when each Applicant was inducted into the said programme. This programme is described as a support group where the offender receives counseling on HIV and at which the offender will receive a health supplement called “PHILANI”. It would have, in my view, been a simpler matter to state when each of the Applicants were put on the programme. It is not surprising therefore that the fifteen Applicants with the sole exception of one denies any knowledge of the Wellness Programme. Most deny even knowledge of the existence of the programme. It was contended by counsel for

the Respondents that this was a factual dispute. I point out later that this is more apparent than real.

It would seem to me that the supply of "Philani" is seen by the Respondents as part and parcel of the Wellness Programme whereas the Applicants see them as being different, one of which they have no knowledge whatsoever. Interestingly enough SAREL FRANCOIS MARAIS employed by the Third Respondent as Assistant Director responsible for making bookings for prisoners at King Edward VIII Hospital (KEH) refers to the "Philani Clinic" as being the place at which "Philani" is distributed. He says that it is part and parcel of the Wellness "Clinic" referred to by SISHUBA. The denial by the Applicants of any knowledge of the Wellness Programme seems to me to arise out of this confusion. The denial therefore makes sense in this context. There is therefore no genuine dispute of fact.

[23] I have looked carefully at the answering affidavit with particular reference to what SISHUBA says in respect of each of the Applicants and find only a single reference to anything possibly being done before the 28th of October 2005, and that sole reference is to the Fifteenth Applicant where she says that during 2005 he did not qualify to be placed on the ART programme because his CD 4 count was above 200/mm³. (my emphasis)

Not in respect of any of the other Applicants does she make any reference whatsoever to them being on the ART programme. If the ART programme is somehow given the same appellation as the "Wellness Programme" she should have

said so. In any event at paragraph 6(b) of her answering affidavit she draws a clear distinction between the two. She says the following:

“(b) If the offender’s results are positive the doctor will then direct that a CD 4 cell count test be done. Irrespective of the result of the CD 4 count test the doctor will refer the offender to the Wellness Programme. This is where he will receive counseling and support from the support groups. If the offender has an opportunistic infection the doctors at WCC will treat it. If the CD 4 count is less than 200/mm³ the offender will be enrolled on the Anti-Retroviral Therapy (ART) Programme. This programme is offered by the institution of cities which have been accredited by the Department of Health (DoH) as ART sites.” (my emphasis)

There is not one iota of evidence forthcoming from the Respondents that any of the Applicants were enrolled in the ART programme prior to October 2005. We do know now after the ALP letter of the 28th of October 2005 and the launch of this application in April 2006, that:

- (i) the First Applicant has an appointment with the family clinic at KEH on the 27th of June 2006;
- (ii) the Second Applicant has an appointment with KEH on the 14th of June 2006;
- (iii) The Third Applicant has an appointment with KEH on the 23rd of May 2006;
- (iv) The Fourth Applicant is already on ARV treatment and his appointments were on the 28th of February 2006, 14th of March 2006, 26th of March 2006 and the 24th of April 2006;
- (v) The Fifth Applicant has an appointment at KEH on the 22nd of June 2006;
- (vi) The Sixth Applicant has an appointment for the 21st of June 2006 and it was only made when the ALP brought it to the notice of the

Respondents in March 2006 that he had a CD 4 cell count of less than 200. This is an admission that the Respondents make;

