Chapter Three: South Africa´s Treatment Action Campaign (TAC): An example of a successful human rights campaign for health

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> ?The Treatment Action Campaign (TAC), ? has shifted the debate firmly to one of fundamental human rights and utilized the human rights machinery established by the same government to force its hand on the ARV issue.?[1]

Introduction:

In earlier chapters of this article I have argued that a Framework Convention on Global Health (FCGH) must be located in a human rights framework, and that the impetus for it needs to come first and foremost from communities and people that are being denied health care. I also argued that a push for the prioritization of health in national politics would be assisted if there was an international framework that set out global standards and national duties in relation to health. However, these two assertions beg the question as to whether there are successful examples of campaigns for better health that have been driven by human rights and taken advantage of legal systems. If there are, are there contextual prerequisites that will either facilitate or frustrate the use of human rights? What are the ingredients that are required for the successful utilization of human rights demands for health by a social movement?

In this chapter, to try to answer these questions, I examine the experience of the Treatment Action Campaign (TAC) in South Africa
and attempt to draw out the approaches behind and factors influencing its activity. A study of comparable movements for health in countries such as Thailandand Brazilwould be helpful but is not undertaken here.

Beginnings:

The TAC was launched on 10 December 1998, Human Rights Day in South Africa
, by a small group of political activists. The rudimentary consensus within the group was that equitable access to health care, and in particular medicines for HIV, is a human right. In addition the TAC?s leaders appreciated that HIV, albeit a virus, is a symptom of deeper social and political crisis that faces poor people, and that the growth of HIV to pandemic proportions is because transmission is often via social fault lines created by poverty, inequality and social injustice.[2] TAC?s intention was to popularise and enforce what was loosely described as ?the right of access to treatment? through a combination of protest, mobilization and legal action.

The founders of TAC had little prior understanding of public health or its politics. Initially, the TAC argued that the primary obstacle to the realisation of the right to health in the context of HIV were privately owned pharmaceutical companies, whose excessive pricing of (and profiteering from) essential anti-retroviral drugs (ARVs) had placed these medicines out of reach of the poor in developing countries.[3]

Therefore TAC?s starting point was that excessive pricing of essential medicines by privately owned pharmaceutical companies violated a range of the human rights that had, since 1996, been entrenched in the South African Constitution, including rights to life, equality, dignity, autonomy and access to health care services. It argued that intellectual property was not a human right, but a device granted by the state for a public purpose.[4]

However, over several years TAC?s experience demonstrated that these rights, when seriously pursued, cannot be narrowly contained or their violation assigned solely to profiteering from medicines. Their protection and promotion has implications for the conduct of government in most spheres of life. The rights to dignity and equality, for example, impact upon (positively or negatively) almost every sphere of social life and political governance. TAC also learnt that governmental neglect of health, even by a progressive government such as that in South Africa
, can be as much of a barrier to the right to health as profiteering by pharmaceutical companies or aspects of economic globalisation.

Equipping a Movement:

Many civil society organizations internationally locate their activities in human rights, particularly in the vision of the Universal Declaration of Human Rights. As, pointed out by M R Reich, in recent years the notion of rights and their articulation by NGOs has, to some extent contributed to the ?reshaping? of the state as new technologies ?have created new sources of power: through the flow of ideas, information, alliances, strategies and money.?[5]

However, effective though they sometimes are, most human rights organizations continue to base themselves on advocacy for ideas via an apparatus and a handful of professionals, rather than working with a social movement that becomes its own proponent of the rights of its constituency. TAC has adopted a different approach. From the outset TAC sought to build a capacity to pursue human rights entitlements directly amongst the poor and to catalyse a political movement for health.

Part of the rationale for this was a distrust of the professional ?AIDS and human rights movement? -- unlike academics, or professionals who take up human rights issues out of conscience, poor people require rights out of necessity. Their needs do not disappear when NGO employees change jobs, or NGOs change priorities.

But to do this required that community based activists learn not just an understanding of how to mouth human rights, but also how to apply them as demands in relation to specific social issues. The right to health, for example, cannot be effectively utilized by community activists unless health itself is understood; nor can the right to health be pursued outside of law, politics or issues of governance.

