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In the Face of Crisis: The Treatment Action Campaign Fights Government Inertia with Budget Advocacy and Litigation

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At the turn of the millennium the South African government allocated a total of R214 million (US\$28.5 million) to the fight against HIV/AIDS, an epidemic that had reached crisis proportions.² Less than 10 years later this figure has risen, in inflation-adjusted terms, to R3.96 billion (US\$528 million), a real increase of over 1,850 percent.³ This growth in the budget allocated to HIV/AIDS treatment and prevention is largely the result of the government's adoption of two public health policies aimed at addressing the crisis: 1) the provision of drugs that significantly reduce the likelihood of HIV-positive women passing the virus onto their children when they give birth (Prevention of Mother-to-Child Transmission, or PMTCT); and 2) the national distribution of Antiretroviral (ARV) drugs to those living with HIV. From a number of pilot projects in the early 2000s, the PMTCT initiative has grown to cover 80 percent of all pregnant women receiving care within the public health sector and intends to cover 95 percent by 2012. In terms of ARV treatment, despite a slow start in 2004, there are now approximately 1.2 million South Africans receiving ARV treatment through the public health sector.

Many stakeholders attribute this incredible increase in budget allocations and subsequent expansion of public HIV/AIDS programs largely to pressure exerted on the South African government by the Treatment Action Campaign (TAC) and its partner organizations.⁴ The TAC was launched in 1998 to campaign for equitable access to health care, particularly access to medicines to treat HIV/AIDS — access which, its founders argue, is a basic human right. A broad-based membership organization led by inspirational chairperson Zackie Achmat — himself HIV positive — the TAC initially focused on pressuring pharmaceutical companies into lowering the prices of the drugs used to treat AIDS. In the face of government inaction on the HIV/AIDS crisis, the TAC concurrently used a number of tactics backed up by evidence from its budget analysis to advocate for a stronger government response.

1. Background

There are a number of interrelated reasons for the South African government's initial refusal to implement HIV/AIDS prevention and treatment regimes, including the supposed toxicity of certain treatment options and then-President Thabo Mbeki's much publicized questioning of the

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² "What Budget 2002 Means for HIV/AIDS," *IDASA Budget Brief*, No. 90, February 2002, p. 9.

³ "Review of South Africa's HIV and AIDS Budget: A Quick Update," CEEGA, *Budget Policy Brief*, No. 1, December 2009, p. 3.

⁴ S. Friedman and S. Mottiar, "Seeking the High Ground: The Treatment Action Campaign and the Politics of Morality," in R. Ballard (et al), *Voices of Protest: Social Movements in Post-Apartheid South Africa*, Scottsville, 2006, pp. 23 – 24.

link between HIV and AIDS (“AIDS denialism”). One key issue the government raised time and again with regard to rolling out comprehensive HIV/AIDS prevention and treatment plans was that of cost. From as early as 1998, the question of affordability was singled out by the government as the principle reason it could not introduce drug-based prevention and treatment regimes. The government cited not only costs related to procuring the drugs but also those associated with rolling out any treatment plan, such as the need to provide for counselling and testing, and items like formula milk.⁵ The issue of affordability, along with “AIDS denialism,” dominated the political dialogue around HIV/AIDS treatment for at least the next five years.

The TAC adopted a number of different strategies in its ongoing campaigns for treatment access, combining negotiations with the government, mass mobilization of its members (including civil disobedience campaigns), and litigation via the courts. As Mark Heywood, the executive director of Section 27, a public interest law center in South Africa, notes, the TAC’s campaigning followed a specific process in that it “responded first with research and rational argument, and resorted to litigation and protest only after this failed to bring about a change in policy.”⁶

While the TAC included various strategies in its advocacy, the following campaign descriptions focus on the role that its use of budget analysis and litigation played in the success of its two key campaigns. A discussion of how these primary tools and tactics were amplified and complemented by other factors is taken up in a later section.

2. The TAC’s Mother-to-Child Transmission Campaign

Since its inception, the TAC had called on the South African government to introduce a comprehensive PMTCT program. However, the government consistently rejected this call on the grounds of cost. In 1998 the government suspended its PMTCT AZT trials, stating that an AZT-based program would cost R80 million (US\$10.6 million), which would put “strain” on the “already limited health budget.”⁷ In March 1999 the health minister stated that it would cost R500 (US\$67) to treat one pregnant woman, which was, in her opinion, “too much.”⁸ For at least the next two years, the government continued to claim that a PMTCT treatment plan was unaffordable, despite extensive research that demonstrated that preventing new infections by implementing an AZT PMTCT program was cost effective.⁹

⁵ “Government Continues to Focus on Aids Prevention,” 27 October 1998, <http://www.doh.gov.za/docs/pr/1998/pr1027.html>; “Lend a Caring Hand of Hope – Statement by the National Executive Committee of the ANC,” 20 March 2002, <http://www.anc.org.za/ancdocs/pr/2002/pr0320a.html>; and “Lend a Hand in the Campaign of Hope Against HIV/AIDS!: An Update on Cabinet’s Statement of 17 April 2002 on Fighting HIV/AIDS,” 9 October 2002, <http://www.doh.gov.za/docs/pr/2002/pr1009a.html>. See also, M. Heywood, “The Price of Denial,” p. 111; and N. Nattrass, *The Moral Economy of Aids in South Africa*, Cambridge, 2004, p. 178.