- (vii) The Seventh Applicant has an appointment at KEH for the 18th of May 2006. He was First referred to McCORDS hospital on the 9th of December 2005;
- (viii) The eighth Applicant was released on parole from WCC on the 11th of April 2006. On the 5th of May 2006 he reported to the Maphumulo Correctional Unit as part of his confirmatory process;
- (ix) The Ninth Applicant has an appointment at KEH for the 19th of June 2006. He had been referred to King George Hospital in 2005. We do not know if this was before the ALP's interest in the matter in October 2005. The Respondents do no say when in 2005 that he was so referred;
- (x) The Tenth Applicant has an appointment at KEH for the 26th of June 2006;
- (xi) The Eleventh Applicant has an appointment at KEH for the 28th of June 2006;
- (xii) The Twelfth Applicant has his appointment at KEH for the 29th of June 2006;
- (xiii) The Thirteenth Applicant has been prescribed ARV Treatment on the 6th of April 2006 and had gone through the ART programme (presumably Therapy). But we do not know from when;
- (xiv) The Fourteenth Applicant has an appointment with KEH on the 20th of June 2006. We know that he has been treated for TB since June 2005;
- (xv) The Fifteenth Applicant is now on the ART programme and has an appointment with KEH on the 20th of June 2006. During 2005, (we do not know which month), he was placed on the ART programme.

What is significant about what is detailed above is that apart from the Fourteenth Applicant for whom some tests were done in June 2005, there is not a single mention of anything being done for any of the other Applicants, by reference to month or date between November 2004, March, April and August 2005 up to October 2005 when

the ALP showed an interest in the matter or until the 12th of April 2006 when this application was launched.

I am therefore inclined to accept the submission by Ms GABRIEL that it was only after the launch of these proceedings that some movement on the part of the Respondents is detected. It has always been, as I perceive it, that the Respondents have delayed without good cause in circumstances where life and death mattered.

The parties may not be too apart right now, but as I see it intervention by this Court is called to ensure that the Respondents urgently comply with their constitutional and statutory obligations not only to the first fifteen Applicants (except for the two in respect of whom relief is no longer claimed), but also to similarly situated prisoners.

[24] The dilatoriness and lack of commitment by the Respondents as evidenced by the correspondence forming part of the founding affidavit is quite evident. It seems to me that but for the intervention of the State Attorney, who used his good offices to convene the round table meeting which took place on the 15th of December 2005, the ALP may well have had good cause to have launched this application earlier. It is not necessary to me to detail the correspondence that passed between the ALP, the WCC and other State Departments. They are on record. I observe a singular lack of any commitment to appreciate the seriousness and urgency of the situation by anyone apart from the Regional Commissioner of Correctional Services who, in his letter to the ALP dated the 13th of January 2006 (“AMG 35”) and also his letter of the 20th of December 2003 addressed to the Ethikweni Health District, says *inter alia*, that:

“Looking at the seriousness of the whole exercise, which is a matter of life and/or death, and the urgency which it deserves this office deems it necessary to urge your office to promptly fast track the whole ART issue at Westville Correctional Services on receipt of this communication.”

He makes the point that HIV and AIDS at WCC is a reality, with ± 110 HIV and AIDS related deaths since the beginning of 2005, and ± 50 offenders with a CD 4 count of less than 200.

[25] The Respondents have not made the lack of resources an issue. Their case is that they are complying with their obligations. The issue boils down to whether the Respondents are taking reasonable steps or measures to ensure whether the Applicants are receiving adequate medical treatment. Ms GABRIEL’s illustration of the irrationality of the arrangement which WCC had reached with Dr DE VILLIERS ZITA, the head of the ARV roll out at KEH with regard to the four counselling sessions is well made. The evidence in this regard is that KEH is only able to book an appointment for one offender per day for four days a week, being Monday to Thursday. What is contemplated is that the sessions are held a week apart with the hope that during this process the patient will have had enough time to reflect on the implications of starting the ART programme.

Disregarding the two Applicants who are no longer concerned with this Application, there are thirteen others. Ms GABRIEL has illustrated, convincingly, that on the basis that KEH can see only four offenders in one week, it will take 3¼ weeks for all thirteen to get only their First counselling. The plan she submitted, is simply

unworkable. If the pattern is followed, it will take approximately a year before all 50 similarly affected prisoners are on treatment.

