

Progressive realization



Article 2 & Governments' Budgets

*Budget increases and meeting
the obligation of progressive realization*

The case in brief

As of 2003, 5.3 million adults and children in South Africa were living with HIV/AIDS. Despite the human tragedy these figures represented, the South African government refused to implement a comprehensive HIV/AIDS prevention and treatment program. High-ranking government officials, including President Thabo Mbeki, were in AIDS denial, questioning the link between HIV and AIDS, refusing to accept the findings of scientific research. The government also maintained that the implementation of comprehensive drug-based prevention and treatment was not affordable.

That was in 2003. By a decade later, South Africa had increased the public money going to the fight against HIV/AIDS by an astounding 1,850 percent—from R214 million (US\$28.5 million) to R3.96 billion (US\$528 million). This increase reflected the adoption of two public health policies that were instrumental in enabling the South African government to progressively realize the right to health of people in the country: the provision of drugs that prevent the transmission of HIV from mother to child (PMTCT), and distribution of anti-retroviral drugs (ARVs) to people living with HIV. As of 2013, the PMTCT program reached close to 100 percent of the women receiving care in the public health sector. More than 1.2 million people received ARVs.

These achievements were not the result of chance. The Treatment Action Campaign (TAC), launched in 1998 with the purpose of ensuring access to treatment for people living with HIV/AIDS, played a crucial role. Over the years TAC grew into a vibrant movement of outspoken activism, community organizing, mass mobilization, and civil disobedience. TAC has used strong, evidence-based arguments (derived in part on budget analysis) as well as negotiation when those approaches have worked, and has resorted to more confrontational tactics of protest and legal action when the latter have been needed to move government.



The human rights issue

Article 11 of the South African constitution guarantees the right to life, and article 27 promises access to health care services. Article 27 also obligates the state to “take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of [the right to health care services].” This latter phrasing echoes ICESCR article 2’s obligation on governments to progressively achieve ESC rights using the maximum of available resources.

Articles 11 and 27 also have counterparts in article 6 of the International Covenant on Civil and Political Rights (ICCPR), which guarantees the right to life, and article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), which guarantees the right to health. The latter elaborates further by providing that States Parties must take steps necessary “for

the reduction of [...] infant mortality and for the healthy development of the child.” It also obligates government to work for the “prevention, treatment and control of epidemic [...] diseases.”

The CESCR’s General Comment 14 on the right to health reiterates these guarantees in the ICESCR by specifying as core government obligations:

- To ensure reproductive, maternal (pre-natal as well as post-natal) and child health care [para. 44(a)]
- To take measures to prevent, treat and control epidemic and endemic diseases [para. 44(c)]
- To provide essential drugs [para. 43(d)]

The human rights argument

South Africans suffering from HIV/AIDS have a right to life and to health care services (South African Constitution, arts. 11 and 27) as well as “enjoyment of the highest attainable standard of physical and mental health” (ICESCR, art. 12). These guarantees mean that government must progressively prevent, treat and control HIV/AIDS, an epidemic disease, and should prioritize child health. An important weapon in the fight against HIV/AIDS is drugs—those that are effective in controlling the spread of HIV/AIDS to newborn children, as is Nevirapine, and those, such as anti-retrovirals, that are effective in treating people already suffering from it.

Progressive realization means that people should enjoy increasingly better health, and that an increasing number of people over time should be healthy. When increasing government expenditures can lead directly to ensuring that fewer people catch the disease and more are able to live a healthier life, as was and is true in this case, government has an obligation to devote the maximum of available resources to the effort.





Case study in detail

The fight for PMTCT

By 1994 medical research had concluded that the anti-retroviral drug AZT could dramatically reduce the risk of transmission of HIV from mother to child. This meant that it had become possible to prevent many children from being infected with HIV during childbirth and while breastfeeding. This evidence provided a strong basis for the demand made by the Treatment Action Campaign (TAC) since its inception for a comprehensive PMTCT program. However, the South African government denied the existence of an HIV-AIDS link; it even suspended its own PMTCT AZT trials. It additionally claimed that such a PMTCT program would be too costly. Indeed, the health minister went on record in March 1999 saying that the R500 (US\$67) needed to treat one pregnant woman was too much and would strain an already limited budget.

Soon thereafter, new scientific evidence revealed that Nevirapine was as effective as AZT, and could be administered in a single dose at a considerably lower cost. In April 2001 the Medicines Control Council of South Africa cleared Nevirapine for use in the country. The government, however, refused to act. TAC filed papers with the High Court, claiming that the government's position was unconstitutional.


