The Consumption of Ideas: Tuberculosis, the Constitutions of Canada and South Africa, and the Progressive Development of Human Rights Instruments

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The connections between Canada's Charter of Rights and Freedoms *and South Africa's* Bill of Rights *provide a positive example of how human rights instruments, and their underlying norms, can evolve through building upon the achievements of their antecedents elsewhere. A broader example of similar evolution is seen in how the experiences of different countries have informed the progressive integration of human rights into the global response to HIV. However, such foreign influence does not always lead to progressive developments in the law, as demonstrated by the impact of Canadian jurisprudence in South Africa around the involuntary confinement of tuberculosis patients.*

Using the key South African case of Minister of Health of the Province of Western Cape v Goliath*, this paper illustrates how approaches taken in other countries can be used as justification for restrictions on rights when courts do not explore whether the underlying approach itself is reasonable and transferable.* Goliath *relied heavily upon the Canadian case of* Toronto (City, Medical Officer of Health) v Deakin*, drawing direct parallels between analogous provisions of the* Charter *and the* Bill of Rights *in upholding the involuntary detention of tuberculosis patients. Neither case gives due attention to properly balancing the rights of the individual against infringements necessary for public health. Fortunately, this appears to have been only a shared stumble, as both countries are once again moving, albeit at different speeds, on a more progressive path toward integrating human rights into the response to tuberculosis. The paper concludes that Canada would do well to draw the right lessons from experiences elsewhere to hasten the expansion of its incorporation of emerging human rights norms.*

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> I would not look to the US Constitution, if I were drafting a constitution [today]. I might look at the Constitution of South Africa. That was a deliberate attempt to have a fundamental instrument of government that embraced basic human rights, had an independent judiciary . . . it really is, I think, a great piece of work that was done. Much more recent than the US Constitution, Canada has a *Charter of Rights and Freedoms*. It dates from 1982 . . .. Yes, why not take advantage of what there is elsewhere in the world?[1]
>
> Ruth Bader Ginsberg, Associate Justice of the Supreme Court of the United States

Introduction: Borrowing Tools and Building for the Future

Effective human rights instruments are not usually built from scratch; instead, their construction is a process that involves examining what has worked—and what has not worked—at other times and in other places. After the storm clouds of apartheid lifted to reveal the Rainbow Nation of South Africa in 1994, the first democratically elected government was tasked with drawing up a new constitution that would properly enshrine the human rights that had long been denied the majority of citizens. One

1. "US Supreme Court Justice Ruth Bader Ginsburg to Egyptians: Look to the Constitutions of South Africa or Canada, Not to the US Constitution" (30 January 2012) at 00h:02m:39s, online (video): *Memri TV* <www.memritv.org/clip/en/3295.htm>.

source drawn upon in developing the new South African *Bill of Rights*[2] was the *Canadian Charter of Rights and Freedoms*,[3] itself then little more than a decade old. Viewed together, the Canadian and South African instruments represent progressive advances in the constitutional enshrinement of human rights; as such, each reflects an enlightened view of human rights at the time it was drafted, with subsequent jurisprudence reflecting further attempts to accommodate emerging global norms.

As an example, at the same time that the South African *Bill of Rights* was being drafted to offer the world's first[4] explicit constitutional recognition of equality based on sexual orientation,[5] the Supreme Court of Canada was reading in similar protections as an analogous ground under the *Charter*.[6] In turn, the South African document is also more expansive in other areas than its Canadian antecedent, particularly in its incorporation of social and economic rights that are absent from the *Charter*; this reflects shifts in international acceptance of socio-economic rights not merely as aspirational goals, but as rights to be claimed and adjudicated.[7] Thus, just as important as the similarities between the documents is how they serve as an example of a positive approach by which countries can look to each other in the progressive development of human rights norms: by recognizing shared values and using existing models as foundations for building even better human rights tools.

At the same time, looking to the experiences of other jurisdictions can also hinder the progressive development of human rights norms, including through impacting the jurisprudence underpinning those norms. This occurs when one state uses the experiences of another to justify its own actions as meeting existing standards, rather than evaluating whether those standards are themselves sufficient. It was this latter approach South Africa took in

2. See *Constitution of the Republic of South Africa, 1996*, No 108 of 1996, ss 7–39 [*Bill of Rights*].

3. Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11 [*Charter*].

4. See Dennis Altman, "HIV, Homophobia, and Human Rights" (1998) 2:4 Health & Hum Rts 15 at 21.

5. *Supra* note 2, s 9(3).

6. See *Egan v Canada*, [1995] 2 SCR 513, 124 DLR (4th) 609.

7. See Bruce Porter, "Socio-Economic Rights in a Domestic Charter of Rights: A Canadian Perspective" in *Human Rights and Peace-Building in Northern Ireland: An International Anthology* (Belfast: Committee on the Administration of Justice, 2006) 73.

drawing direct parallels between the *Bill of Rights* and the *Charter* in order to justify its actions regarding involuntary confinement of tuberculosis (TB) patients. One poorly reasoned case thus led to a second, thousands of kilometres away. In exploring how this came to pass, this article examines the issue of evolving human rights instruments and norms from a number of angles.

First, in order to illustrate how such instruments can influence each other directly, it explores the connections between the Canadian *Charter* and the South African *Bill of Rights*. Next, parallels between the two instruments with regard to balancing human rights and public health are outlined in more detail. The paper then turns its attention to the integration of human rights into the response to the global HIV epidemic, and how the global human rights framework evolved as it incorporated the experiences of different countries emphasizing different rights under different circumstances. The story of HIV and human rights is then contrasted with that of TB, a disease that has attracted considerably less attention from a human rights perspective despite its longer history. The paper next returns to the interplay between the *Charter* and the *Bill of Rights* to highlight the negative influence of the Canadian *Toronto (City, Medical Officer of Health) v Deakin*[8] case on the *Minister of Health of the Province of Western Cape v Goliath*[9] case in South Africa. It then explores subsequent developments relating to TB and human rights in both jurisdictions, outlining both stumbles and advances on the path toward treating human rights as an essential consideration within the broader legal and policy response to TB, while pointing toward avenues for positive influence on the development of Canadian human rights jurisprudence in the future.

I. Constructing Constitutions and Search for Precedent

In 1989, just prior to her appointment to the Supreme Court of Canada, McLachlin J commented upon the challenges that the *Charter* had posed for the judiciary since its 1982 introduction: "The difficulty is that the *Canadian Charter of Rights and Freedoms* is a new experience. We have not had anything like it before. Our judges cannot rely on their own experience

8. [2002] OJ No 2777 (QL), (*sub nom Basrur v Deakin*) 2002 CarswellOnt 2401 (WL Can) (Ont Ct J) [*Deakin*].

9. [2008] ZAWCHC 41 [*Goliath*].

to breathe life into the *Charter*; instead, they must find that life elsewhere."[10] As to where such life might be found, she noted "there are other sources of comparable experience which should be directly applicable to our *Charter*", including "charters of rights in many countries throughout the world".[11] As such, Canadian courts interpreting the *Charter* drew from other jurisdictions, including from the case law surrounding human rights instruments that had directly influenced the drafting of the *Charter*, such as the *European Convention on Human Rights* (*ECHR*).[12]

In turn, Canada would influence the drafting of South Africa's *Bill of Rights*. Its influence stemmed not only from the ostensible merits of the *Charter* itself, but also Canada's direct links to the development of the South African instrument. As one South African analysis concludes, "the nationality of most foreign experts, and of the precedents most heavily consulted in the process of drafting the Constitutions, follows the nationality of funds fairly closely".[13] Such influence included both the provision of Canadian experts to South Africa and funding for South Africans wishing to acquire relevant foreign expertise.

Canadian influence would thus also be reflected in the choice of foreign case law subsequently used for interpretation of the new instrument. South Africa's *Bill of Rights* is in fact explicitly designed to take notice of legal developments elsewhere; under section 39(1), a court interpreting the *Bill of Rights* may consider foreign law, and must consider international law.[14] In turn, "[d]espite Canada's relatively short history of constitutional adjudication, Canadian references are strikingly prominent in the case law, as might be expected in the light of the clear debt that the South African Bill of Rights owes to its Canadian counterpart."[15] For instance, the case of *R v Big M Drug*

10. The Honourable Madam Justice Beverley McLachlin, "The Charter of Rights and Freedoms: A Judicial Perspective" (1989) 23:3 UBC L Rev 579 at 580.