This capability had to be built from scratch. To achieve this TAC became the first AIDS organization to pioneer the concept and practice of HIV ?treatment literacy? in a developing country.[6]
Treatment literacy is a programme of health education and communication that aims to educate HIV-vulnerable and poor people about the science of HIV, health and the benefits of treatment. To do this, TAC developed a range of educational materials (including posters, booklets and videos)[7]
and combined this with an extensive training programme.[8]
People who were trained and satisfactorily completed an internal examination process were appointed as ?treatment literacy practitioners? (known as TLPs) for a year and assigned to clinics, hospitals and community organizations where they conduct further training. They are also linked to TAC?s community branches, supposedly the nerve centre for TAC?s local organizing.

However, treatment literacy is not taught in a neutral or bio-medical fashion. Information about the science of medicine and health is linked to political science, human rights, equality and the positive duties on the state. In addition, the infrastructure of the programme doubles up as a means for mobilization and local organization.

TAC?s high profile campaigns and court cases have garnered much comment and superficial research. But overlooked has been the fact that treatment literacy training has been ongoing behind all of them

Treatment literacy proved to be the basis both for self-help and social mobilization. Armed with proper knowledge about HIV, poor people became their own advocates, personally and socially empowered by the info
rmation they received.[9]
In the communities where TAC organized this fed the demand for access to anti-retroviral treatment by people with AIDS at local clinics, leading to higher rates of take-up and adherence than in comparable communities where a TAC branch was not present. But in addition, access to accurate information about health and linking this information to rights, empowered marginalized people who began to assume both a public voice and a visibility.

Gradually this combination of mobilization and education consolidated TAC?s membership in a growing number of communities across South Africa
. With new tools, a vision and the necessity of gaining access to health care services a new generation of human rights

Aided by the trade mark ?HIV positive? T-shirt, people with AIDS ceased being silent victims and became political agitators for their human right to treatment.

The results of this approach has relevance for other social justice issues, particularly those that demand that governments pursue social policies that actively aim at creating social justice and dignity, including policies to improve access to quality education and housing, for ?sufficient food and water?[10]and employment.

Indeed, the potential of such an approach is argued for by Colm Allen of the Centre for Social Accountability (CSA) in the Eastern Cape of South Africa. Allen argues that in genuine constitutional democracies such as South Africa ?s civil society should view the democratic state as a mechanism of enablement, rather than constraint, which should be subject to the pressure of organised civil society so as to ensure the progressive realization of human rights. According to Allen we must ask what:

> ?democracy actually means in practice and what the implications are for the shape of the democratic state if we are to conceive of this as anything other than repressive constraint on the freedom of individuals, or a tool for the manipulation of social agents. In particular, what are the conditions of possibility for an enabling state with the capacity to effectively and progressively realise the social and economic (as well as political and civil) rights of individuals in line with its available resources.?

In his view:

> ?the purpose of the democratic state, ? is not primarily to provide citizens with a forum for deliberation, participation or co-governance. Rather, it is to provide a mechanism for ensuring the accountable use of public resources for purposes of progressively realising peoples? human rights.?[11]

Of course in countries that do not have a rights-based constitution or legal framework, or which have them but do not respect them, such an approach is not feasible. However, there are developing counties, such as Indiaand Brazil , and even transitional economies, such as China, where such a space either does exist or can begin to be created.

The value of resorting to *universal*human rights as the touchstone for *local* demands is aided by the fact that shared socio-economic deprivations often have shared political roots ? and continue precisely because they are not effectively challenged. In India , for example, the problem of permanent semi-starvation that is endured by millions of people has its origin in hunger-denialism (a refusal to admit the prevalence or causes of hunger), similar to the AIDS denialism demonstrated by the South African government. Denialism exists when governments try to create images of economic or political security that do not want to let in truths about the extent of poverty, HIV or hunger.[12]Denialism is best overcome by activism.

Strategy and Tactics - The Duties of Government:

In 2003 TAC was criticized by Cameron Dugmore, an ANC member of Parliament, for having a ?narrow? focus on the right of access to anti-retroviral medicines.[13]
This criticism necessitates a discussion of what strategies will (or will not) legitimate human rights advocacy as a means to pursue claims for social justice.