⁶ Mark Heywood, “The Price of Denial,” p. 114. Zackie Achmat, the TAC’s chairperson during this period, noted that members had to “learn law, epidemiology, science, mathematics, medicine, pharmacology, ethics, political economy, and international relations,” quoted in A. de Waal, *Aids and Power: Why There Is No Political Crisis – Yet*, London, 2006, p. 37.

⁷ “Government Continues to Focus on Aids Prevention,” 27 October 1998, <http://www.doh.gov.za/docs/pr/1998/pr1027.html>. Azidothymidine (AZT) is an antiretroviral drug.

⁸ See, <http://www.tac.org.za/Documents/MTCTPrevention/mtcthist.rtf>.

⁹ See, for example, N. Geffen, “Cost and Cost-Effectiveness of Mother-to-Child Transmission Prevention of HIV,” TAC Briefing Paper, December 2000; E. Marseille (et al), “Cost-Effectiveness of Antiviral Drug Therapy to Reduce Mother-To-Child HIV Transmission in Sub-Saharan Africa,” *AIDS*, 1998, p. 12; J. Skordis & N. Nattrass, “What Is

In early 2000, in the face of the government's intransigence, the TAC threatened legal action to try to compel the government to introduce a PMTCT program, claiming that the government's failure to do so was "immoral, uneconomical and unlawful."¹⁰ During 2000 research revealed that another drug, Nevirapine, was as effective as AZT, could be administered in a single dose, and was considerably cheaper.¹¹

Throughout 2000 the TAC maintained its pressure on the government to roll out a PMTCT program, including continuing to threaten legal action. When Nevirapine was cleared for use for PMTCT in South Africa by the Medicines Control Council (MCC) in April 2001, "the TAC decided that both morally and politically it had no other options than to launch a case against the government."¹² In August 2001 the TAC filed papers with the High Court that stated that the government's current position was unconstitutional and asked the court to enjoin the government to:

make Nevirapine available to pregnant women with HIV who give birth in the public health sector, and to their babies, where in the judgment of the attending medical practitioner or health professional this is medically indicated.¹³

A series of affidavits were drawn up, including one from a health economist, Professor Nicoli Natrass, that provided evidence showing that public funds spent on a PMTCT program would actually save money by reducing future HIV infections, and the associated costs. In her affidavit, Natrass states:

My analysis shows that the total cost to the health sector of MTCT programmes (i.e., the costs of voluntary counselling and testing, the costs of the anti-retroviral regimen and the costs of treating all children born HIV+ despite the MTCT programme) is less than the costs of treating all children born HIV+ in the absence of a MTCT programme. In other words, saving children from HIV infection by implementing a MTCT programme will save the state money because the costs of a MTCT programme are less than the costs associated with treating the additional children who would be born HIV+ if no MTCT programme was in place. It is therefore not tenable to argue that a MTCT reduction programme is too costly.¹⁴

Affordable: The Political Economy of Policy on the Transmission of HIV/AIDS from Mother to Child in South Africa," paper presented to the AIDS in Context Conference, University of the Witwatersrand, April 2001.

¹⁰ See, <http://www.tac.org.za/Documents/MTCTPrevention/mtcthist.rtf>.

¹¹ M. Heywood, "Preventing Mother-to-Child Transmission in South Africa: Background, Strategies and Outcomes of the Treatment Action Campaign Case Against the Minister of Health," *South African Journal of Human Rights*, 19, 2003, p. 285.

¹² *Ibid*, p. 290.

¹³ *Ibid*, p. 294.

¹⁴ Affidavit C.C. Natrass, 15 August 2001, section 5, www.tac.org.za/documents/MTCTCourtCase/ccmnnatt.rtf.

Nattrass demonstrated that by using Nevirapine the government would save at least R341,000 (US\$45,000) every six months, providing evidence that “there is no basis to the government’s claim that it cannot afford a MTCT reduction programme.”¹⁵

Despite this evidence, the government opposed the TAC’s case, arguing that the safety of Nevirapine had not been fully proved and that it was too expensive to introduce in South Africa. The government presented evidence to the court to indicate that a full provincial roll out of Nevirapine would cost R250 million (US\$33.33 million).¹⁶ In response, the TAC drew attention to the 2001 Intergovernmental Fiscal Review, which reported that provincial departments of health had actually underspent their budgets by R473 million (US\$63.1 million) in 2000.¹⁷ In December 2001 the High Court found in favour of the TAC and ordered the government to draw up a plan by March 2002 that sets out a national program for the prevention of mother-to-child transmission using Nevirapine. The judge argued that it was clear that a countrywide MTCP program using Nevirapine was affordable. He stated that:

[t]o the extent that the impression was created in the affidavits filed on behalf of some of the respondents that the further roll out of the programme will depend on the availability of resources, it must be dispelled. The resources will have to be found progressively. The availability of resources can only have an influence on the pace of the extension of the programme.¹⁸