11. *Ibid.*

12. See e.g. Errol P Mendes, "Interpreting the Canadian Charter of Rights and Freedoms: Applying International and European Jurisprudence on the Law and Practice of Fundamental Rights" (1982) 20:3 Alta L Rev 383. See *Convention for the Protection of Human Rights and Fundamental Freedoms*, 4 November 1950, 213 UNTS 221 (entered into force 3 September 1953) [*ECHR*].

13. François du Bois & Daniel Visser, "The Influence of Foreign Law in South Africa" (2003) 13:2 Transnat'l L & Contemp Probs 593 at 631. The plural "Constitutions" includes the interim Constitution in effect for a brief period prior to the current instrument (*ibid*).

14. See *supra* note 2, s 39(1).

15. du Bois & Visser, *supra* note 13 at 646.

Mart[16] was "cited at least 31 times in the Constitutional Court in cases dealing with a variety of issues" by 2011.[17] Once introduced, particularly at the level of the Constitutional Court, the influence of principles imported from Canadian jurisprudence trickled down to percolate throughout the system.

It must also be noted that influence between the *Charter* and the *Bill of Rights* has tended to flow primarily in one direction. The potential for mutual exchange has long been recognized, however. For instance, in 1998, Peter Hogg, arguably the pre-eminent scholar on Canadian constitutional law, spoke at a conference in the Constitutional Court of South Africa. After noting that "the Canadian Charter of Rights is the closest in its language and structure to the South African Bill of Rights" and commenting on the extensive citation of Canadian case law in South African courts, he expressed his admiration for the high quality of South African jurisprudence, and concluded: "When Canadian lawyers become aware of this resource, and the reports become widely available, the South African decisions will become very useful in Canada, and any debt now owed to Canada will be fully repaid with interest!"[18] As illustrated later in the paper, collecting on this debt when it comes to health and human rights could yield dividends for Canada.

II. Balancing Public Health and Human Rights

The parallels between these two instruments prove particularly relevant when it comes to the balancing of public health and human rights. Public health law measures such as involuntary isolation of patients with infectious diseases can result in serious infringements of individual civil liberties. At the same time, some infringement upon individual rights may be necessary to protect the public. This balance is recognized under international law.[19] Thus, the fact

16. [1985] 1 SCR 295, 18 DLR (4th) 321.

17. C Rautenbach, "The South African Constitutional Court's Use of Foreign Precedent in Matters of Religion: Without Fear or Favour?" (2015) 18:5 Potchefstroom Electronic LJ 1546 at 1555.

18. Peter W Hogg, "Canadian Law in the Constitutional Court of South Africa" (1998) 13:1 SA Publiekreg 1 at 2.

19. See e.g. *The Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights*, UNESCOR, 41st Sess, Annex, Agenda Item 18, UN Doc E/CN.4/1985/4 (1984).

the *Charter* and the *Bill of Rights* share a "structure of establishing rights that are subject to reasonable limitations and the central role played by the notion of proportionality"[20] has direct implications for how these instruments can be compared when striking a balance between human rights and public health. Rather than adopt the absolutism of the American *Bill of Rights*, Canada had drawn upon international instruments like the aforementioned *ECHR* in crafting its section 1 limitations clause.[21] Section 1 reads: "The *Canadian Charter of Rights and Freedoms* guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society."[22] In turn, South Africa "borrowed heavily from Canada in first establishing the fundamental rights of individual persons and then providing a limitations clause to set criteria for situations when those rights may be infringed for the benefit of society".[23] This is readily visible in the influence that Canada's *R v Oakes* [24] case, and its eponymous test, had on the drafting and development of the limitations clause found in section 36 of the *Bill of Rights*.[25] Section 36 reads as follows:

> 36. (1) The rights in the Bill of Rights may be limited only in terms of law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including—
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> (a) the nature of the right;
> (b) the importance of the purpose of the limitation;
> (c) the nature and extent of the limitation;
> (d) the relation between the limitation and its purpose; and
> (e) less restrictive means to achieve the purpose.

20. Ursula Bentele, "Mining for Gold: The Constitutional Court of South Africa's Experience with Comparative Constitutional Law" (2009) 37:2 Ga J Intl & Comp L 219 at 237.

21. See e.g. Berend Hovius, "The Limitation Clauses of the European Convention on Human Rights: A Guide for the Application of Section 1 of the Charter?" (1985) 17:2 Ottawa L Rev 213.

22. *Charter*, *supra* note 3, s 1.

23. Bentele, *supra* note 20 at 228.

24. [1986] 1 SCR 103, 26 DLR (4th) 200.

25. See e.g. IM Rautenbach, "Proportionality and the Limitation Clauses of the South African Bill of Rights" (2014) 17:6 Potchefstroom Electronic LJ 2229 at 2240.

> (2) Except as provided in subsection (1) or in any other provision of the Constitution, no law may limit any right entrenched in the Bill of Rights.[26]

As will be discussed, these parallels served both to bring *Deakin* and *Goliath* together, and to mask the underlying failure of both cases to properly conduct this balancing act. More broadly, as the next sections illustrate, many traditional public health law measures were developed at a time when both conceptions of human rights and scientific understanding of disease were very different than they are today. As such, the law must continue to evolve, not only in how it balances the infringement of individual rights against the protection of public health using the best available evidence, but also in how it recognizes that public health and human rights are more frequently in harmony than in opposition. Indeed, measures to realize the full spectrum of human rights, including socio-economic rights, can themselves have a positive public health impact.

III. HIV: Building the First Human Rights-Focused Approach

Before turning to the interaction of these two cases, it is instructive to take a broader look at how different approaches to balancing public health and human rights have been adopted and adapted across borders. A particularly pertinent comparison in this regard is that between TB and another disease, one that has attracted far more global attention: HIV, the virus that causes AIDS.

Comparing approaches to these two diseases is particularly apt in South Africa, which not only has the largest number of people living with HIV in the world,[27] but also among the highest levels of TB.[28] Exacerbating the problem, the diseases interact with and reinforce each other; from a biomedical perspective, being HIV-positive is the single greatest risk factor for a person

26. *Bill of Rights*, *supra* note 2, s 36.

27. See Joint United Nations Programme on HIV/AIDS, *UNAIDS Data 2017* (2017) at 40, online (pdf): *UNAIDS* <unaids.org/sites/default/files/media_asset/20170720_Data_book_2017_en.pdf>.

28. See World Health Organization, *Global Tuberculosis Report 2017* (Geneva: WHO, 2017), online (pdf): *ReliefWeb* <reliefweb.int/sites/reliefweb.int/files/resources/9789241565516-eng.pdf> [WHO, *Tuberculosis Report 2017*].

infected with the TB bacteria falling ill from the disease.[29] Furthermore, in South Africa (as in Canada) both diseases are closely associated with poverty and other social disadvantages. Thus, these two diseases affect not only the same communities, but frequently the same individuals; in South Africa, nearly two thirds of TB patients are HIV-positive.[30] This high level of co-infection compounds the separate burdens of the two diseases and magnifies a problem that exists all over the globe: that the consideration afforded to human rights in the response to disease often differs considerably depending on which disease is being addressed, even for the same patient. In South Africa, this dissonance was clearly illustrated during the period when eligible HIV patients could receive additional support through a government grant,[31] while a patient with drug-resistant TB could not only be involuntarily isolated, but would lose any social assistance during the period of their isolation, even if other family members relied upon that assistance for survival.[32] In turn, the differing responses to these diseases also showcase the two very different approaches to learning from the experiences of others described above, contrasting the sluggish recognition of human rights in the response to TB with their rapid global integration into the response to HIV.

In the case of HIV, global norms now fully establish human rights as a central pillar in the response, to the point that it is virtually impossible today to find an international HIV policy document that does not highlight the importance of human rights—even if the realization of these rights in practice frequently falls short. The rapid integration of human rights into the global HIV response, and the evolving emphasis on a broader range of rights, have been dependent upon the global exchange of ideas and experiences. The focus on human rights began in the United States, where the disease that would come to be known as AIDS was first discovered in 1981.[33] There, the disease

29. See Peter Godfrey-Faussett & Helen Ayles, "Can We Control Tuberculosis in High HIV Prevalence Settings?" (2003) 83:1/2/3 Tuberculosis 68 at 68.