What Dugmore and others of his ilk miss is that TAC?s focus on the right of access to treatment (ARVs) was grounded in the reality of the AIDS epidemic, rather than public health theory. Pregnant women infected with HIV needed ARVs to reduce the risk of HIV to their babies (known as ?vertical transmission?). People living with AIDS needed medicines in order to stay alive. Availing these medicines to people was the primary task ? broader questions about health systems would follow, as they did.

Thus rather than reflecting on a misplaced strategy, TAC?s initial campaigns say more about the methods by which social movements can be constructed: people who are directly in need of health care, in this case people with HIV, will mobilize around tangible needs, rather than general and abstract complaints of inequality.

Further, as demonstrated by the huge international wave of concern unleashed in 2001 as a result of the attempt by 41 by multi-national pharmaceutical companies to block South Africa?s amended Medicines Act, global pressure for changes to health policy is more likely to come as a result of a real community and national mobilization that is driven by people actually needing health care, than if it flows from abstract denunciations of injustice, however true these may be.

It was for these reasons that TAC?s first campaign, launched on December 10_{th}
1998, was to demand that the South African government introduce a national programme to prevent mother to child HIV transmission (PMTCT).[14]
TAC?s call was for access to a simple medical intervention (a short course of AZT), that could significantly reduce the risk of HIV infection from pregnant mother to baby.

The campaign initially focused on the right of access to AZT, because clinical trials had demonstrated that it could reduce the risk of HIV transmission and was feasible for implementation in developing countries health systems.

Initially TAC was told by South Africa
?s then Health Minister, Dr Nkosazana Dlamini-Zuma, that the primary barrier to the use of AZT was the drug?s high price.[15]
In response TAC argued that profiteering by GlaxoSmithKline from an essential medicine denied people the right to life ? and needed to be challenged.

This campaign caught the attention of young women with HIV and - for the first time in Africa - began to galvanize a social movement around HIV that was made up of people who were predominantly poor, black and living with HIV. Nationally and internationally the campaign garnered substantial positive media coverage[16] which assisted TAC to amplify stories of the human cost of denial of HIV medication to a national and international audience. The human right of access to treatment for HIV became a moral dilemma for society as a whole, including those who would normally ignore, dismiss ? or be alienated by ? the privations of the poor.

However, by framing profiteering as a rights violation and challenging it with reference to the South African constitution TAC made it an issue that ought also to have a legal remedy. This campaign (and future ones), therefore, revolved around setting out the duties of the South African government arising from their being tied to the human rights that are entrenched in the South African constitution.

These rights apply to a range of issues and are explicit, measurable and justiciable. For example:

- s 24 says people have a right ?to have the environment protected?;
- s 25 says ?
  The state must take reasonable legislative and other measures, within its available resources, to foster conditions which enable citizens to gain access to land on an equitable basis?;
- s 26 says ?The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of.. the right to have access to adequate housing?;
- s 27 says ?The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of?.. the rights to access to health care services, sufficient food and water, social security.?

Thus, in campaigns around the price of medicines TAC argued that the fact that the constitution creates a legal duty to fulfill certain human rights obligations (in this instance the right of access to health care services) dictates that the government take steps to overcome problems such as the affordability of medicine, especially when it has a legal means to do so. The legal means are the threat of compulsory licensing or parallel importation, legal measures the government had vigorously defended from both the pressures of the USgovernment and pharmaceutical companies over South Africa?s amended Medicines Act.

But in making claims for the right to a PMTCT programme (and subsequently in the demand for a national ARV treatment plan), TAC went further than just demanding that government comply with its legal obligations. It also worked with scientists and researchers to develop plans and alternative policy proposals which would fulfil the definitions of reasonableness that the *Constitutional Court* has said the government must comply with.[17]

Consequently, what distinguishes TAC from other South African campaigns, such as for a People?s Budget or Basic Income Grant (BIG), is that it can frame its policy alternatives not simply as ?better pro-poor policy? but as demands based on legal entitlement -- and therefore as positive duties that lie with national governments and, where relevant, the multinational corporations (MNCs) and multilateral institutions. To enforce these duties TAC has created the capacity to utilize a combination of negotiation, litigation and mobilization ? sometimes simultaneously.[18]

Some people will undoubtedly argue that such an approach will reveal its limitations when it comes up against defences based on arguments about resource constraints and ?available resources?. However, in a system of governance in which

African Chief Justice calls the ?culture of justification?. This means that they must be determined by more than just what state treasuries (in their own wisdom) tell us is affordable. In countries such as South Africa that have embedded human rights in their legal systems it is *legally required* that there be transparency about the methods used to calculate ?available resources?.[19]
Further, when faced with legitimate budgetary constraints that may limit rights then consideration should be given as to how some costs might be reduced (by, for example, licensing generic medicines) or further resources acquired (by taking over essential property or facilities).