The judge also argued that the roll out would require either a “reorganisation of priorities” or “further budgetary allocations.” He drew attention to the provincial health departments’ underspending of their HIV/AIDS budgets, particularly in the Eastern Cape, and argued that “the figures show that the cost of a universal programme is not beyond the means of the provinces.” The judge’s concluded that “a MTCT prevention programme with full coverage is affordable with proper planning.”¹⁹ The judge found that the state had violated Section 27 of the South African Constitution in that it had not taken reasonable steps within its available resources to provide women access to programs that prevent HIV transmission from mother to child, leading him to conclude that a “countrywide MTCT programme is an ineluctable obligation of the state.”²⁰

The government immediately appealed to the Constitutional Court, again claiming that such a roll out was unaffordable and would “cripple” an “already overburdened public health care system.”²¹ In July 2002 the Constitutional Court concurred with the decision of the High Court and found in favour of the TAC. The Constitutional Court argued that the state had indeed breached Section 27 of the Constitution and stated that “the administration of Nevirapine is well within the available resources of the state.”²² It ordered the government, “without delay,” to “remove the

¹⁵ Ibid, section 23. See also, N. Nattrass, *The Moral Economy*, pp. 75-99.

¹⁶ The government’s claim was further undermined by the fact that the manufacturer had offered the South African government a five-year supply of free Nevirapine.

¹⁷ M. Heywood, “Preventing Mother-to-Child Transmission,” p. 297.

¹⁸ “Judgment TAC and others v Minister of Health and others.” High Court of South Africa (Transvaal Provincial Division) Case no.: 21182/2001 Available at www.tac.org.za/Documents/MTCTCourtCase/mtctjudgement.doc.

¹⁹ www.cptech.org.za/ip/health/sa/sa12142001.

²⁰ www.tac.org.za/newsletter/2001/ns14_12_2001.txt

²¹ M. Heywood, “Preventing Mother-to-Child Transmission,” p. 305.

²² www.tac.org.za/documents/MTCTCourtCase/ConCourtJudgmentOrderingMTCTP-5July2002.pdf.

restrictions that prevent Nevirapine from being made available for the purpose of reducing the risk of mother-to-child transmission of HIV at public hospitals and clinics.”²³

3. The TAC’s Antiretroviral Medicine Campaign

On World Aids Day, 1 December 2000, the South African Minister of Health noted that the government’s decision not to implement a large-scale antiretroviral program was “not an ideological stance” but was based on the fact that such a program was “unaffordable.”²⁴ As with the PMTCT program, the government opposed the wholesale roll out of ARV treatment in South Africa, repeatedly claiming that the medicines and supporting delivery systems were unaffordable.

This placed the TAC in almost exactly the same position as with the PMTCT issue, i.e., having to provide evidence that an ARV treatment plan was affordable. To do so, the TAC formed a Research Committee in 2001 of health economists and medical professionals that produced a draft National Treatment Plan (NTP) based on analyses of the necessary delivery systems and medicines and their associated costs. This NTP became the focus of TAC advocacy, and in June 2002 the TAC and the Congress of South African Trade Unions (COSATU) jointly convened a National HIV/AIDS Treatment Congress. After this congress, the TAC entered into negotiations for a NTP with government representatives and labour and business leaders at the National Economic, Development and Labour Council (NEDLAC).

While NEDLAC was established to provide a forum for negotiations between labour, government, and business, the TAC turned to it because of the continued refusal of the Minister of Health to even consider a NTP.²⁵ Mark Heywood notes that union leaders persuaded the TAC of the benefits that would come from holding discussions within NEDLAC, which would allow the TAC to engage more formally with union and business leaders but also “move the issue of HIV/AIDS beyond the exclusive control of the Minister of Health – but still keep government ... in the talks.”²⁶

To assist with this process, the TAC commissioned two research papers, which were published in February 2003. One looked at the effect that a NTP would have on HIV/AIDS-related mortality and infections and concluded that a comprehensive prevention and treatment program would save 3 million lives and prevent 2.5 million new infections by 2015.²⁷ The second analysis included a budget-based costing exercise, which demonstrated that the cost of providing comprehensive ARV treatment would rise from R224 million (US\$31.8 million) in 2002, to R6.8

²³ Ibid, p. 312.

²⁴ Minister of Health, Speech on World Aids Day, 1 December 2000.

²⁵ One of NEDLAC’s objectives is to “seek to reach consensus and conclude on matters pertaining to social and economic policy.” See, M. Heywood, “Shaping, Making and Breaking the Law in the Campaign for a National HIV/AIDS Treatment Plan,” in *Democratising Development: The Politics of Socio-Economic Rights in South Africa*, Boston, 2005, p. 189.

²⁶ Ibid, pp. 189-190.