[26] We know from Dr VENTER's evidence that there is need to fast track the process in respect of those who show a willingness to take the treatment, if medically indicated. (my emphasis) We know also that there are other designated sites apart from KEH which the WCC has still not accessed and afford no reason for not doing so. These are R K Khan, Wentworth Hospital, Clairwood Hospital, Prince Mshiyeni Hospital, Addington Hospital and Osindweni Hospital.

[27] Dr VENTER says that a person with HIV/AIDS who has demonstrated the requisite commitment to taking ARV medicines should commence ARV treatment no later than the point when his/her DC 4 count is below 200. People with CD 4 counts of less than 200, he says, require immediate assessment for ARV treatment. Now, it does not seem to me that the steps taken by WCC are in the least bit adequate. The plan envisaged by them is patently unworkable unless other designated sites are accessed immediately. There is no commitment by the Respondents to adhere to any workable or rational time frames. Notwithstanding an appreciation by the Regional Commissioner of the Third Respondent that the whole issue at WCC be fast tracked, the only obstacle that so far has been removed, which is now common cause, is the issue that all prisoners no longer have to have ID Books to access treatment.

More pertinent to this application we hear of no commitment on the part of the Respondents committing themselves to time frames in respect of those other

similarly situated prisoners. There is a deafening silence on this issue. This is perhaps understandable because they deny that the fifteen Applicants have *locus standi* to represent other prisoners in a class action.

[28] The Applicants say that the Respondents' undertakings given at the round table meeting on the 15th of December 2005, have not been honoured. The Respondents say that they have taken reasonable and adequate steps to ensure that the Applicants are placed on the ART programme expeditiously in terms of the agreements reached. I do not see any evidence of this and what they now propose has been illustrated by the Applicants' counsel to be illogical and unworkable.

THE SPECIAL CIRCUMSTANCES PRISONERS AND THE REASONABLENESS OF POLICY AND STATUTORY OBLIGATIONS:

[29] I am acutely conscious, speaking from my own experience, that when sentencing a prisoner to a long term of imprisonment, that his or her prospects of emerging from prison alive is seriously compromised because of the HIV/AIDS pandemic. I believe that that thought would also engage most of my colleagues in this division. Much has been said and continues to be said about severe overcrowding from official sources. This is something about which I believe I can take judicial notice of – as did the Court in ***STANFIELD v MINISTER OF CORRECTIONAL SERVICES AND OTHERS 2004 (4) SA 43 (CPD)*** where the Court associated itself with the call by the Judicial Inspectorate of Prisons (headed by FAGAN J). This is what appears at paragraph 128 of that judgment at page 80:

“The facts set forth in the most recent annual report of the Judicial Inspectorate of Prisons (paragraph [51] above) indicate a shocking state of affairs. Despite the huge increase in the prevalence of HIV/AIDS and

other terminal diseases in our prisons, only the tiniest percentage of prisoners suffering from such diseases were released on medical grounds during 2002. I associate myself fully with the call by Inspecting Judge JJ Fagan that the release of terminally ill prisoners should receive far more attention, if not priority attention, than is the case at the present time. The alternative is grotesque: untold numbers of prisoners dying in prisons in the most inhuman and undignified way. Even the worst of convicted criminals should be entitled to humane and dignified death.”

It is regrettable that prisoners, being of a class, very vulnerable to infection, were not given special consideration in the Operational Plan and Guidelines. Applicants' counsel drew attention to the fact that when the Operational Plan and Guidelines were drawn, it was manifestly drawn with the general public in mind. I agree. This explains why there is only a passing reference to prisoners in both documents.

The Operational Plan provides as follows:

“In order to offer HIV and AIDS care and treatment, tight linkages with the public health system will be needed, so that patients requiring evaluation for Anti-Retroviral Therapy can be appropriately assessed and started on ARV's by skilled clinicians. The health care team will refer prisoners back to Correctional Services for ongoing primary care follow-up for HIV, with referrals for specialized care in public facilities according to National Treatment Guidelines.”