The approach described above would be denounced by many on the left as reformism.[20]
It differentiates TAC from social movements who have campaigned vociferously around socio-economic rights such as access to land or electricity, but stop short of engaging with governments on what a reasonable plan to provide for these rights would entail, because they do not believe that ?under capitalism? such a plan is possible.

But whilst TAC?s agrees that the roots of much inequality are to be found within capitalism and aspects of the globalization of the world economy, it operates from the political conviction that significant reforms and policy shifts *can*be attained within the current econo-legal framework ? but only if they are fought for and if they are linked a more refined and legally developed argument about the positive obligations of the state.[21]

This is explored below.

The Redistributive Effects of TAC?s Human Rights campaigns

After all that has been said above it seems an odd omission that TAC?s constitution originally said nothing about human rights! Instead it describes its objectives as including to:

> ?Challenge by means of litigation, lobbying, advocacy and all forms of legitimate social mobilisation, any barrier or obstacle, including unfair discrimination, that limits access to treatment for HIV/AIDS in the private and public sector;?[22]

However, in a discussion document adopted at its 2008 National Congress TAC defines its vision as being to support:

?the constitutional vision that every person is born with the inalienable rights to life, dignity, health, freedom and equality.
In the context of the HIV/AIDS epidemic, the TAC aims to achieve universal access to prevention, treatment and care for all people living with HIV/AIDS and other illnesses.

Equality for women, the eradication of gender inequality and gender-based violence is indispensable to HIV prevention, treatment and care.

A single, equal, free-at-point of use, quality and adequately resourced public health service for all people is the right of every person and the duty of every state. Universal access to HIV/AIDS prevention, treatment and care requires the building of such a system without delay.?[23]

Achieving the vision above will not be possible without a significant shift of resources (or what Richardson calls a ?wealth transfer?)[24]
from both the state and the private business sector to poor people. To illustrate: successfully bringing down the price of medicines redistributes a value, that would otherwise have been claimed as profit by shareholders, to poor communities. Similarly, forcing a government to introduce a new health service, such as a PMTCT programme, requires an investment in infrastructure and human resources that might otherwise not take place. This is a net gain for poor people that goes beyond the direct benefit received by the people in need of treatment.

Analysing these wealth transfers provides another interesting way to assess the outcomes of TAC?s right to health campaign. Through price reductions, cost of care averted and increases in budgetary allocations it is possible to reveals the tangible benefits of a mobilization for human rights.

In the early 2000s the combined campaigns of TAC, and international NGOs such as Medecins Sans Frontieres and Oxfam,[25]
put the pharmaceutical industry under a harsh spotlight that contributed to dropping prices. I am not aware of any analysis that has attempted to quantify the redistributive results of these campaigns, but
below I attempt a rough calculation of the wealth transfers.[26]

Price reductions:

When TAC was founded in late 1998 the price of the traditional first-line regimen of anti-retroviral medicines (AZT, 3TC, NVP, DDI, D4T) was approximately R4500 per month. However, in the early 2000s the introduction of generic competition via ARV production in Brazil and Thailand, together with the international campaign that reached an apex when TAC caused the Pharmaceutical Manufacturers? Association (PMA) to withdraw legal action against the South African government,[27]
led these prices to begin to drop significantly. By 2007 the first line regimen cost less than R300 per month.