²⁷ See, N. Geffen, N. Nattrass, and C. Raubenheimer, “The Cost of HIV Prevention and Treatment Interventions in South Africa,” CSSR Working Paper No. 28, University of Cape Town, 2003, http://www.hst.org.za/uploads/files/cost_sa.pdf; and www.tac.org.za/.../CostsAndBenefitsOfTreatmentAndPrevention.pdf.

billion (US\$907 million) in 2007, to a potential peak of R18.1 billion (US\$2.4 billion) by 2015.²⁸ The researchers noted that actual costs were likely to be less because their calculations assumed there would be no further reductions in the costs of medicines and did not include an estimate of the savings the state would realize from reducing the number of AIDS orphans who would need public support. In addition, the researchers noted that other cost reductions were not factored in, such as those related to the social and economic costs associated with HIV/AIDS-related sick leave and mortality among ordinary South Africans.

The TAC acknowledged that the NTP had “very serious cost implications” but argued that within five years there would be measurable cost savings.²⁹ The TAC stated that “refusing to provide anti-retroviral treatment to people with AIDS does not amount to expenditure saved, it merely leads to a drain on the fiscus of similar dimensions but through other channels,” therefore, the comprehensive roll out of ARVs was affordable within available resources.³⁰

At the end of 2002 a draft agreement was reached at NEDLAC for a national plan for the phased roll out of ARVs. However, this agreement was immediately rejected by the government, which claimed it was awaiting the results of a Joint Task Team that was established by the Treasury and the Department of Health to research the costing of an ARV plan before taking any action.³¹

In response to the government’s continued delays, the TAC announced a civil disobedience campaign and stated that it was considering legal action against the government for failing to implement an ARV program.³² In early 2003 the TAC was given a leaked copy of the report from the Joint Treasury and Health Task Team, which demonstrated that an ARV treatment plan was affordable and would save hundreds of thousands of lives.³³ The TAC released this information to the public, which Heywood felt made it legally and morally inevitable that the government would introduce a treatment plan.³⁴ On 8 August 2003 the government announced that the Department of Health had been instructed to draw up a plan for an ARV program in South Africa, and, after some further delays, a plan was approved by the cabinet in November 2003.

4. Explaining the Changes

It is clear from this review of the TAC’s campaigns for a PMTCT program and ARV roll out that the organization’s ability to use various analytical tools to generate evidence that these two initiatives were not only affordable but could actually save public funds played a significant role in the success of the campaigns. Not to detract from the significance of the budget analysis in the efforts to pressure the South African government to take action, but it is important to fully

²⁸ Ibid.

²⁹ See, www.tac.org.za/.../TreatmentPlan/NEDLAC_AGREEMENT_20021206.doc.

³⁰ See, www.tac.org.za/Documents/TreatmentPlan/CosatuTACRationaleForNTP.doc. Such costs relate to the need to treat opportunistic infections and care for orphans.

³¹ M. Heywood, “Shaping, Making and Breaking,” p. 191.

³² TAC Annual Report, 2002/03, p. 14.

³³ See, <http://www.tac.org.za/Documents/TreatmentPlan/slideshowongovernmentcostingstudy.pdf>.

³⁴ M. Heywood, “Shaping, Making and Breaking,” p. 203.

explore other factors that may have contributed to the government's decision to establish the PMTCT program and initiate the ARV roll out. The following describes a number of features of the TAC itself and of its campaigns that added to its effectiveness, as well as several issues that created a political environment that made it very difficult for South Africa's African National Congress (ANC)-led government to resist the TAC's calls for action on the HIV/AIDS crisis.

In the next two sections we describe internal and external or contextual factors that contributed to TAC's impact. There are also other actors and dynamics that contributed to the impact that TAC achieved. For that reason we also consider some alternative explanations of change.

Internal factors

Inspirational leadership

As indicated earlier, the TAC benefitted from the dynamic leadership of its chairperson, Zackie Achmat, which played a significant role in the success of its campaigns. Achmat, who is HIV positive, successfully demonstrated his commitment to the political and moral legitimacy of the TAC by refusing to take ARV drugs despite becoming very ill. In doing so, he courted much media attention and personalized the struggle for ARVs, becoming a very real representative of those who were fighting for access to life-saving drugs.³⁵ His decision not to take ARVs and the media attention this generated, led to him receiving a number of international humanitarian awards, as well as being officially nominated for the Nobel Peace Prize.³⁶ All of the high-profile media attention on Achmat certainly contributed to raising the profile of the TAC, both in South Africa and overseas.

A number of political analysts also note that TAC's success largely stems from its reimagining of anti-apartheid activist strategies. As one commentator notes, the TAC had older socio-political roots in various kinds of anti-apartheid activism in the 1980s and early 1990s. Indeed the TAC emerged from a social network consisting of radical, activist components.³⁷

Such "radical activists" not only bestowed legitimacy on the TAC but also brought a varied set of advocacy techniques into the organization that had proven effective during the struggle against apartheid.³⁸ This activist background of many of the founders of the TAC resulted in it pursuing a varied and sophisticated advocacy approach that incorporated a number of different strategies.

The TAC's civil disobedience campaign clearly made reference to the ANC's 1950s Defiance Campaign, thus cleverly locating the struggle for the right to healthcare within the anti-apartheid struggles for freedom.

³⁵ M. Mbali, *The New Struggle*, pp. 314 – 315.