30. See WHO, *Tuberculosis Report 2017*, *supra* note 28 at 188.

31. See Suzanne Leclerc-Madlala, "'We Will Eat When I Get the Grant': Negotiating AIDS, Poverty and Antiretroviral Treatment in South Africa" (2006) 5:3 African J AIDS Research 249.

32. See AIDS Law Project, *Protecting Public Health and Human Rights in the Response to TB in South Africa: State and Individual Responsibilities* (2009) at 31.

33. See MS Gottlieb et al, "*Pneumocystis* Pneumonia: Los Angeles" (1981) 30:21 Morbidity & Mortality Weekly Report 250.

was initially associated with marginalized populations; homosexual males were the first to bear the brunt of both the disease itself and its associated stigma, as exemplified by the fact the disease was briefly known as GRID, or Gay-Related Immune Deficiency.[34] In turn, stigma around the disease echoed that historically faced by persons with leprosy, resulting in similar calls for those affected to be isolated away from society.[35] However, HIV was also the first major disease to emerge in a post-WWII era where human rights were increasingly emphasized, beginning with the *Universal Declaration of Human Rights* in 1948.[36] A greater sensitivity to human rights was cemented domestically by societal shifts in the United States such as the civil rights movement, the gay rights movement, and the deinstitutionalization of people with mental illness.[37] As such, rather than allowing public health powers to outweigh individual interests in liberty and privacy in response to HIV, rights advocates built upon these prior advances in favour of protecting the civil rights of persons with HIV. Indeed, they went a step further to successfully argue that such protections would in fact assist in protecting public health by keeping the epidemic in the open, where it could be monitored and those affected could receive medical attention, rather than pushing it underground by creating fears of public health sanctions and fuelling stigma. Much the same story unfolded in Canada,[38] while comparable measures were also adopted in Western Europe, which shared similarities around both human rights norms and the epidemiology of the epidemic itself.[39]

The human rights-based response went global under Jonathan Mann, a vigorous proponent of this approach and the first head of the World Health Organization's (WHO) Global Programme on AIDS.[40] The 1987 inclusion

34. See e.g. Lawrence K Altman, "New Homosexual Disorder Worries Health Officials", *The New York Times* (11 May 1982), online: <www.nytimes.com/1982/05/11/science/new-homosexual-disorder-worries-health-officials.html>.

35. See e.g. Dorothy Rasinski Gregory, "AIDS: The Leprosy of the 1980s: Is There a Case for Quarantine?" (1988) 9:4 J Leg Med 547.

36. *Universal Declaration of Human Rights*, GA Res 217A (III), UNGAOR, 3rd Sess, Supp No 13, UN Doc A/810 (1948).

37. See Larry Gostin, "The Future of Communicable Disease Control: Toward a New Concept in Public Health Law" (2005) 83:4 Milbank Q 1.

38. See David M Rayside & Evert A Lindquist, "AIDS Activism and the State in Canada" (1992) 39:1 Studies in Political Economy 37.

39. See Rolf Rosenbrock et al, "The Normalization of AIDS in Western European Countries" (2000) 50:11 Soc Science & Medicine 1607.

40. See Jonathan M Mann & Kathleen Kay, "Confronting the Pandemic: The World Health

of non-discrimination toward HIV-positive people in the WHO's first global AIDS strategy marked the first time that concern about the human rights of patients was made an integral part of the international strategy to control an epidemic.[41] An approach emphasizing human rights was thus in place as the global standard just as the epidemic in sub-Saharan Africa exploded. It soon became apparent, however, that a human rights response whose origins lay in protecting the civil rights of a stigmatized minority in wealthy countries was an imperfect fit for responding to a generalized heterosexual epidemic in impoverished countries with limited health resources.[42]

Yet this too proved to be an opportunity to adapt and develop borrowed ideas rather than reject them; South Africa, and its new *Bill of Rights*, soon occupied a central position in expanding the conversation from civil and political rights to social and economic rights in the response to HIV. At a time when the administration of President Thabo Mbeki publicly cast doubt on the link between HIV and AIDS, it was South African civil society that moved the conversation forward.[43] Combining tactics learned from American HIV advocacy groups with the large-scale domestic social movements that had challenged apartheid, they made effective use of socio-economic rights found in the new constitution, wielding it against both pharmaceutical companies and their own government.[44] In particular, the constitutional right of access to health care under the *Bill of Rights*[45] proved crucial in decisions solidifying a right to access life-saving antiretroviral drugs.[46] During the same period, other socio-economic rights under the *Bill of Rights*, particularly the right to housing,

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Organization's Global Programme on AIDS, 1986–1989" (1991) 5:2 AIDS S221.

41. See Sofia Gruskin, Jonathan Mann & Daniel Tarantola, "Past, Present, and Future: AIDS and Human Rights" (1998) 2:4 Health & Hum Rts 1 at 1.

42. See David Patterson & Leslie London, "International Law, Human Rights and HIV/AIDS" (2002) 80:12 Bull World Health Organization 964 at 965–66.

43. See generally Nicoli Nattrass, *Mortal Combat: AIDS Denialism and the Struggle for Antiretrovirals in South Africa* (Scottsville, S Afr: University of KwaZulu-Natal Press, 2007).

44. See Mark Heywood, "South Africa's Treatment Action Campaign: Combining Law and Social Mobilization to Realize the Right to Health" (2009) 1:1 J Human Rights Practice 14 at 20–23.

45. See *supra* note 2, s 27.

46. See especially *Minister of Health v Treatment Action Campaign (No 2)*, [2002] ZACC 15.

were also being successfully litigated in South African courts,[47] attracting international attention to the justiciability of such rights[48] and even influencing the language of the newly drafted *Optional Protocol to the International Covenant on Economic, Social and Cultural Rights*.[49]

Other countries, such as Brazil[50] and Thailand,[51] similarly relied upon newly enshrined health rights in their constitutions to promote affordable access to HIV treatment. In the space of just a few years, the international consensus on access to antiretroviral drugs shifted from impossible, unaffordable pipe dream to global health and human rights dogma, including explicit inclusion within the Millennium Development Goals.[52] Thus, domestic exercise of human rights under constitutions and other instruments—from early victories for civil rights in the United States to successes in realizing socio-economic rights in South Africa—helped drive the evolution of international human rights norms around the disease. Today, although HIV remains a serious health issue, and the rights of persons living with HIV may still be better recognized on paper than in practice, the progressive integration of human rights into the global response to the disease shows how the international transmission of ideas has been crucial in shaping how HIV is treated under the law today.

47. See e.g. Richard J Goldstone, "A South African Perspective on Social and Economic Rights" (2006) 13:2 Human Rights Brief 4.

48. See Cass R Sunstein, "Social and Economic Rights?: Lessons from South Africa" (2000) 11:4 Const Forum Const 123.

49. See Bruce Porter, "Reasonableness and Article 8(4)" in Malcolm Langford et al, eds, *The Optional Protocol to the International Covenant on Economic, Social and Cultural Rights: A Commentary* (Pretoria: Pretoria University Law Press, 2016) 173; *Optional Protocol to the International Covenant on Economic, Social and Cultural Rights*, GA Res A/RES/63/117, UNGAOR, 63rd Sess, UN Doc A/63/435 (2008) (entered into force 5 May 2013).

50. See Dirceu B Greco & Mariangela Simão, "Brazilian Policy of Universal Access to AIDS Treatment: Sustainability Challenges and Perspectives" (2007) 21:4 AIDS S37.

51. See Taweesap Siraprapasiri et al, "The Impact of Thailand's Public Health Response to the HIV Epidemic 1984–2015: Understanding the Ingredients of Success" (2016) 2:4 J Virus Eradication 7.

52. See *United Nations Millennium Declaration*, GA Res 55/2, UNGAOR, 55th Sess, Supp No 49, UN Doc A/RES/55/2 (2000) 4 at para 19.