In early 2004 TAC?s legal challenge of excessive pricing via South Africa
?s Competition Commission (launched in September 2002) led to seven voluntary licenses being issued to generic drug manufacturers, increasing supply and reducing cost.[28]

treatment programme.[29]

Similarly, in 2000 the anti-fungal Fluconazole, held under patent by Pfizer in South Africa
, cost over R100 per pill. However, as a direct result of TAC?s threat of legal action in May 2000 Pfizer announced its Diflucan donation programme to the South African government. This programme was criticized harshly by TAC for its restrictiveness. Indeed even after the announcement of the donation TAC considered it necessary to launch its Christopher Moraka Defiance Campaign against Patent Abuse. [30]
The pressure of the campaign and close monitoring of the Diflucan donation (TAC established a ?Diflucan watch?) ensured that the donation became more extensive than would otherwise have been the case. This too was a significant cost saving to government, which estimated that over the course of the programme Pfizer would contribute more that $50m worth of Diflucan.[31]

Finally, in a number of cases the mere threat of legal action by TAC and the ALP was enough to bring about a reduction in the price of several essential medicines for HIV-related opportunistic infections, including Amphotericin B. [32]

Costs of Care:

Linked to cost savings won for both the government and the private health sector on the price medicines (which have permitted much wider access), it should also be possible to calculate the costs of the need for care that has been averted as a result of providing people with effective medicines. For example, through its successful mobilization and litigation to compel the government to have a reasonable programme to prevent mother to child HIV transmission TAC has saved the government the costs of medical care for tens
of thousands of infants who might otherwise have been infected with HIV. The PMTCT programme has brought about the expansion of health infrastructures and services to poor people, constituting both a cost and cost saving to government.[33]

TAC had from the outset campaigned for a national anti-retroviral treatment programme for adults and children. Until August 2003 this met with fierce resistance from the South African government ? a resistance which only buckled because of the pressure of TAC. But after 2004 South Africa
established the fastest growing anti-retroviral treatment programme in the world. By early 2008, it was estimated that over 350,000 people were receiving treatment. However, as with the Diflucan programme TAC remained vigilant after the programme was started. Mobilisations, now targeting roll-out at a provincial and facility level, continued. In addition TAC helped to establish a network dedicated to monitoring and reporting on the ARV roll-out?s progress.[34] This has made the programme the most closely monitored programme in South Africa
, requiring the government to constantly account for its omissions and weaknesses.

As a result of this programme, at least 350,000 people are alive who would have died. From this it should be possible to calculate the costs of medical care averted, as well as the social and economic costs of orphan care averted as parents remain alive.

In addition to the above the TAC could claim as ?non-redistributive outcomes? of its human rights based campaigns, the high levels (so far) of adherence to anti-retroviral treatment by patients (compared particularly with TB where South African has a dismally low cure rate), and the injection of a new enthusiasm into certain levels of health delivery, as a result of increased resources and the ability of health care workers to actually improve their patients lives.

Increased Budgetary Allocations for HIV and Health:

As a result of the ?natural? pressure of the epidemic on the health system, but driven faster by activist demands, the allocation in the budget to health in general and HIV in particular has witnessed five years of expansion. In 2007 according to the Treasury:

> ?Spending on HIV and AIDS grew sharply from R618 million in 2003/04 to R2,4 billion in 2006/07 and is budgeted to grow to R3,9 billion by 2009/10.?

However, in the 2008 budget speech expenditure had been further revised upwards to R6.5 billion a year by 2010/11. [35]According to the budget review this:

> ?Additional funding should allow 500,000 more people access to treatment in addition to the 418,000 already on treatment, as well as increasing the numbers of people tested, and expanding a range of prevention programmes.?[36]

Most significantly of all, in 2007, the South African Cabinet endorsed the
National Strategic Plan on HIV, AIDS and STIs (2007-2011)
? known as the NSP - which contains a preliminary costing of R45 billion. This is significantly more than the Medium Term Budget Framework allocation of R14 billion between 2007 and 2009.

Although not widely known, the process of drafting the NSP was heavily influenced by TAC, which linked the finalization of an ambitious plan, to its willingness to trust and work with the government after the debacle caused by South Africa?s Health Minister at the 2006 International AIDS conference in Toronto.[37]
The plan contains the seeds of future human rights campaigns and sets an example by being the first programe to simultaneously model its costs, based on actual interventions, rather than to set interventions within predetermined costs. Whether, the South African state can be persuaded to fund this programme, is an as yet unwritten chapter of this history.

Developing a New Model for the Use of Law and Legal systems that Empowers the Disadvantaged

Throughout this chapter I have made a number of large assumptions about the rule and role of law: these include that there is a genuine separation of powers and that the executive will respect orders of the courts; that the courts themselves are politically impartial and genuinely abide by the dictates of the Constitution; and that human rights organizations are able to utilize the courts.