It is plain to see from that statement that the public health system should be involved. The Guidelines on the other hand are completely silent on the matter. The Guidelines do not, for example, deal with the relevance and/or the application of the psycho-social criteria (paragraph 15 *supra*) in a prison context.

This to my mind, is important, to take but two examples:

- i. Prisoners are at the mercy of prison officials to ensure regular and timeous attendance at HIV/AIDS clinics and hospitals;
- ii. House visits, provided for in the psycho-social criteria, is not possible in the prison context and there may well be room for abbreviated time periods between visits to ensure earlier assessment.

All this indicates that there is room for flexibility in the contexts of HIV/AIDS victims in the prison context. Guidelines are what they purport to be – guidelines and no more. They are not cast in stone as the Respondents seem to suggest. So too, I imagine would be the Operational Plan in the prison context because the ordinary process, if followed to the letter, in the prison context, would result in unnecessary delay and put the Applicants and similarly situated prisoners, who succumb to the virus, at the risk of losing their lives.

[30] A good starting point to the enquiry into whether the conduct of the Respondents was and is reasonable or not would be to take note of the comment of YACOOB J in **GOVERNMENT OF THE RSA v GROOTBOOM 2001 (1) SA 46 (CC)**, bearing in mind of course that the implementation of law and policy and fulfillment of legal duties, must be reasonable. This is what YACOOB J said in **“GROOTBOOM”**:

“The State is obliged to act to achieve the intended result, and the legislative measures will invariably have to be supported by appropriate, well-directed policies and programs implemented by the Executive. These policies and programs must be reasonable both in their conception and their implementation. The formulation of a program is only the first stage in meeting the State’s obligation. The program must also be reasonable implemented. An otherwise reasonable program that is not

implemented reasonably will not constitute compliance with the State's obligations."

In the context of the factual position about which much has already been said, I am in full agreement with the Applicants' contentions as articulated by their counsel in her heads of argument that the Respondents implementation of the laws and policies is unreasonable in that:

- (a) it is inflexible;
- (b) it is characterized by unjustified and unexplained delay, and
- (c) some of the steps taken by the Respondents after the institution of these proceedings, in particular the manner in which the appointments were set up, are irrational.

[31] The Applicants have come to Court on the basis that their fundamental constitutional rights are being infringed. Section 237 of the Constitution provides that all constitutional obligations must be performed diligently and without delay. In ***RAIL COMMUTERS ACTION GROUP v TRANSET LTD t/a METRORAIL 2002 (5) SA 359 (CC)***, O'REGAN J in the context of a threat to fundamental rights said that each case must be judged according to its own circumstances. One of the considerations would be that the graver the threat to fundamental rights, " - - - ***the greater is the responsibility on the duty bearer.***" That observation is a salutary one. On the facts of this case, I come to the conclusion that the treatment and medical care afforded to the First to the Fifteenth Applicants and other similarly situated prisoners at WCC is neither adequate nor reasonable in the circumstances. The Respondents have, I find, fallen short of their constitutional and legislative obligations to the Applicants. Had steps been taken as early as November 2004 in the case of one

Applicant or in March, April or August 2005 in the case of the others, the current serious impasse could well have been avoided.

THE STRUCTURAL INTERDICT:

[32] My initial reaction to the idea of a structural interdict, when first I read the papers was one of skepticism because in respect of the First to the Fifteenth Applicants, the Respondents had shown some sense of commitment, however inadequate and irrational, to redress their plight. I was also conscious of the submission by Mr MOERANE in his heads and in argument before me that Courts are reluctant to make such orders because, depending on the circumstances, it may amount to an unwarranted interference with the authority and discretion of the executive arm of government, thereby violating the principle of separation of powers. I am conscious of these sensitivities and the debate surrounding the issue. However, nothing rational or workable has been forthcoming from the Respondents with regard to the Applicants and nothing at all about similarly situated prisoners at WCC, presumably because of the stance the Respondents have taken that the sixteen Applicants have no *locus standi* to bring the Application on their behalf. I am of the view therefore that structured relief is justified based on the facts before me and the circumstances of the case.