IV. Tuberculosis: Justifying the Traditional Public Health Approach

By contrast, TB has largely remained cordoned off as a public health issue, with little integration of human rights into the response until very recently. This is despite the fact that, quite unlike the sudden appearance of HIV less than forty years ago, TB is one of humankind's oldest diseases.[53] In nineteenth-century Europe, TB was widespread at all levels of society, with death from "consumption" romanticized in literature, and even in popular operas like *La Traviata*.[54] As a result, it was also a central part of life during the period in which modern Western medicine emerged; indeed, TB was one of the first diseases to be linked with its bacterium, *Mycobacterium tuberculosis*.[55] More directly, TB played a fundamental role in the development of public health practices ranging from contact tracing to involuntary isolation in TB hospitals and sanitariums, leading one commentator to remark that "[i]t is trite to say that rarely, if ever, has a disease played such a role in the history of humanity and of clinical, experimental and social medicine."[56]

At the same time, to an even greater extent than with HIV, the history of TB also exemplifies the effects of the social determinants of health and their associated socio-economic rights. Prevailing socio-economic conditions meant TB was Canada's leading cause of death at the time of Confederation.[57] In turn, it was improvements in living conditions throughout the first half of the twentieth century that led to a rapid decline in tuberculosis, well before the seeming coup de grâce of the widespread availability of effective treatment

53. See M Cristina Gutierrez et al, "Ancient Origin and Gene Mosaicism of the Progenitor of *Mycobacterium tuberculosis*" (2005) 1:1 PLoS Pathogens 55.

54. See Linda Hutcheon & Michael Hutcheon, "Famous Last Breaths: The Tubercular Heroine in Opera" (1996) 2:1 Parallax 1 at 11–12, 16.

55. See E Cambau & M Drancourt, "Steps Towards the Discovery of *Mycobacterium tuberculosis* by Robert Koch, 1882" (2014) 20:3 Clinical Microbiology & Infection 196 at 196.

56. Annik Rouillon, "Tuberculosis: A Model for Approaching Disease Control" (1979) 76:6 Chest 739 at 739.

57. See Public Health Agency of Canada, *The Chief Public Health Officer's Report on the State of Public Health in Canada, 2013: Infectious Disease—The Never-Ending Threat*, by David Butler-Jones, Catalogue No HP2-10/2013E (Ottawa: PHAC, September 2013).

beginning in the 1940s to 1950s.[58] Despite this clear illustration of the impact of socio-economic factors, however, such broader systemic issues did not become a focus of TB policy in the post-WWII era.

Instead, within the space of a few decades after the development of effective drugs, TB had largely fallen off the international public health radar. By the late 1980s, only two staff at WHO headquarters were dedicated to TB.[59] As a result, there was no perceived need to modify the existing TB response for a more human rights-conscious era. This is aptly illustrated in its re-emergence in New York City in the late 1980s and early 1990s in the more serious guise of multi-drug resistant TB (MDR-TB), a disease that had evolved far more rapidly than had the public health response.[60] Quite unlike the wild conspiracy theories that circulated in the early years of HIV, there is no question that MDR-TB is a man-made disease; it arises not because the disease is left untreated, but as the direct result of poor quality treatment. Where insufficient steps are taken to ensure patients who receive drugs are completely cured, the disease can become resistant to those drugs. This resistant strain can then spread directly to others.

TB budgets in New York, as elsewhere, had been slashed throughout the 1980s, and the consequences soon became all too readily apparent.[61] Unfortunately, just as TB had been marginalized by the public health community, it re-emerged in communities marginalized by society. Those most affected were prisoners and the homeless, groups poorly positioned to effectively mobilize in defence of their rights like the gay community had done in response to HIV. The result was two overlapping epidemics with parallel responses. Even as HIV advocates marched through the streets of New York City advocating for human rights, authorities charged with responding to TB simply dusted off the public health statutes that had been shelved when drugs first became available, and put them back to work. By 1994, public health powers in New York City had been expanded to allow not only for the involuntary detention

58. See Thomas McKeown, RG Record & RD Turner, "An Interpretation of the Decline of Mortality in England and Wales During the Twentieth Century" (1975) 29:3 Population Studies 391.

59. See MC Raviglione & A Pio, "Evolution of WHO Policies for Tuberculosis Control, 1948–2001" (2002) 359:9308 Lancet 775 at 777.

60. See generally Lee B Reichman with Janice Hopkins Tanne, *Timebomb: The Global Epidemic of Multi-Drug-Resistant Tuberculosis* (New York: McGraw-Hill, 2002).

61. See *ibid* at 153.

of TB patients who posed a risk to public health, but also the detention of those whose past behaviour suggested they *might* not be able to adhere to drug treatment.[62] The result—being involuntarily confined for something one might do in the future—has echoes of Orwell or Kafka, a particularly appropriate allusion given that both authors died of TB.[63] By contrast, comparatively little effort was made to address underlying systemic issues, like homelessness or poor prison conditions, which not only affected treatment adherence but vulnerability to TB in the first place.[64]

Events in New York City helped rekindle interest in a problem that had been smouldering in many corners of the globe, including behind the newly lifted Iron Curtain.[65] The WHO came to the sensible realization that the best way of addressing drug-resistant TB was preventing it in the first place. The result was a global treatment program for drug-sensitive TB called Directly Observed Therapy, Short Course, better known by its acronym DOTS. By 2007, more than ninety-nine percent of all cases notified to the WHO were treated in DOTS programs.[66] DOTS, the signature component of which requires monitoring of patients by healthcare professionals to ensure that all prescribed drugs are taken, has been criticized as paternalistic.[67] When executed properly, however, DOTS was seen as highly effective in treating drug-sensitive TB; it was also extremely cost-effective, making it a good value investment in low-resource settings.[68] As such, DOTS was widely employed in South Africa.

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62. See e.g. Carlos A Ball & Mark Barnes, "Public Health and Individual Rights: Tuberculosis Control and Detention Procedures in New York City" (1994) 12:1 Yale L & Pol'y Rev 38.

63. See "Tuberculosis" (2007) 13:3 Nature Medicine 263 at 263.

64. See Barron H Lerner, "New York City's Tuberculosis Control Efforts: The Historical Limitations of the 'War on Consumption'" (1993) 83:5 American J Public Health 758.

65. See Reichman with Hopkins Tanne, *supra* note 60 at 139.

66. See *WHO Report 2011: Global Tuberculosis Control* (Geneva: WHO, 2011) at 29, online (pdf): *World Health Organization* <apps.who.int/iris/bitstream/handle/10665/44728/9789241564380_eng.pdf?sequence=1&isAllowed=y>.

67. See e.g. SM Carter, VA Entwistle & M Little, "Relational Conceptions of Paternalism: A Way to Rebut Nanny-State Accusations and Evaluate Public Health Interventions" (2015) 129:8 Public Health 1021.

68. See Christopher JL Murray et al, "Cost Effectiveness of Chemotherapy for Pulmonary Tuberculosis in Three Sub-Saharan African Countries" (1991) 338:8778 Lancet 1305 at 1305, 1307.

However, a program designed to treat drug-sensitive TB offered little assistance for an under-diagnosed epidemic of drug-resistant TB, particularly once the world's first case to be defined as extensively drug-resistant TB (XDR-TB)—the legacy of decades of substandard care under apartheid—was diagnosed in the South African town of Tugela Ferry.[69]

Just as in New York, once authorities were aware of drug-resistant TB, the response was involuntary isolation. Indeed, one prominent commentary explicitly called for the "[e]mulation of New York's aforementioned successful approach in controlling its TB outbreak [which] could empower health officials in South Africa and elsewhere to act decisively in tackling emerging XDR-TB and MDR-TB outbreaks."[70] This approach was not used sparingly; at one point, "approximately 1,700 people, including children," were detained in TB isolation facilities in South Africa, many of them in substandard conditions, in response to drug-resistant TB.[71] Patients objected to this violation of their rights. In one instance, a patient was shot during protests about conditions for MDR-TB and XDR-TB patients.[72] In another, South Africans with drug-resistant TB did what those with HIV had done before them: they attempted to assert their constitutional rights in court.

V. *Deakin* and *Goliath*: Jurisprudence as Building Block or Ceiling?

The case of *Goliath* in the High Court of South Africa (Cape of Good Hope Provincial Division) illustrates, first of all, that the wheels of justice can grind too slowly for everyone to effectively assert their rights; of the four patients with XDR-TB who were initially voluntarily admitted but later protested an order permitting their continued isolation in the Brooklyn Chest Hospital in Cape Town, two died before the matter was heard. Second of all, it also illustrates the pitfalls of emulating *what* another country does rather than drawing upon *why* it did so. As noted earlier, South Africa's *Bill of Rights* explicitly acknowledges the

69. See Sheela Shenoi & Gerald Friedland, "Extensively Drug-Resistant Tuberculosis: A New Face to an Old Pathogen" (2009) 60 Annual Rev Medicine 307.