These assumptions may hold in South Africa, at this point in time. But, as was seen in Pakistan in late 2007, they are far from immutable. A social movement that makes a fetish of the rule of law is making a grave mistake. On the other hand a social movement that disavows human rights because they implicate law is making just as great a mistake. The ideas of the rule of law therefore require further analysis and elaboration.

In this and earlier chapters I have tried to show how combining human rights advocacy with litigation and legal argument about State?s duties towards health, does (and can) bring about tangible improvements. But this begs another issue about access: it is well and good for a skilled social movement to use the law to the advantage of the poor, but can the poor replicate this approach in every day life?

In the next two chapters I look at South Africa ?s constitution and how it has been used ? up to this point ? to challenge discrimination against people with HIV and to promote and fulfill the right of access to treatment. But the bigger question is what does the Constitution, which embodies the legal system, require of the government in terms of improving access to itself; what of the systems that would make this a reality? I therefore now ask whether a similar argument about state duties in regard to health can and should be mounted in relation to legal systems.

ENDS

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[1] L London, Health and Human Rights: What Can Ten Years of Democracy in South Africa Tell Us? *Health and Human Rights, An International Journal,* Vol 8 no 1, January 2006.

[2] Heywood, M. How the Poor Die: HIV/AIDS and Poverty in South Africa, *The African Communist, journal of the South African Communist Party,* No 153, 2000, 14-21. Heywood, M, Altman, D. Confronting AIDS: Human Rights, Law and Social Transformation, *Health and Human Rights,* Vol 5:1 2000, 149-179.

[3] The history of the TAC?s campaigns is not the subject of this article. This can be found in several other sources. See for example: Friedman, S & Mottiar, S. Rewarding Engagement? The Treatment Action Campaign and the Politics of HIV/AIDS, A Case Study for the UKZN project entitled Globalisation, Marginalisation and New Social Movements in post-Apartheid South Africa, 2004; Heywood, M. 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*, Martinus Nijhoff Publishers, 2005; N Nattrass, *Mortal Combat, AIDS Denialism and the Struggle for Antiretrovirals in South Africa*, UKZN Press, 2007.

[4] B Loff and M Heywood, Patents on Drugs: Manufacturing Scarcity or Advancing Health, *Journal of Law, Medicine and Ethics*, 30 (2002): 621-631.

[5] M R Reich, Reshaping the State from Above, from Within, from Below: Implications for Public Health, *Social Science and Medicine*, 54 (2002) 1669-1675.

[6] Specifically in relation to HIV the concept was first utilized in the United States by groups such as the Gay Men?s Health Crisis (GMHC), who in 1999 came to South Africa to provide training to the first cadre of TAC treatment literacy activists.

[7] See TAC, ALP, *HIV in Our Lives, A Book of Information Sheets for People Living with HIV, Support Groups and Clinics* (2003); TAC & ALP, *Pregnancy and HIV/AIDS*, 2003; TAC, *ARVs in Our Lives, A Handbook for People Living with HIV and treatment advocates in Support Groups, Clinics and Communities* (2006); *TB in Our Lives*, 2007; *HIV and Nutrition*, 2008. All are available at: www.tac.org.za

[8] This aspect of TAC?s work is overlooked by researchers. And yet it is the largest part of TAC?s apparatus. In 2007 over 200 people trained and deployed as treatment literacy practitioners throughout South Africa. According to TAC Chairperson Zackie Achmat, the TLPs reach over 100,000 people per month (see Chairperson?s Report to TAC National Congress, 2008), It is also the largest part of TAC?s budget, approximately $1.5 million in 2007.

[9] For example, in interviews TAC volunteers are quoted as saying things such as ?I am living because of TAC? ?TAC puts self-esteem back into people? and ?In TAC you are in a university. You learn and grow with knowledge.? See, Boulle, J and Avafia T, Evaluation of the TAC, June 2005, available at www.tac.org.za

[10] SA Constitution s 27(1)(b) . Despite this provision of the Constitution, there is still endemic malnutrition in South Africa and the right to sufficient food has not yet become the focus of social justice campaigns.