³⁶ *Time* magazine named Achmat as one of the "Heroes" of 2003, while the *New Yorker* magazine claimed that he was "South Africa's most important dissident since Nelson Mandela," see, S. Jacobs & K. Johnston, "Media, Social Movements and the State: Competing Images of HIV/AIDS in South Africa," *African Studies Quarterly*, Vol. 9, No. 4, 2007, p. 133.

³⁷ M. Mbali, *The New Struggle*, pp. 276 – 277.

³⁸ See, S. Friedman & S. Mottiar, "Seeking the High Ground," p. 25; M. Mbali, *The New Struggle*, p. 343; and S. Robins, "Long Live Zackie, Long Live," p. 666.

Relationship with the law

Heywood recently noted that the TAC approached the government pragmatically precisely because it believed that significant social reform and resource allocation was possible within the framework of the South African Constitution.³⁹ While the TAC had faith in the Constitution, which was ultimately vindicated, it did not mean that the organization was not also willing to break the law to achieve its objectives. Therefore, in much the same way that the TAC had a sophisticated approach to the government, it had a flexible approach to the law, which it simultaneously sought to use (via the courts) and break (during civil disobedience campaigns). While the TAC was prepared to break the law during the disobedience campaign it did so within very strictly defined parameters. At the time of the campaign it stated that “the TAC civil disobedience campaign is not promoting ungovernability. It is not promoting gratuitous law-breaking. It is not calling for the overthrow of the government!”⁴⁰ This approach enabled the TAC to recognise the legitimacy of the democratically elected ANC government, while at the same time exerting pressure on the government by courting arrest by such means as occupying buildings or stopping traffic.

While it is hard to evaluate the impact, if any, that the civil disobedience campaign had, it was clearly seen as a legitimate protest mechanism by the TAC, demonstrating the complexity and sophistication of the organization’s advocacy strategy.

Relationship with the government

It would be easy to characterize the TAC’s relationship with the South African government as one of constant conflict and animosity. However, this fails to acknowledge the complexity of the relationship during its campaigns.

Initially, the TAC’s mission was to mobilize support for the government in its fight against the Pharmaceutical Manufacturers’ Association (PMA), which took the government to court in 1997 over proposed legislation that would allow the government to import and produce cheap generic versions of patented drugs.⁴¹ It was only during the fight for access to Nevirapine and ARVs that the relationship between the TAC and the government began to deteriorate. However, the TAC still continued to engage positively with certain elements within the South African government and always remained open to collaboration with the government. Illustrating this shifting relationship is the fact that, a couple of months before the TAC took the government to court over access to drugs for PMTCT, it was accepted as a “friend of the court” in the government’s battle with the PMA.⁴²

The TAC’s *modus operandi* for all its demands was to first follow all the formal established channels of communication with the government before embarking on court action or civil disobedience.⁴³ As Achmat noted in April 2003, “civil disobedience is an action of last resort for

³⁹ Mark Heywood, “Civil Society and Uncivil Government...,” p. 22.

⁴⁰ “Dying for Treatment: TAC Briefing Document on the Civil Disobedience Campaign,” March 2003, <http://www.tac.org.za/Documents/CivilDisobedience/briefingdocument.htm>. Achmat said in 2004, “We want to get medicine to the people, we don’t want to cause a revolution.” Quoted in N. Nattrass, *Mortal Combat*, p. 46.

⁴¹ Mark Heywood, “Civil Society and Uncivil Government...,” p. 10.

⁴² Mark Heywood, “Civil Society and Uncivil Government...,” p. 10.

⁴³ S. Friedman & S. Mottiar, “Seeking the High Ground,” p. 33.

us, because exhaustive efforts at engagement have not worked.”⁴⁴ This strategy allowed the TAC to demonstrate to the government and South African public that it had made exhaustive efforts before resorting to more confrontational forms of advocacy, which lent legitimacy to its more oppositional activities.⁴⁵

The TAC leadership recognized the importance of adopting a dynamic and strategic relationship with the government in South Africa; one which, in Heywood’s words, “always preferred collaboration with government rather than conflict.”⁴⁶ It was a relationship characterised by both conflict and cooperation but, critically, it recognised that allies could be found within the government even when the TAC was being more confrontational.

Grassroots Mobilization

Mobilizing grassroots support for its objectives was a key strategic focus of the TAC. It did so by the “creative re-appropriation of locally embedded political symbols, songs and styles of the anti-apartheid movement.”⁴⁷ The TAC focused on AIDS awareness and treatment literacy campaigns at the local level by going to schools, churches, union meetings, football matches, and community centers, and by going door-to-door to encourage community members to support its objectives.⁴⁸

International Solidarity

The TAC actively courted international alliances and support for its objectives in much the same way that the anti-apartheid movement had done.⁴⁹ For example, civil society organizations (CSOs) like Act Up and the Stop Aids Campaign organized solidarity events all over the world in support of the TAC.⁵⁰ In addition, the TAC’s support for the government in its fight against the PMA resonated with activists outside of South Africa who were similarly opposed to the corporate interests of multinational drug companies.⁵¹ Analysts argue that its tactics gave the TAC an “iconic status” internationally, which is said to have exerted additional pressure on the ANC government.⁵² Observers have noted that the TAC’s “most strategically important alliance” was with overseas CSOs, which both enabled it to exert pressure on pharmaceutical company head offices and secured international opposition to the ANC government’s policy on ARVs, which it is argued, “played a role in winning the ‘roll out.’”⁵³

Alliance Building

⁴⁴ Zackie Achmat quoted in, “The Long Walk to Civil Disobedience,” *Mail and Guardian*, 4 April 2003.