70. Jerome Amir Singh, Ross Upshur & Nesri Padayatchi, "XDR-TB in South Africa: No Time for Denial or Complacency" (2007) 4:1 PloS Medicine 19 at 22.

71. AIDS Law Project, *supra* note 32 at 1.

72. See Adele Baleta, "Forced Isolation of Tuberculosis Patients in South Africa" (2007) 7:12 Lancet Infectious Diseases 771 at 771.

importance of foreign and international law in its interpretation.[73] In *Goliath,* reference to outside sources was particularly inevitable given that, as noted in the judgment, the *National Health Act* relied upon by the state at the time:

> [C]urrently does not provide for a power to 'arrest' and 'detain'. It is envisaged in the Act that this question will eventually be dealt with by way of regulations, to be adopted in terms of s 90 of the Act relating to 'Communicable Diseases'. However, such regulations have not yet been promulgated and currently only exist in draft form.[74]

Consequently, given this lack of domestic guidance, coupled with the enshrined importance of outside jurisprudence for interpretation, the Court in *Goliath* looked extensively to other jurisdictions to support the conclusion that "national legislation in other open and democratic societies also permits the isolation of patients with infectious communicable disease".[75] The decision provides numerous citations to support the—entirely accurate—conclusion that this is permissible in other countries as well as under international law, including under both the *International Covenant on Civil and Political Rights* and the *ECHR*.[76] Where it falls short is in determining *when* such isolation is permissible, and how the rights of the public and the individual are to be balanced in making this determination.

Here, the Court does not use foreign precedent to inform the development of a South African position that effectively sets out when and how individual rights may be limited in the interests of public health under the constitutional umbrella. Instead, it uses the *mere existence* of foreign jurisprudence permitting isolation, rather than the underlying rationale guiding such jurisprudence, as justification for its actions infringing upon constitutionally protected human rights. The decision relies particularly heavily upon Canadian sources, namely the Ontario *Health Protection and Promotion Act*[77] and its application in the 2002 case of *Deakin*.

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73. See *supra* note 2, s 39(1).

74. *Supra* note 9 at para 50, citing *National Health Act, 2003* (S Afr), No 61 of 2003, s 90.

75. *Ibid* at para 37.

76. See *ibid*; *International Covenant on Civil and Political Rights*, 19 December 1966, 999 UNTS 171 arts 9–14 (entered into force 23 March 1976) [*ICCPR*]; *ECHR*, *supra* note 12.

77. RSO 1990, c H.7.

One obvious reason the South African High Court relied so heavily on *Deakin* is because of the ease of comparing the Canadian and South African human rights instruments. In its judgment, the Court draws direct parallels between articles under the *Charter* and the *Bill of Rights* to arrive at a similar conclusion.[78] Section 7 of the *Charter* states: "Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice."[79] Section 12(1) of the *Bill of Rights* expands upon this further, reading as follows:

> Everyone has the right to freedom and security of the person, which includes the right—
>
> (a) not to be deprived of freedom arbitrarily or without just cause;
> (b) not to be detained without trial;
> (c) to be free from all forms of violence from either public or private sources;
> (d) not to be tortured in any way; and
> (e) not to be treated or punished in a cruel, inhuman or degrading way.[80]

The South African decision notes that the Ontario Court of Justice showed "no hesitation in granting an order for [Deakin's] further detention" and underscores this point by inserting the corresponding South African constitutional provisions into a direct quote from the Canadian judgment: "(The patient's) rights under s 7 of the *Charter* [equivalent to s 12(1) of our Constitution] have indeed been violated. But those breaches were justified."[81]

In the paragraph immediately following this excerpt, and without further discussing the applicability of *Deakin* to the underlying facts of the case before them, the South African Court concludes that the Minister has made his case, and upholds the detention order.[82] The speed with which the South African decision settles for emulating the Canadian result, rather than

78. See *Goliath*, *supra* note 9.

79. *Supra* note 3, s 7.

80. *Supra* note 2, s 12(1).

81. *Goliath*, *supra* note 9 at paras 61–62.

determining whether the Canadian decision was itself sound before carefully applying its approach to the facts before them, is troubling. For one, despite its international reputation as a country respectful of human rights, Canada has an extensive body of jurisprudence around the criminalization of persons with HIV that is highly unsatisfactory from both a public health and a human rights perspective,[83] and which ironically stands in stark contrast to South Africa, suggesting that the precedential value of Canadian cases of this kind should not be accepted without some degree of critical examination.

More importantly, the Court in *Goliath* fails to conduct a proper analysis of the constitutional rights in question. As one strongly critical commentary puts it, the conclusion comes "after a most cursory rights-analysis and a very superficial inquiry into the legality, necessity and proportionality of the isolation".[84] In particular, the Court does not actually consider whether any infringement of the right was reasonable and justifiable in terms of the factors listed in section 36 of the Constitution. Instead, it simply lists a number of provisions from foreign statutes and international treaties which allow for isolation of patients for the protection of public health.[85] This is despite the fact that both the *Charter* and the *Bill of Rights* include limitations clauses whose interpretations are guided by proportionality.[86] Other aspects of the decision under South Africa's constitutional framework, such as whether the Court's expansive interpretation of the term "health services" under the *National Health Act* to include involuntary isolation is in compliance with the *Bill of Rights*, have also been questioned.[87] Even a parallel legal commentary supportive of the

82. See *ibid* at para 63. The judgment then discusses an application by the patients for declaratory relief on a number of grounds, most of them related to the conditions of detention, but no final order is made on the application (*ibid* at 65–72).

83. See e.g. Cecile Kazatchkine et al, "HIV Non-Disclosure and the Criminal Law: An Analysis of Two Recent Decisions of the Supreme Court of Canada", Note, (2013) 60:1 Crim LQ 30.

84. Marius Pieterse & Adila Hassim, "Placing Human Rights at the Centre of Public Health: A Critique of *Minister of Health, Western Cape v Goliath*" (2009) 126:2 SALJ 231 at 233.

85. *Ibid* at 234–35.

86. See George Barrie, "The Application of the Doctrine of Proportionality in South African Courts" (2013) 28:1 Southern African Public L 40.

87. See Annelize Nienaber, "The Involuntary Isolation of Patients with XDR-TB: Is the Term 'Health Service' in Section 7 of Act 61 of 2003 Interpreted Too Broadly?", Case Comment on *Goliath*, *supra* note 9, (2009) 24:2 SA Publiekreg 659.

Court's conclusion in upholding involuntary isolation in response to XDR-TB admits that a discussion of the relevant domestic law "could indeed have been highly instructive and would undoubtedly have added value to the judgment".[88]

Furthermore, when it comes to providing helpful guidance about the constitutional rights of TB patients, *Deakin* is a remarkably poor model to follow in the first place. As with the patients in *Goliath,* Deakin had initially consented to hospitalization, but later objected to a further extension of an order to detain and treat him under section 35 of the Ontario *Health Protection and Promotion Act*. In particular, Deakin objected to the physical and chemical restraints that had been applied during his initial detention, which included being shackled to his bed during violent outbursts and being physically restrained during outdoor smoke breaks to prevent his escape.[89] In considering the Medical Officer of Health's application to renew the order, the Ontario Court of Justice begins by rejecting arguments by the facility where Deakin was confined that the *Charter* did not apply.[90] However, the Court's subsequent application of the *Charter* leaves much to be desired.

In an extremely short decision, the Court quotes approvingly from the Attorney General's brief, which refers to the "tremendous risk to the public" posed by Deakin.[91] However, the same quoted excerpt reminds the "Court to strike a balance, both substantively and procedurally, between the interest of the person who claims his right has been limited and the protection of the public".[92] This balancing act never appears in the decision. Indeed, the very next sentence after the excerpt from the brief is the Court's conclusion that the detention order will be granted as requested.[93] Only later in its conclusion does the Court briefly note "Mr. Deakin's rights under s. 7 of the Charter have indeed been violated. But those breaches were justified."[94] However, it does very little to actually establish this justification in a way that might usefully aid future decisions.

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88. Pieter Carstens, "The Involuntary Detention and Isolation of Patients Infected with Extreme Resistant Tuberculosis (XDR-TB): Implications for Public Health, Human Rights and Informed Consent", Case Comment on *Goliath*, *supra* note 9, (2009) 30:2 Obiter 420 at 427.

89. See *Deakin*, *supra* note 8 at paras 19, 21.

90. See *ibid* at para 24.

91. *Ibid* at para 27.