[11] C Allan, ?Social Accountability, Power, Corruption and Poverty?, unpublished paper, June 2007. This paper provides a critique of both neo-liberal and determinist Marxist analyses of poverty, human rights and the state. However it makes the mistake of calling for recognition of ?a right to social accountability?, rather than appreciating that social accountability is fundamental to a number of human rights that are already recognized, including access to info
rmation, just administrative action and access to courts.

[12] The right to food movement in India
has certain similarities with TAC?s approach. It too carries out rigorous research into and monitoring of starvation, which is then developed into concrete policy alternatives. Right to food organizations and activists, such as the People?s Unionfor Civil Liberties, have also undertaken legal action that has resulted in far reaching judgments. Since 2001 the Indian Supreme Court has issued a series of orders interpreting the Indian Constitution in the light of the human right to food. The court orders address the systematic violations of this right in social programmes such as the Targeted Public Distribution System, Employment Guarantee and the Midday Meal Scheme for school children. (See, Centre for Equity Studies, *Commissioners to the Supreme Court on the Right to Food: A Brief Introduction*, undated). However, there are key differences. First of all ?hunger literacy? does not appear to exist or be seen as a means of mobilizing people. Secondly there might be an over-reliance on litigation, creating the impression that rather than using the law as just one prong of a strategy it has been separated from the day to day struggles of the hungry. Consequently, the campaigns have remained in the hands of a small number of lawyers leaving starving people invisible, and largely unorganized.

[13] See Heywood M. ?TAC?s Focus on Anti-Retrovirals is Not Narrow?, republished in *TAC Newsletter*
, 5 May 2003: ?To assert the right to life, to continue to breathe, is not "narrow". Unfortunately, the AIDS epidemic is a reality, and for many people in the late stages of HIV infection access to medicines determines whether or not that right is extinguished.?

[14] See www.tac.org.za/treat.html

[15] At the time TAC was not aware that the real reason was the AIDS denialism of the President. In 2007 a series of articles were published providing evidence that President Mbeki?s AIDS denialism originated during this time, initially linked to efforts by the ANC to finalise the development of a drug that it imagined would be a lucrative alternative to AZT. See: J Myburgh, ?The Virodene affair (I), The secret history of the ANC's response to the HIV/AIDS epidemic?: http://www.politicsweb.co.za/politicsweb/view/politicsweb/en/page71619?oid=83156&sn=Detail

[16] In this campaign media reportage of avoidable infant infections pricked at the conscience of middle class people who are otherwise insulated from the pain of people with living with HIV. Contrary to pro-poor struggles that marginalize middle class people and consider their support redundant, TAC has actively solicited the involvement and engagement of this class of society ? whilst holding firmly to positions of principle. Whilst TAC positions is an organization whose membership are overwhelmingly from the poor, and whilst it is on the ?left? of social policy, it has avoided presenting HIV crudely as ?class issue? in which all people with power or wealth are cast as enemies.

TAC?s avoids espousing glib political dogmas which deny that far-reaching reforms are possible under capitalism, or without an impossible reverse of the processes of globalisation. This has contributed to a broad cross-class and cross-race support for all of TAC?s campaigns, including breaking the law to import generic drugs in 2001, and civil disobedience against the ANC government in 2003. One result has been that multi-national pharmaceutical companies, with huge resources, fall prey not just to the accusations of a shard of AIDS activists, but became demonized across the whole spectrum of society ? their conduct denounced in law, literature and science. Similarly, the pro-Mbeki ANC leadership, despite its huge reservoir of post liberation support and trust, failed with its multiple calumnies to depict TAC as an enemy of the ANC. For a recent article on the role of the media see, S Jacobs, K Johnson, ?Media, Social Movements, the State and HIV/AIDS in South Africa?, *African Studies Quarterly* (forthcoming in 2008).

[17] When coming to socio-economic rights the concept and definition of reasonableness has acquired great importance in South African jurisprudence. According to the *Constitutional Court*

, reasonableness requires: xxx?

[18] Since 1999 TAC has undertaken major constitutional litigation on at least five occasions, including for a national programme to prevent mother to child HIV transmission (2001-2002); for access to the implementation plan for the anti-retroviral roll out (2004); for access to ARV treatment for prisoners at Westville prison (2006-2007); to challenge the pricing structures of GlaxoSmithKline and Boehringer Ingelheim (2002); to defend the Medicines Act against charlatans such as Matthias Rath (2006-2008).