⁴⁵ The TAC’s relationship with the government was further complicated by the fact that the ANC government was the first democratically elected government in South Africa after apartheid, so the TAC a difficult terrain where antagonism towards the ANC government was read by some as antagonism towards South Africa’s fledgling democracy. As Heywood noted in 2002, “we never wanted this fight with the government. It is unseemly to fight over people’s rights, especially with this government.” Heywood quoted in, “Nevirapine: Court Rules for the People,” *Mail & Guardian*, 4 April, 2002.

⁴⁶ Mark Heywood quoted in S. Jacobs & K. Johnston, “Media, Social Movements and the State,” p. 140.

⁴⁷ S. Robins, “Long Live Zackie, Long Live,” pp. 664 – 665.

⁴⁸ M. Mbali, *The New Struggle*, pp. 317 – 318.

⁴⁹ S. Robins, “Long Live Zackie, Long Live,” p. 664.

⁵⁰ See, for example, www.tac.org.za/documents/dayofactionreport.doc.

⁵¹ S. Robins, “Long Live Zackie, Long Live,” p. 665.

⁵² S. Friedman & S. Mottiar, “Seeking the High Ground,” p. 23.

⁵³ S. Friedman & S. Mottiar, “Seeking the High Ground,” p. 35.

As well as building alliances internationally, the TAC was highly effective in building local networks of supporters, including seeking alliances with organizations that it had clear differences with. For example, the TAC worked with the Catholic Church in South Africa, despite the church's opposition to the use of condoms, and also worked throughout this period with the Congress of South African Trade Unions (COSATU), despite the Congress being a partner in government with the ANC.⁵⁴ This flexible and dynamic approach resulted in significant support from numerous institutions within civil society. Nathan Geffen from the TAC observed that it would not have forced the government into implementing a national treatment plan without the support of "all the NGOs, unions, churches, volunteers and health-care workers who helped us in this struggle."⁵⁵

Using the Mass Media

Analysts have noted that the TAC made exceptional use of mass media opportunities during its struggle for access to treatment, making extensive use of radio, newsprint, television and the Internet to popularize its messages. One political analyst recently remarked that the TAC "achieved extraordinary media visibility and shaped public opinion through sophisticated networking and media imaging."⁵⁶ Observers have noticed that the TAC's media campaign was successful because it did not frame its struggle for treatment in narrow terms simply relating to HIV/AIDS, but rather as a wider human rights issue. As Achmat noted in 2004, the TAC "unashamedly pursues a social democratic, pro-poor and pro-human rights agenda."⁵⁷ This framing resonated with activists in South Africa and among overseas CSOs concerned broadly with human rights and led to extensive media attention. Another factor that contributed to the TAC's positive relationship with the media was its "meticulous research," which made it a trusted source for journalists.⁵⁸ By producing thorough analyses of the impact of HIV/AIDS prevention and treatments programs on the public purse, the TAC was able to enhance its credibility with the media and other key stakeholders.

External factors

In addition to the internal, strategic choices that paved the way to TAC's impact, it also managed to leverage benefit from a set of external factors.

Divisions within the ANC Government

Throughout the TAC's battle for access to treatment there was support for it from within the structures of the ANC, and within government more generally. This support effectively led to two revolts within the ANC over the provision of medication for HIV and AIDS. First, a number of provincial health departments (Western Cape, Kwa-Zulu Natal, and Gauteng) began distributing Nevirapine against the instructions of the national Department of Health, while the government was appealing the TAC's December 2001 High Court victory over Nevirapine.⁵⁹

⁵⁴ S. Friedman & S. Mottiar, "Seeking the High Ground," p. 33. Heywood notes the 'painstaking' efforts that went into building alliances, see, Mark Heywood, "Civil Society and Uncivil Government..." p. 21.

⁵⁵ Nathan Geffen quoted in, M. Mbali, *The New Struggle*, p. 343.

⁵⁶ S. Robins, "Long Live Zackie, Long Live," p. 665.

⁵⁷ S. Jacobs & K. Johnston, *Media, Social Movements and the State*, p. 143.

⁵⁸ M. Mbali, *The New Struggle*, p. 322.

⁵⁹ Provinces in South Africa have a significant degree of financial autonomy.