92. *Ibid*.

93. See *ibid* at para 28.

94. *Ibid* at para 31.

For one thing, despite the Court's conclusion that "[t]here is simply no other, realistic method to deal with the problem",[95] less rights-restrictive options are never explored. Although there are references to submissions on section 1 of the *Charter*, the issue is not actually addressed directly by the Court. This is despite the fact that Deakin's TB is described as being "eminently treatable"[96] and the Court's acknowledgement that throughout his detention, "[m]oral persuasion" has been effective in getting him to take his medication without the need to resort to coercion.[97] Furthermore, while tuberculosis is a disease that could in theory pose a "tremendous risk"[98] to the community, the true risks in this particular case are not effectively assessed. For instance, the specific incident cited as posing a risk to the community, in which Deakin absconded from the premises to buy beer, is not examined in terms of the actual risk posed by that activity, which, in the case of brief, casual contact, would be minimal. Any risk is likely to have been further reduced if, as the decision suggests, Deakin was on medication at the time.[99] Although such an incident may serve as evidence of a pattern of attitudes and behaviours that may well pose a risk to the community—an analysis that can be and has been done effectively by Canadian courts, as discussed later—that is not quite the same thing as actually establishing the existence of a tremendous risk justifying the infringement of Deakin's rights. As a result, the text of the decision itself provides little support for the judge's conclusion.

Ultimately, the failure to provide more than lip service to the infringement of Deakin's rights, and whether such infringement is proportional to any public health benefits, means that *Deakin* is remarkably unhelpful as precedent. At best, *Deakin* can be taken to stand for the conclusion that there are circumstances under which it is lawful to order the detention and treatment of a patient with tuberculosis despite infringement upon the section 7 rights of the individual. Without guidance as to what those circumstances are, this is hardly a particularly novel conclusion.

95. *Ibid* at para 29.

96. *Ibid* at para 26.

97. *Ibid* at para 21.

98. *Ibid* at para 27.

99. See e.g. Yousang Ko et al, "Duration of Pulmonary Tuberculosis Infectiousness Under Adequate Therapy, as Assessed Using Induced Sputum Samples" (2017) 80:1 Tuberculosis & Respiratory Diseases 27 at 32.

Even if it is accepted for the sake of argument that *Deakin* was the correct result on its own (vague) set of facts, however, considerable differences between the prevailing situations in the two cases, and the two countries, mean the Canadian outcome cannot simply be transposed upon South Africa. First, being confined until cured has different implications in these two instances. In contrast to Deakin's "eminently treatable" TB,[100] for which a standard six-month treatment period would likely have a high chance of success, treatment of XDR-TB at the time, as noted by the Court in *Goliath,* lasted between eighteen and twenty-four months[101] and was not proven to cure the disease.[102] Consequently, isolation in *Goliath* could literally be a life sentence, with the patient remaining isolated until they succumbed to the disease.

Second, in most communities in Canada, infectious tuberculosis (even when drug-sensitive) is sufficiently rare that a single infectious case increases the proportionate risk to the public. By contrast, most cases of drug-resistant TB in South Africa at the time *Goliath* was decided were undiagnosed, meaning the utility of isolating individual, identified cases in preventing the spread of the disease in communities was minimal.[103] Indeed, even among those patients who were diagnosed with drug-resistant TB, many were being waitlisted or turned away from treatment at the same time that others were being confined.[104] Furthermore, as has been well established in the context of HIV, fear of involuntary isolation could serve as a disincentive to getting a diagnosis in the first place, to the detriment of both the patient and the public.[105] This counterproductive aspect is a further element that should factor into the analysis of which rights-infringing measures actually benefit public health.

Once again, this is not to say that tuberculosis, particularly when drug-resistant, is not a serious public health concern, or that faced with such a concern it is impermissible to restrict the personal liberties of infectious patients. As noted by the Court in *Goliath*, the ability, and indeed the necessity,

100. *Deakin*, *supra* note 8 at para 26.

101. See *Goliath*, *supra* note 9 at para 29.

102. See *ibid* at para 27.

103. See Leslie London, "Confinement in the Management of Drug-Resistant TB: The Unsavoury Prospect of Balancing Individual Human Rights and the Public Good" (2008) 1:1 South African J Bioethics & L 11 at 15.

104. See Jason Andrews et al, "XDR-TB in South Africa: Theory and Practice" (2007) 4:4 PLoS Medicine 770 at 771.

105. See AIDS Law Project, *supra* note 32 at 21.

of doing so are widely accepted principles under international law.[106] However, it is also well established that the power to impose such restrictions is not an absolute one to be exercised with no regard to the rights of the individual. As noted above, some manner of ensuring that infringements on individual rights are proportional to their societal benefits is required internationally as well as under both the *Charter* and the *Bill of Rights*. Yet in neither the Canadian nor the South African case does the court attempt any detailed analysis of less restrictive measures or a genuine balancing of the rights of the individual against the actual risks they pose to the community.

Similarly, many patient behaviours that contribute to the risk to public health, including non-adherence to treatment, are themselves likely to be affected by underlying issues with human rights implications, including individual circumstances such as substance use and mental health concerns, as well as broader social and economic determinants ranging from nutrition to adequate housing that also increase the likelihood of the disease in the first place.[107] Thus, what are perceived as failings of the individual necessitating involuntary isolation may really be, in whole or in part, failures of the state to meet its own human rights obligations. Steps to address these underlying issues are as deserving of consideration in determining minimally restrictive measures as are confinement options. Unfortunately, rather than recognizing the shortcomings of the Canadian decision in its treatment of constitutional rights, and addressing those shortcomings in an effective manner, the South African decision opted to justify the status quo, even when it infringed upon individual rights in favour of measures unlikely to have a practical or proportionate impact on public health.

Lastly, the shortcomings of *Deakin* (and in turn *Goliath*) do not arise from venturing into uncharted territory in striking this balance between public health and human rights in the case of tuberculosis. Contrast these decisions with both legislation and case law emerging from New York City's MDR-TB epidemic. Although, as noted earlier, New York City strengthened its powers of detention for TB patients in the early 1990s, those strengthened provisions are balanced against evidentiary requirements regarding the particular circumstances of each case. Thus, while an order for detention and treatment can be issued for

106. See *supra* note 9 at para 42.

107. See Salla A Munro et al, "Patient Adherence to Tuberculosis Treatment: A Systematic Review of Qualitative Research" (2007) 4:7 PLoS Medicine 1230 at 1237–41.

someone with tuberculosis "where there is a substantial likelihood, based on such person's past or present behavior, that he or she can not be relied upon to participate in and/or to complete an appropriate prescribed course of medication for tuberculosis and/or, if necessary, to follow required contagion precautions for tuberculosis",[108] any court proceeding to enforce that order requires that the Health Commissioner "shall prove the particularized circumstances constituting the necessity for such detention by clear and convincing evidence".[109]

The 1995 case of *City of New York v Antoinette R*[110] is an example of a decision in which the Court goes to great lengths to outline the particular individual's past history of non-adherence to TB treatment, and how, in its view, options other than involuntary isolation would not be effective. In this case, the patient had a history of dropping out of contact with health authorities while receiving treatment as an outpatient, only to seek emergency treatment under a variety of aliases whenever her condition worsened. While the outcome is much the same as in the cases at hand, the key difference is that the underlying reasoning by the Court in *Antoinette* is both clearly stated and capable of providing guidance for similar situations elsewhere. Consequently, *Deakin* was a lousy choice of foreign guidance in effectively striking the risk and rights balance for TB patients in South Africa, even if the constitutional parallels were simpler to draw.

VI. Building Toward the Future?

Hearteningly, South Africa has subsequently emerged from the shadow cast by *Goliath* and taken strides toward integrating human rights into the response to TB. This is part of a broader international trend; the same year as the *Goliath* judgment, the WHO updated its guidance to shift toward emphasizing the importance, and effectiveness, of community-based alternatives to involuntary hospitalization for patients with drug-resistant TB.[111] In South Africa in particular, this shift has come largely as a direct result of the interwoven nature of the TB and HIV epidemics, and the recognition that they cannot be successfully

108. *New York City Health Code*, § 11.21(d)(5)(ii).

109. *Ibid*, § 11.21(e).

110. 630 NYS (2d) 1008 (Sup Ct 1995).