[19] Although I am not aware of jurisprudence stating as much it is clear that this is required by the Constitution. For example, the repeated mention of ?available resources? in the Constitution, must be connected to rights to access to information (s32), just administrative action (s33), and the section dealing with basic values and principles governing public administration (s195) which explicitly requires transparency, accountability and ?efficient, economic and effective? use of public resources.

[20] It is sad that in the hands of a number of social movements these issues sometimes appear to be more valuable as a whip to beat capitalism and the ANC, than a means to bring about measurable reform and improvements.

[21]
See K Johnson, AIDS and the Politics of Rights in South Africa: A Contested Terrain, *Human Rights Review*, Vol 7:2, 2006; M Heywood, TAC and the Politics of Constitutionalism,

[22]
Constitution of the TAC, as amended, December 2004.

[23] TAC, National Executive Document for Discussion and Proposed Congress Resolutions Based on Organisation Review Commission and Evaluation, 24 September 2007.

[24] H J Richardson III, Patrolling the Resource Transfer Frontier: Economic Rights and the South African Constitutional Court?s Contributions to International Justice,
African Studies Quarterly, The Online Journal for African Studies, Fall 2007.

[25]
See: MSF?s ?Access to Medicines? campaign, Oxfam?s ?Cut the Cost? (www.maketradefair.com/en/).
Organizations such as Health_Gap in the USA
also have contributed greatly to raising awareness in developed countries of the iniquity of unaffordable medicines.

[26] TAC does not claim sole credit for these outcomes. However, either via litigation or mobilization or both it provided the initial impetus for each of these breakthroughs and then sustained pressure to ensure their implementation.

[27] See TAC Newsletter, 24 April 2001, www.tac.org.za/newsletter/2001/ns010424.txt

[28] See: TAC Newsletter, 10 December 2003 ?Competition Agreements Secure Access to Life-saving Affordable Medicines?, www.tac.org.za/newsletter/2003/ns10_12_2003.htm

[29] See Heywood: ?Debunking ?Conglomo-talk?: A Case Study of the *Amicus Curiae*
as an Instrument for Advocacy, Investigation and Mobilisation? *Law, Democracy and Development*
, 2002; ALP, ?The Price of Life ? Hazel Tau and Others v GlaxoSmithKline and Boehringer Ingelheim: a report on the excessive pricing complaint to South Africa?s Competition Commission?, available online at
http://www.alp.org.za/modules.php?op=modload&name=News&file=article&sid=222; and MSF www.accessmed-msf.org

[30] See TAC Newsletter www.tac.org.za/newsletter/2000/ns001017.txt

[31] Department of Health Press Statement, ?South African Ministry of Health and Pfizer Initiate Diflucan Partnership Programme?, 1 December 2000.

[32] J Berger (presentation to SA HIV Clinicians Society)

[33] See Heywood, M. Preventing Mother to Child HIV Transmission in South Africa
: Background, Strategies and Outcomes of the TAC case against the Minister of Health, *South African Journal on Human Rights*
, Vol 19 part 2, 2003. In March 2007 the SA government issued a media statement claiming that ?More than 80% of government clinics are currently providing prevention of mother to child transmission of HIV service and the target is to have these services available in all clinics by December 2007? The statement added that ?3 382 out of 3 663 primary health care facilities (clinics) were offering the service. ?This represents 83% of public health clinics." ?At least 580 880 pregnant women accessed the PMTCT services during the calendar year 2006. Of these, 74 052 antenatal clients received Nevirapine prophylaxis. A total of 19 758 babies born to mothers living with HIV were tested for HIV infection. 16 288 babies tested HIV-negative while 3 470 babies tested HIV-positive.?

[34] See Joint Civil Society Monitoring Forum (JCSMF) at www.jcsmf.org.za

[35] Budget Speech for 2008, 20 February 2008.

[36] See National Treasury, Intergovernmental Fiscal Review, 2007, Provincial Budgets and Expenditure Review, 2003/04 ? 2000/10, Chapter 3, Health pp 45-47 available at: www.treasury.gov.za/publications/igfr/2007/prov/default.aspx .

[37] See M Heywood, The End of Politics in ALP 2006/7 Annual Review available at www.alp.org.za

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