The Respondents submit that this application was unnecessary because they are implementing the Operational Plan and Guidelines. Having carefully considered the evidence before me, I come to the conclusion that such steps that have been shown to be taken by the Respondents are unworkable and characterized by delays,

obstacles and restrictions which seriously compromises the health of the thirteen remaining Applicants.

An order that does not take into consideration the plight of other similarly situated prisoners at WCC will result in continued denial of access to ARV treatment for them and consequently an infringement of their constitutional rights.

Dr VENTER's uncontested evidence is that there is room for flexibility. In my mind such an order is justified in the special circumstances of this case, more especially, as I see it, there has been and continues to be a violation of the Applicants' constitutional rights. There is nothing forthcoming from the Respondents despite the evidence, on their own version, that there are other prisoners at WCC who are affected by the virus and that there are problems associated with their access to assessment for therapy and treatment. A structured order with a supervisory component is therefore just, equitable and appropriate.

[33] The time limit of one week suggested to which the Respondents should be committed to file an affidavit setting out the manner in which they will comply with paragraph 4 of the order, as suggested by Ms GABRIEL, even given the urgency, is somewhat optimistic and impractical. There will have to be consultations within and between departments of State, and no doubt with legal counsel and with accredited hospitals and clinics in order to come up with a comprehensive and workable plan not only having regard to the Applicants but other similarly situated prisoners at WCC. A two week period, I believe will be more realistic. I expect that during this period, counselling and treatment of those affected will continue. I should also make

provision in the order for the Applicants to approach the Court again in the event that the steps proposed by the Respondents in compliance with paragraph 4 of the order are unreasonable. Such an approach could be made on submission of further affidavits before any judge of this division as I do not consider myself in such eventuality, to be seized with the matter.

I must however express the hope that whatever plan the Respondents come up with, if there is any disagreement, good sense will prevail and a settlement reached through negotiation in the interests of those affected prisoners whose vulnerability cannot be denied. Any protracted litigation can only be counter-productive and harmful to those in whose interest this application was launched.

COSTS:

[34] There can be no reason why a costs order should not follow the usual course and be awarded to the successful party.

ORDER:

[35] I accordingly make the following order:

1. That the Respondents are hereby ordered with immediate effect to remove the restrictions that prevent the First, Second, Third, Fifth, Sixth, Seventh, Ninth, Tenth, Eleventh, Twelfth and Fifteenth Applicants, and all other similarly situated prisoners at WESTVILLE CORRECTIONAL CENTRE, who meet the criteria as set out in the National Department of Health's Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa, from

accessing Anti-Retroviral Treatment at an accredited public health facility.

2. That the Respondents be and are hereby ordered with immediate effect to provide Anti-Retroviral Treatment in accordance with the aforesaid Operational Plan to the First, Second, Third, Fifth, Sixth, Seventh, Ninth, Tenth, Eleventh, Twelfth and Fifteenth Applicants and all other similarly situated prisoners at WESTVILLE CORRECTIONAL CENTRE at an accredited public health facility;
3. That the Respondents are hereby ordered on or before the 7th day of July 2006 to serve on the Applicants' attorneys and lodge with the Registrar of this Court, an affidavit setting out the manner in which it will comply with paragraph 2 of this order.
4. The Applicants may within five (5) days of the delivery of the affidavit by the Respondents contemplated in paragraph 3 of this order, deliver a commentary thereon, under oath.
5. The Respondents may within five (5) days of the delivery of the commentary contemplated in paragraph 4 of this order, deliver a reply under oath.
6. Thereafter the matter may be enrolled for hearing in consultation with the Registrar of this Court.

7. The Respondents are ordered to pay the costs of the Applicants jointly and severally.

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