111. See *Guidelines for the Programmatic Management of Drug-Resistant Tuberculosis: Emergency Update 2008* (Geneva: WHO, 2008), online (pdf): *World Health Organization* <who.int/tb/publications/2006/who_htm_tb_2008_402.pdf>.

addressed separately. The *National Strategic Plan for 2012–2016* (*NSP*) combined the two responses for the first time, doing so in a manner that heavily emphasized the rights-based approach taken for HIV.[112] As an illustration of the implications, while the term "human rights" appeared nearly fifty times in the earlier *HIV & AIDS and STI Strategic Plan for South Africa, 2007–2011*,[113] with "Human Rights and Access to Justice" appearing as one of four key priority areas, is completely absent from the main text of the parallel *Tuberculosis Strategic Plan for South Africa, 2007–2011*, with only a single reference appearing in an annex.[114] Transposing an HIV response onto TB is not a perfect solution, particularly given that the two diseases possess their own unique characteristics and risk factors; much like the broader approach to developing human rights norms, the precise approaches to the two diseases are not interchangeable, but could learn from and build upon one another. Nonetheless, the formal integration of human rights into the TB response is itself a progressive move. Similarly progressive is the thread running through the combined *NSP* of tying the response to both diseases to realization of socio-economic rights under the *Bill of Rights*.[115] While the implementation of the *NSP* encountered challenges, as has its present 2017 to 2022 successor, the integration of the HIV and TB responses, and the recognition of human rights in the TB context, have been positive steps for both public health and human rights.

This shift in attitude in favour of human rights, and of highlighting state responsibilities relating to those rights, is also in evidence in a more recent case involving TB. Once again, it involves involuntary confinement, albeit with the causal relationship between TB and confinement reversed. The plaintiff in *Lee v Minister of Correctional Services* had contracted tuberculosis while in prison.[116] Although it was clear that he contracted TB while incarcerated, the

112. See *National Strategic Plan on HIV, STIs and TB, 2012–2016* (2011), online (pdf): *South African National AIDS Council* <www.hst.org.za/publications/NonHST%20Publications/hiv-nsp.pdf> [AIDS Council, *NSP*].

113. See South African National AIDS Council, *HIV & AIDS and STI Strategic Plan for South Africa, 2007–2011* (May 2007), online (pdf): *UNAIDS* <data.unaids.org/pub/externaldocument/2007/20070604_sa_nsp_final_en.pdf>.

114. See Department of Health, *Tuberculosis Strategic Plan for South Africa, 2007–2011* (2007), online (pdf): *Government of the Republic of South Africa* <www.gov.za/sites/default/files/tbstratplan_0.pdf>.

115. See AIDS Council, *NSP*, *supra* note 112 at 30.

116. [2012] ZACC 30 at para 10.

exact causation of his illness was difficult to determine, as precisely when and how he contracted the disease, or exactly what the prison could have done to prevent that specific event from happening, was not possible to establish. A trial judgment in his favour was overturned by the Supreme Court of Appeal based on a narrow application of the test of causation—the "but-for" test. A key question facing the Constitutional Court was not only "whether causation had been established, but if it had not, whether the common law need[ed] to be developed to prevent" an unfair outcome in relation to the constitutional rights of the individual.[117] The Court ultimately split 5–4 on this question, with the majority finding the Ministry liable for damages under existing law. The minority opinion concludes the existing test is not met. "But", it continues, "that should not lead to defeat for Mr Lee. In my view, our law should be developed to compensate a claimant negligently exposed to risk of harm, who suffers harm."[118]

Both opinions, while reaching opposite conclusions on whether the existing common law test had been met, underscore the Court's recognition of the importance of the progressive evolution of the law in order to achieve a just result when the rights of a person with TB, particularly a member of an especially vulnerable population such as prisoners, are violated. Although this decision has proven controversial, that controversy has focused largely on the broader implications of the case for the law of factual causation rather than the justice meted under its particular circumstances.[119] Perhaps even more importantly from a human rights perspective, *Lee* has spurred internal reform in the prison system itself, while also fuelling subsequent court cases to promote further prison reforms from the outside.[120]

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117. *Ibid* at para 2.

118. *Ibid* at para 79, Cameron J, dissenting. Of note, Cameron J is a prominent activist and legal scholar on HIV and human rights. See e.g. Edwin Cameron, *Witness to AIDS* (London, UK: IB Tauris & Co, 2005).

119. See e.g. Anton Fagan, "Causation in the Constitutional Court: *Lee v Minister of Correctional Services*" (2014) 5 Constitutional Court Rev 104; Andrew Paizes, "Factual Causation: Which 'Conditio' Must Be a 'Sine Qua Non'? A Critical Discussion of the Decision in *Lee v Minister for Correctional Services*" (2014) 131:3 SALJ 500; Alistair Price, "Factual Causation After *Lee*" (2014) 131:3 SALJ 491.

120. See Emily Nagisa Keehn & Ariane Nevin, "Health, Human Rights, and the Transformation of Punishment: South African Litigation to Address HIV and Tuberculosis in Prisons" (2018) 20:1 Health & Hum Rts 213.

By contrast, while Canadian government reports and frameworks for action on tuberculosis prevention and control acknowledge the role of social determinants of health, and identify marginalized communities that bear the brunt of both the disease and underlying social issues such as homelessness and poverty,[121] explicit references to human rights or the *Charter* are consistently lacking. Inequality continues to fuel tuberculosis in Canada; notably, Indigenous Canadians constitute four percent of the population, but make up twenty-one percent of all cases of TB.[122] The historical roots of these inequalities are interwoven with the legacy of public health laws themselves; for instance, Stephen Lewis, formerly the United Nations Special Envoy for HIV/AIDS in Africa, recently called for greater transparency and accountability around the once widespread practice of removing patients from Inuit communities to treatment centres in the south, from which many never returned.[123]

While involuntary confinements continue to occur in Canada today, they infrequently garner much attention, let alone lead to helpful judicial precedent. The fact that scholars have resorted to citing *Deakin,* despite its numerous faults, for the principle that *Charter* rights may be infringed to protect public health highlights the paucity of domestic case law in the area.[124] However, what limited post-*Deakin* case law exists addressing detention of TB patients, almost all of it from Ontario, has in fact advanced considerably. Interestingly, explicit *Charter* considerations have played a relatively minor role in these developments. For instance, although an application for *Charter* relief was filed in *Doucette v Medical Officer of Health*,[125] the judge determined a trial would be more appropriate and ordered the application be converted into an action; no such action seems to have subsequently occurred. Even without

121. See Public Health Agency of Canada, *The Time Is Now: CPHO Spotlight on Eliminating Tuberculosis in Canada*, by Theresa Tam (Ottawa: PHAC, 22 March 2018) at 2–3, 9–13; Health Canada & Public Health Agency of Canada, *Tuberculosis Prevention and Control in Canada: A Federal Framework for Action*, Catalogue No HP40-89/2013E (Ottawa: PHAC, 2014).

122. See Public Health Agency of Canada, *Tuberculosis in Canada 2014 Pre-Release*, Catalogue HP37-5/1E (Ottawa: PHAC, 2016) at 2.

123. See Bob Weber, "Canada Must Release Data on Inuit Tuberculosis Treatment in 1950s–60s: Stephen Lewis", *Toronto Star* (11 September 2017), online: <www.thestar.com/news/canada/2017/09/11/canada-must-release-data-on-inuit-tuberculosis-treatment-in-1950s-60s-stephen-lewis.html>.

124. See e.g. Nola M Ries, "Public Health Law and Ethics: Lessons from SARS and Quarantine" (2004) 13:1 Health L Rev 3 at 4.

125. 2011 ONSC 5774.

explicit reference to the *Charter*, however, courts have done a better job of explicitly balancing public health concerns against individual rights. In *ML v Porcupine Health Unit*, the Court carefully examined the risk posed by a woman isolated in her own home to her spouse and child before making a decision that acknowledged that the risks involved would change considerably if the child had already been infected, demonstrating keen consideration of the specific circumstances of the case, including both medical evidence and the needs of different parties.[126]

Similarly, *Medical Officer of Health (City of Toronto) v McKay*[127] marks a considerable step forward in explicitly weighing the other potential options for treating an involuntarily isolated TB patient. Like *Deakin*, *McKay* deals with an application to extend a detention order under the *Health Protection and Promotion Act*. The decision highlights the fact that McKay was the only patient ever diagnosed with XDR-TB in the country "whose drug-resistance has developed in Canada, due entirely to non-compliance with TB treatment".[128] It explains in detail the personal circumstances that create obstacles to treatment adherence for McKay, including his diabetes, and especially his struggles with substance use. In turn, it outlines why less restrictive options, such as living in the community with the support of his partner, are likely to be ineffective, explicitly examining the question of risk both at the present moment and in the future before ordering McKay's continued detention and treatment.[129] The scope of the reasoning thus resembles *Antoinette* more than it does *Deakin.* Not only is *McKay* a step forward in Canada, it could even provide a reference point at the international level, as the most recent WHO guidance on involuntary confinement of tuberculosis patients[130] offers little specific guidance in addressing complicated questions around extreme cases of barriers to future adherence.