It asked the Court to order 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."

In this case progressive realization of the right to health was directly related to increases in allocations in the budget. A budget increase was necessary to pay for the new interventions as well as new drugs, as these had not previously been available in the public health system. As the budget increased year by year, more people had access to the interventions and drugs. However, in other situations, a budget could increase without a comparable increase in people's enjoyment of their rights. Funds could be directed to ineffective interventions, not spent, wasted, etc. In other words, the correlation between increases in the budget and the progressive realization of rights is not always direct and clearly visible. (See the booklet on progressive realization).

Debunking the government's argument

To strengthen their case, TAC requested affidavits from diverse experts, one of which included cost projections that TAC could not have done on its own. However, because of the legitimacy of its demands as well as its solid network of relationships, it was able to identify an expert willing to do such a projection. Health economist Nicoli Natrass produced evidence showing how public funds spent on a PMTCT program would save the government money in the long run by reducing the costs associated with future HIV/AIDS cases. In her affidavit Natrass pointed out how the total cost of a comprehensive PMTCT program (Nevirapine, counselling, testing and ARV treatment for children that required it) would be less than the costs of treating all children who would be born HIV-positive in the absence of such a program.

Natrass combined the cost of individual interventions into a comprehensive package of treatment, then estimated the global costs of attending all mothers and children that were projected to require interventions in a given time frame. She took a further step, comparing these projections to projections of the monetary cost of government inaction, which would inevitably translate into recurrent hospitalizations of and



interventions for HIV-positive children. Natrass provided solid evidence showing that by using Nevirapine the government would save at least R341,000 (US\$45,000) every six months, thus countering the government's claim of the unaffordability of a PMTCT program.

In its defense, the government presented evidence to the court indicating that a full roll-out in the provinces of Nevirapine would cost R250 million (US\$33.33 million), arguing, once again, that such a sum was not available. TAC debunked this claim, pointing out that the government was currently failing to use the maximum of available resources. This fact emerged from the 2001 Intergovernmental Fiscal Review, which reported that in 2000 provincial departments of health had underspent their budgets by R473 million (US\$63.1 million)—considerably more than a full roll-out of Nevirapine would cost.

This case underscores the integral relationship between the three obligations in article 2. In this case, TAC's ability to push for progressive achievement of the right to health depended in part on its ability to demonstrate that the government had failed to use the maximum of its available resources to realize the right to health.

In December 2001 the High Court ruled in favor of TAC and ordered the government to draw up a plan for the implementation of a national PMTCT program using Nevirapine. It was clear to the judge that such a program was affordable, and that the availability of resources could thus only influence the pace of the program's extension. While additional resources would have to be made available, proper planning would make full coverage possible. Ultimately, the judge found that the state had violated Section 27 of the South African Constitution, by failing to take reasonable steps within its available resources to provide women access to programs that would prevent HIV transmission from mother to child. Following an appeal by the government, this ruling was confirmed by the country's Constitutional Court, which ordered the government to remove the restrictions that prevented Nevirapine from being made available at public hospitals and clinics.

Careful planning is necessary for the progressive realization of rights, but plans alone are not enough. It is essential that the government develop realistic, targeted budgets that are in line with details in the plans. In this way it can better ensure that there will be sufficient funding to allow implementation to proceed smoothly and effectively. In this context, a performance budget, which relates a government's plans closely to its budgets, can be valuable. Multi-year budgets are also important, because "progressive realization" by its nature requires several years, and it is necessary to know the funds that will be necessary in future years to implement well-conceived plans

Pushing farther

The PMTCT case was not the last time TAC had to demonstrate the financial viability of an HIV/AIDS program. The South African government's resistance extended to the roll-out of a large-scale anti-retroviral (ARV) program. To bring the government to the table, TAC established a broad coalition with unlikely allies, such as the Congress of South African Trade Unions (COSATU) and the National Economic, Development and Labour Council (NEDLAC). It also formed a research committee of health economists and medical professionals that was tasked with producing a draft comprehensive National Treatment Plan (NTP).