One observer noted that “the national government had by this time effectively lost control over the provinces.”⁶⁰ One leading journalist stated at the time that the government was under “remorseless *internal* and external pressures,” clearly demonstrating the extent of the divisions within the ANC at the time.⁶¹

Second, it appears that a similar revolt took place over the ANC’s decision to announce a national plan for the distribution of ARVs in August 2003. One analyst noted the decision was driven by a number of senior government ministers who forced the government to make the announcement, allegedly against the wishes of both the Minister for Health and President Mbeki.⁶²

Another area where divisions within the government appear to have assisted the TAC is in accessing government information on HIV/AIDS. Heywood recalls how, during the TAC’s campaigns for Nevirapine and the national treatment plan, elements within government denied access to information and reports on HIV/AIDS by withholding or doctoring such reports. Despite this, and indicative of divisions within the government, information was continually leaked to the media or CSOs like the TAC.

Far from being passive in all of this, the TAC can be credited with creating an enabling environment within which members of the ANC could voice their dissatisfaction with policy priorities, especially by providing credible evidence of the budgetary impact of treatment and prevention programs.

Morality

Another factor that contributed to the TAC’s success was simply that the government’s refusal to dispense life-saving medicines to those who needed them was morally indefensible. This moral argument was strengthened by the TAC’s budget analysis that showed that providing treatment was affordable. Political analysts have drawn attention to the importance of morality to the TAC, with one remarking that by demonstrating to the world that the South African government’s position was immoral the TAC created a “moral consensus” that exerted pressure on the government.⁶³ Achmat noted in July 2002 that “the political scenario in South Africa has lost its moral content. The poorest of the poor are dying, only the rich have access to treatment. My fight is essentially about this. If we don’t have morals in our politics, then South Africa is doomed.”⁶⁴

The South African Constitution

⁶⁰ N. Nattrass, *Mortal Combat: AIDS Denialism and the Struggle for Antiretrovirals in South Africa*, UKZN Press, 2007, p. 101.

⁶¹ “Will Minister Bend or Break?,” *Mail & Guardian*, 1 February, 2002. Emphasis added.

⁶² “Aids: Ministers Revolt,” *Mail & Guardian*, 15 August, 2003; see also, “OPINION: What Bent Mbeki?” *Mail & Guardian*, 19 April 2002.

⁶³ S. Friedman & S. Mottiar, “Seeking the High Ground: The Treatment Action Campaign and the Politics of Morality”, in R. Ballard (et al), *Voices of Protest: Social Movements in Post-Apartheid, South Africa*, UKZN Press, 2006, pp. 30-32.

⁶⁴ “A Fight for the Soul of SA: An Ailing Zackie Achmat Is Determined to Continue to Pressure the Government to Provide Anti-retrovirals to all South Africans,” *Mail & Guardian*, 12 July 2002.

One commentator notes of the TAC's campaign for treatment, "the coincidence between South Africa's transition to democracy and the intensification of its AIDS epidemic allowed activists to bring HIV/AIDS into national debates on constitutionalism and defining the content of democratic rights in the new dispensation."⁶⁵

In this way, the TAC's ability to garner support and exert enormous pressure on the government was also, in part, simply a product of timing. The TAC presented the new democratically elected government with its first true challenge. Perhaps more important, as one leading newspaper editorial stated, "[T]he TAC's constitutional court battles with the government will shed light on the state's responsibilities on constitutionally enshrined socio-economic rights. It will also clarify the question of the separation of powers between the executive and the judicial branches of the state."⁶⁶

Therefore, some of the attention that the TAC received, and the political power that came with it, was motivated by a deep interest in how the organization and its partners were testing the limits of South Africa's new democracy, rather than specifically in their struggle for treatment. This is not to imply that there was anything inevitable in the TAC victories. The TAC clearly researched, mobilized, and advocated in dynamic and sophisticated ways throughout its struggle for treatment. As one analyst noted, "it was hardly inevitable that HIV/AIDS would be seen so widely as a cause of sympathy. Activism made it so."⁶⁷

5. Alternative explanations

A number of alternative explanations for the changes in government's AIDS policy can be advanced. While it is unlikely that these factors would have brought such changes about on their own, it is clear that they made a discrete contribution to these changes.

Upcoming Elections

A number of observers have noted that the ANC's August 2003 announcement to draw up a plan for the nationwide provision of ARVs was not simply the product of the TAC's campaigning. Newspaper reports in August 2003 reported that the ANC's Head of Elections had stated to the government that an ARV plan had to be in place before the general election that was due in April 2004 because the ANC "would lose the debate on AIDS."⁶⁸ Clearly this suggests that the motivation for announcing the plan was also one of political expediency and was not driven exclusively by the TAC's campaigns — a view shared by a number of opposition party members of parliament.⁶⁹ However, the fact that the government feared an electoral backlash if it did not produce a plan before the election clearly indicates the success of the TAC's advocacy. In addition, the timing seems to be far more related to the TAC's July 2003 leaking

⁶⁵ S. Jacobs & K. Johnston, Media, *Social Movements and the State*, p. 134.

⁶⁶ "Editorial: Save Lives and Face," *Mail and Guardian*, 5 April 2002.

⁶⁷ S. Friedman & S. Mottiar, "Seeking the High Ground," p. 32.

⁶⁸ "Aids: Ministers Revolt," *Mail & Guardian*, 15 August 2003. See also, "We are Not Power-Mongers," *Mail and Guardian*, 7 April 2004.