While not explicitly framed as a *Charter* case, *McKay* offers a particularly useful analysis that could serve as a model in future cases. At the same time, recent Supreme Court jurisprudence has underscored the relationship between

126. 2006 CanLII 79548 (Ont HSARB).

127. 2007 ONCJ 444, 286 DLR (4th) 178 [*McKay* cited to DLR].

128. *Ibid* at 183.

129. See *ibid* at 189–90.

130. See *Ethics Guidance for the Implementation of the End TB Strategy* (Geneva: WHO, 2017), online (pdf): *World Health Organization* <who.int/tb/publications/2017/ethics-guidance/en/>.

sections 7 and 1 of the *Charter* in relation to establishing whether a law's negative impact on an individual is, respectively, in accordance with the principles of fundamental justice and proportionate to the pressing and substantial goal of the law in furthering the public interest.[131] A case considering these developments together, addressing involuntary confinement of tuberculosis patients within an explicit *Charter* context that properly examines both the individual and societal impacts, could be a major advance for balancing public health and human rights.

It should also be noted, however, that multiple references to the TB "virus" in the *McKay* decision,[132] an error in basic biology, raise the ongoing question about judicial understanding of scientific evidence, even if in this instance differentiating a virus from a bacterium seems largely irrelevant to the generally sound reasoning of the case. Nevertheless, striking the proper balance between risks and rights requires a thorough understanding of the scientific evidence of the threat posed in each instance. The need to promote better judicial understanding of scientific evidence in the context of HIV transmission has drawn the attention of the scientific and medical communities in Canada;[133] such advances have since informed modest changes to how HIV non-disclosure is addressed in the Canadian criminal justice system.[134] Tuberculosis requires similar attention.

Meanwhile, the absence of explicit socio-economic rights in the *Charter* makes it even more difficult to anchor other crucial interventions in constitutional law, whether ensuring the availability of services to promote treatment adherence, or addressing the underlying causes of illness in the first place. The lack of rights-based tools to address TB reinforces a lack of other more tangible tools; for instance, the last edition of the *Canadian Tuberculosis Standards* acknowledges that less than half of the medicines found on the WHO's Model List of Essential Medicines for drug-resistant tuberculosis have

131. See e.g. *Canada (Attorney General) v Bedford*, 2013 SCC 72 at paras 124–28.

132. *Supra* note 127.

133. See Mona Loutfy et al, "Canadian Consensus Statement on HIV and its Transmission in the Context of Criminal Law" (2014) 25:3 Can J Infectious Diseases & Medical Microbiology 135.

134. See Canada, Department of Justice, *Criminal Justice System's Response to Non-Disclosure of HIV*, Catalogue No J2-473/2017E (Ottawa: DOJ, 1 December 2017), online (pdf): <publications.gc.ca/collections/collection_2017/jus/J2-473-2017-eng.pdf>.

been approved by Health Canada for the Canadian market.[135] This is despite the fact that access to essential medicines has been recognized as a core component of the right to health under the *International Covenant on Economic, Social and Cultural Rights*,[136] to which Canada is a party. While some scholars argue there is ample scope for Canadian courts to use the *Charter* in safeguarding socio-economic rights, as of yet they have proven reluctant to do so.[137]

Conclusion

Both the *Canadian Charter of Rights and Freedoms* and the South African *Bill of Rights* are landmark human rights instruments of which their countries can be justifiably proud. However, each must also be treated as a work in progress, particularly in its application. In contrast to South Africa, where the sheer scale of the TB problem, as well as its inexorable links to the high profile issue of HIV and the associated rights-based response, have likely served to speed necessary evolution, TB in Canada remains a disease of marginalized communities whose rights are too frequently overlooked. While TB affects a comparatively small number of Canadians, this only underscores the lack of excuses for addressing it. As former Supreme Court of Canada Justice Louise Arbour put it, in a speech delivered while serving as United Nations High Commissioner for Human Rights:

> These truths are laid bare in Canada's very hesitant recognition and selective implementation of some of its international human rights obligations. But sixty years of disclaiming

135. See Public Health Agency of Canada, *Canadian Tuberculosis Standards*, 7th ed, by Canadian Lung Association & Canadian Thoracic Society (Ottawa: PHAC, 2014) Chapter 8 at 18, 23. For the most recent list of second-line anti-tuberculosis drugs, see *WHO Model List of Essential Medicines: 20th List* (2017) at 17, online (pdf): *World Health Organization* <www.who.int/medicines/publications/essentialmedicines/20th_EML2017.pdf>.

136. See Committee on Economic, Social and Cultural Rights, *Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights: General Comment No 14 (2000)*, UNESCOR, 22nd Sess, UN Doc E/C.12/2000/4 (2000) 1 at para 43(d).

137. See e.g. Martha Jackman, "Law as a Tool for Addressing Social Determinants of Health" in Nola M Ries, Tracey Bailey & Timothy Caulfield, eds, *Public Health Law and Policy in Canada*, 3rd ed (Markham, ON: LexisNexis, 2013) 91.

> or belittling the equal status of socio-economic rights as enforceable human rights, fundamental to the equal worth and dignity of all Canadians, rings hollow and disingenuous in the light of international and comparative experience.[138]

In turn, it is perhaps not a surprise that commentators have drawn explicit parallels between outlying Canadian decisions such as *Eldridge*[139] that push the boundaries of the *Charter* and the South African approach to socio-economic rights. As Porter states:

> The kind of reasonableness review of resource allocation in light of the needs of vulnerable groups adopted by the Supreme Court of Canada in the *Eldridge* case significantly converges with the approach that has been taken in by the South African Constitutional Court with respect to the right to housing or to health.[140]

This brings to mind the words of then-Justice Claire L'Heureux-Dubé, who remarked upon the fact that although the Supreme Court of Canada was willing to look to other jurisdictions, it was cited by courts like those in South Africa far more often than the reverse.[141] She continued:

> I think more reference to such foreign cases would help courts like Canada's take a greater part in this international dialogue. Even though we have a head start on these countries

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138. Louise Arbour, "'Freedom from Want': From Charity to Entitlement" (LaFontaine-Baldwin Lecture delivered at Quebec City, 4 March 2005) [unpublished], online (pdf): <icc-icc.ca/site/site/uploads/2016/11/LaFontaineBaldwinLecture2005_LouiseArbour.pdf>.

139. See *Eldridge v British Columbia (Attorney General)*, [1997] 3 SCR 624, 151 DLR (4th) 577.

140. Bruce Porter, "Social and Economic Rights and the Canadian Charter of Rights and Freedoms" (Paper delivered at Economic, Social and Cultural Rights: Models of Enforcement, Dublin, 9 December 2005) at 7 [unpublished], online (pdf): *Irish Human Rights and Equality Commission* <www.ihrec.ie/documents/bruce-porter-social-and-economic-rights-and-the-canadian-charter-of-rights-and-freedoms-10-december-2005/>.

141. See The Honourable Claire L'Heureux-Dubé, "The Importance of Dialogue: Globalization and the International Impact of the Rehnquist Court" (1998) 34:1 Tulsa LJ 15 at 27.

> in developing modern human rights jurisprudence, we have much to learn from them through considering their judgments and addressing them in our own decisions. Since their decisions interpret and evaluate our own, our thinking and knowledge will be strengthened by examination of and reflection upon them.[142]

Tuberculosis is an old disease, but one relatively new to human rights considerations. Canada would benefit from looking to its neighbours around the world, and, where appropriate, borrowing the tools it needs to construct an effective response. Such a response includes not only safeguarding the rights of the individual within the context of public health interventions, but also the simultaneous promotion of both public health and human rights through addressing the socio-economic inequalities that continue to fuel the disease.

142. *Ibid*.