Related research that TAC commissioned included a paper that examined the effect an NTP would have on HIV/AIDS-related mortality and infections, which concluded that the plan would save 3 million lives and prevent 2.5 million new infections by 2015. A second analysis found that the cost of providing comprehensive ARV treatment would rise from R224 million (US\$31.8 million) in 2002 to R6.8 billion (US\$907 million) in 2007. An astounding R18.1 billion (US\$2.4 billion) could potentially be needed by 2015, assuming that there were no further reductions in the costs of medicines. While recognizing the serious cost implications of a comprehensive NTP, TAC claimed that failing to spend on ARVs was not actually saving money, but only draining it away through other channels.

The government rejected the draft NTP. It claimed that it was awaiting the results of a Joint Task Team that had been established by Treasury and the Department of Health to research the costing of an ARV plan. Following government delays, TAC announced a civil disobedience campaign and said that it was considering legal action once again. In early 2003 the organization secured, and then leaked, a copy of the report of the Joint Task Team. That report concluded that an ARV treatment plan was affordable and would save hundreds of thousands of lives.

In November 2003 the cabinet approved a plan for an ARV program in South Africa. In 2007, the cabinet endorsed an HIV/AIDS and STI (sexually transmitted infections) Strategic Plan for South Africa (2007-2011). The plan committed the government to spending R45 billion (US\$6 billion) on HIV and AIDS prevention and treatment over a five-year period. The plan was drawn up in consultation with TAC; the organization was able to significantly influence the content of the plan.

Progressive realization of rights, by definition, requires sustained, long-term efforts. The tactics used by TAC, and their engagement with diverse stakeholders and decision-makers over more than a decade, illustrate that, in the fight for progressive realization, there are no short-cuts or easy victories. Civil society organizations must be aware that moving a government's budget into human rights priorities will always be a long-term project.

Questions you might ask yourself or your government about progressive realization and increases in the government's budget:

Does the government monitor progressive realization of ESC rights? If not, why not?

If the government monitors progressive realization of rights, how does it connect these efforts to programmatic and budgetary revisions?

If the realization of rights is not increasing, does it analyze the role of the budget in the failure to progressively realize the rights?

Where funds for ESC rights-related areas are inadequate to allow for progressive realization of the corresponding rights, does the government examine the rest of the budget to determine if there are funds in other areas of the budget that could be re-directed to ESC rights-related areas?

Does the government develop performance budgets for ESC rights-related areas? If not, why not?

Does the government develop multi-year budgets for the purpose of ensuring the sustainability of progressive realization of ESC rights over a number of years?

When the government adopts a significant new program or project, does it cost out how much the program or project will cost? Does it determine whether there will be adequate funds in the budget to realize the program or project now, and in the future?

When the government costs out how much would be necessary to support new programs or projects important for the realization of ESC rights, does it at the same time assess the likely cost to government and society of a failure to adequately support the new programs or projects? Does it make this information publicly available?

Treatment Action Campaign

Founded in December 1998 in Cape Town, South Africa, TAC advocates for increased access to treatment, care and support services for people living with HIV/AIDS, and campaigns to reduce new HIV infections. With thousands of members across South Africa and some 220 staff, TAC has become the leading civil society force behind comprehensive health care services for people living with HIV/AIDS in South Africa. Since its inception TAC has held the government accountable for health care service delivery, campaigned against AIDS “denialism” by government, challenged the world’s leading pharmaceutical companies to make treatment more affordable, and cultivated community leadership on HIV and AIDS.

For more information on TAC, go to:
www.tac.org.za

The Article 2 Project

This booklet is part of the *Article 2 & Governments’ Budgets* handbook. The handbook has been developed by the Article 2 Project, a working group housed first at the Partnership Initiative of the International Budget Partnership (IBP), and then at the Global Movement for Budget Transparency, Accountability and Participation. The project aims to enhance understanding of the implications of article 2 of the ICESCR for how governments should develop their budgets, raise revenue and undertake expenditures. The project encourages the use by civil society and governments of the legal provisions of article 2 to monitor and analyze governments’ budgets. Download the complete handbook at:

www.internationalbudget.org/publications/ESCRArticle2.

The TAC case study is based on: Neil Overy, “In the Face of Crisis: The Treatment Action Campaign Fights Government Inertia with Budget Advocacy and Litigation,” Albert van Zyl (coord.), *From Analysis to Impact*, Partnership Initiative Case Study Series, IBP, 2011; TAC, *Fighting for our Lives: The History of the Treatment Action Campaign 1998-2010*, Cape Town, 2010.

Authors: Ann Blyberg and Helena Hofbauer

February 2014