⁶⁹ P. Strand (et al), "HIV/AIDS and Democratic Governance in South Africa: Illustrating the Impact on Electoral Processes," IDASA, Cape Town, 2004, p. 153. See also, P. Fourie & M. Meyer, *The Politics of Aids Denialism: South Africa's Failure to Respond*, Ashgate, 2010, p. 131.

and publishing of the government's own joint Treasury and Health costing analysis that demonstrated that a national ARV was in fact affordable. This was a point the TAC had been making based on its budget analysis since 2002.

It seems fair to conclude that the upcoming election in early 2004 may have led the government to announce a national plan earlier than it may have wanted to, but evidence suggests that the announcement itself was somewhat inevitable given the extent of opposition both from the TAC and the pressure being exerted from within the government.

International Scientific Discourse

Another factor that contributed to the use of Nevirapine and the adoption of the national plan that cannot be directly attributed to the work of the TAC is the pressure that both the domestic and international scientific communities exerted on the South African government in relation to President Mbeki's dissident views on the link between HIV and AIDS, and the Minister of Health's apparent belief that vitamins and vegetables were a better treatment for AIDS than ARVs.⁷⁰

Both viewpoints contributed to a situation wherein the South African government was continually condemned by the scientific community in South Africa and overseas for its stance on HIV and AIDS. From the Durban Declaration of 2000, where 5,000 doctors and scientists signed a statement affirming that HIV causes AIDS, to the United Nations Special Envoy for AIDS in Africa commenting in 2006 that AIDS policies being pursued by the ANC government were "worthy of a lunatic fringe," pressure was exerted on the South African government to reform its HIV and AIDS policies.⁷¹ While it is debatable how much impact international pressure had on the ANC government, it certainly did much to lend credence to the arguments being made by the TAC.

One analyst observed that the government's August 2003 decision to draw up a plan for the provision of ARVs was driven in part by pressure from the World Health Organization's "3 by 5" campaign, which set out to treat three million people in the developing world by 2005. The analyst notes that this campaign made the South African government's position "even more out of step with global opinion and action in other developing countries."⁷²

Falling Drug Prices

One factor that clearly assisted the TAC in its battle for access to treatment was the constant fall in drug prices during the period under review, driven, in part, by the TAC's persistent and effective activism on this issue. While its advocacy focus changed considerably over the period in response to the attitude of the ANC government to treatment, the TAC never abandoned its efforts to reduce drug prices.

The TAC's advocacy around this issue resulted in a number of victories in 2001, including a reduction in the price of a number of key drugs used to treat AIDS. However, its greatest

⁷⁰ P. Fourie & M. Meyer, *The Politics of Aids Denialism*, p. 40.

⁷¹ P. Fourie & M. Meyer, *The Politics of Aids Denialism*, p. 8.

⁷² N. Nattrass, *Mortal Combat*, p. 119.

success came in 2003 when the Competition Commission of South Africa found in favor of the TAC and a number of partner organizations, who had filed a complaint with the Commission that ARV drug prices were excessive.⁷³ This decision resulted in a number of drug companies agreeing to provide licenses to generic manufacturers, which led to a drop in the price of a yearly frontline treatment for AIDS from \$10,439 per person in 2000 to \$182 by May 2005.⁷⁴

6. Conclusion

In 2007 the South African cabinet endorsed the HIV & AIDS and STI (sexually transmitted infections) Strategic Plan for South Africa (2007-2011), which committed the government to spending R45 billion (US\$6 billion) on HIV and AIDS prevention and treatment over a five-year period.⁷⁵ This plan will increase spending on HIV and AIDS as a proportion of overall health spending from 3.62 percent in 2005 to 5.39 percent in 2011, which should result in 1.625 million people receiving ARV treatment by 2011.⁷⁶ This spending plan was drawn up in consultation with the TAC, which was able to “influence the process substantially.”⁷⁷ A little over six years after taking the government to court to force it to provide access to PMTCT medicines, the TAC was able to assist in the drafting of the most comprehensive ARV treatment plan in the world. As a result of the TAC’s efforts, hundreds of thousands of HIV/AIDS-related deaths have been prevented and significant additional resources have been pushed into the public health system.

Our analysis shows that a complex set of TAC strategies drew on a sophisticated analysis of the governance and social context as well as the internal strengths of the organization. A number of processes independent of their campaigns also contributed to its success.

⁷³ See, E. Cameron, *Witness to Aids*, (Cape Town, 2005), pp. 178 – 183.

⁷⁴ N. Nattrass, *Mortal Combat*, p. 106.

⁷⁵ M. Heywood, “South Africa’s Treatment Action Campaign,” p. 27.

⁷⁶ “Review of South Africa’s HIV and AIDS Budget: A Quick Update,” CEEGA, Budget Policy Brief No. 1, December 2009, p. 9, and <http://www.tac.org.za/community/nsp>. The national Department of Health reports that by January 2011, 4.7 million South Africans had been tested and that 1.2 million were on ARVs. See <http://www.doh.gov.za/docs/newsletters/2011/0119.pdf>.

⁷⁷ TAC Annual Report, October 2006, p. 9.