



In the face of government claims that providing prevention and treatment programs for South Africans was unaffordable, the Treatment Action Campaign used budget analysis to prove the money was, in fact, there to address the HIV/AIDS crisis.

Photo courtesy of the Treatment Action Campaign.

The following case study illustrates how open budget tools can be used in conjunction with advocacy and litigation strategies to pressure governments that refuse to take action on an issue for reasons of "affordability." This is a summary of a more in-depth study prepared by Neil Overy as part of the Learning Program of the IBP's Partnership Initiative. The PI Learning Program seeks to assess and document the impact of civil society engagement in public budgeting.

Download a PDF of the complete case study at <http://internationalbudget.org/wp-content/uploads/LP-case-study-TAC.pdf>.

SOUTH AFRICA: THE TREATMENT ACTION CAMPAIGN FIGHTS GOVERNMENT INERTIA WITH BUDGET ADVOCACY AND LITIGATION

South Africa's government, which was once infamous for its refusal to take action against the spread of HIV/AIDS, now has one of the most comprehensive treatment programs in the world — a dramatic shift that occurred in less than a decade owing largely to the efforts of the Treatment Action Campaign (the TAC), an advocacy group run by people living with HIV/AIDS.

The TAC, which was founded in 1998, funded research and formulated well-evidenced policy recommendations, mobilized protesters, and used the media to raise awareness and fight stigma. Eventually, it also sued the South African government, relying in part on budget analysis to make its case.

At the turn of the millennium the South African government allocated a total of about US\$28.5 million to the fight against HIV/AIDS, an epidemic that had already reached crisis proportion. Less than 10 years later, this figure has risen 18-fold to US\$528 million. This growth in the budget allocated to HIV/AIDS treatment and prevention is primarily the result of the government's adoption of two public health policies aimed at addressing the crisis. The South African government now widely provides drugs that reduce the likelihood of HIV-positive women passing the virus onto their children when they give birth, and it also distributes life-saving antiretroviral (ARV)

medicines to more than 1 million people in a program that continues to expand.

As a result of the TAC's efforts, hundreds of thousands of HIV/AIDS-related deaths have been prevented.

THE ISSUES: SOUTH AFRICA'S REFUSAL TO ACT ON HIV/AIDS

There are a number of interrelated reasons for the South African government's initial refusal to implement HIV/AIDS prevention and treatment regimes.

One was the presence of so-called AIDS denialism. Driven by a distrust of the scientific establishment and a desire to use "indigenous knowledge" to confront the problem, high-level government officials, including then President, Thabo Mbeki, questioned the link between HIV and AIDS.

This contentious stance may have drawn more attention internationally, but another key component of the government's reluctance to support a comprehensive HIV/AIDS prevention and treatment plan was 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 the cost of the drugs and of other features of such a program, including services like counseling and testing and even the provision of baby formula, which is given to HIV-positive mothers as a substitute for breast-feeding, which can transmit the disease.

As early as 1998 the South African government suspended trial testing of a drug called AZT that reduces the chances of a mother passing HIV to her baby, stating that the estimated US\$10.6 million cost of a prevention program for mother-to-child transmission (MTCT) would put "strain" on the "already limited health budget." In 1999 the Minister of Health stated that it would cost the equivalent of US\$67 to treat one pregnant woman, a price that was, in her opinion, "too much."

The government made the same argument against a large-scale ARV program. On 1 December 2000, World Aids Day, the Minister of Health stated that the government's decision not to implement such a program was not an ideological stance but was based on the fact that it was simply "unaffordable."

THE CAMPAIGNS

The TAC used a wide variety of methods to pressure the South African government to provide AIDS treatment. It worked with scientists, academics, and health professionals, teaming up in one instance with Médecins Sans Frontières (Doctors Without Borders) to go so far as to dispatch activists and health workers to local villages to provide the medicine and care that patients need directly. It used the media and public events to shame the government and international pharmaceutical companies and to raise awareness and fight stigma. At the local level, it mobilized citizens with AIDS treatment literacy and awareness campaigns.

With the government remaining intransigent in spite of its pressure, the TAC eventually decided that it would confront the government's claims on affordability head on with a lawsuit.

The mother-to-child transmission campaign

Since its inception, the TAC had called on the South African government to introduce a comprehensive program to prevent the transmission of HIV from mother to child. It threatened to file a lawsuit on the matter when research revealed in 2000 that another drug, Nevirapine, was as effective as AZT, could be administered in a single dose, and was considerably cheaper.

After Nevirapine was cleared for use in prevention of MTCT in South Africa by the Medicines Control Council in April 2001, "the the TAC decided that both morally and politically it had no other options than to launch a case against the government."ⁱⁱ 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 tell government to make Nevirapine available to pregnant women with HIV who give birth in the public health sector and to their babies.

Central to the TAC's argument was the assertion, based on an economic and budgetary analysis, that the government's refusal to implement the program on grounds of cost was untenable. A series of affidavits were drawn up, including one from health economist Professor Nicoli Natrass that provided evidence showing that public funds spent on a MTCT prevention

program would actually save money by reducing future HIV infections and the associated costs. In her affidavit, Natrass said that saving children from HIV infection through the program would trim state expenses by US\$90,000 per year.

The government opposed the TAC's case, arguing that the safety of Nevirapine had not been fully proved and, despite its cost-saving potential, 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 US\$33.3 million.

The TAC used publicly available budget information from the 2001 Intergovernmental Fiscal Review to counter this argument, noting that provincial departments of health had underspent their budgets by about US\$63.1 million in 2000.

In December 2001 the High Court judge found in favor of the TAC and ordered the government to draw up a plan within three months for a national MTCT prevention program, which he described as an "ineluctable obligation" of the state. The judge stated that the program might require further budget allocations, but that it was clear that a countrywide MTCT prevention program using Nevirapine was affordable, citing the TAC's budget evidence.

The government immediately appealed to the Constitutional Court, again claiming that such a roll out was unaffordable and would "cripple" the public health care system. But again the government failed to persuade the courts. In July 2002 the Constitutional Court upheld the previous judgment, arguing that "the administration of Nevirapine is well within the available resources of the state" and ordering the government to put a plan into action.ⁱⁱ

The antiretroviral medicine campaign

As with the MTCT prevention program, the government opposed comprehensive ARV treatment in South Africa, repeatedly claiming that the medicines and supporting delivery systems were too expensive. This placed the TAC in almost exactly the same position as before, having to provide evidence that an ARV treatment plan was fiscally affordable. To do so, the TAC formed a Research Committee of health economists and medical professionals that produced a draft National Treatment Plan (NTP) with details of everything that would be required for such a massing undertaking.

With the government still recalcitrant, the TAC turned efforts toward labor unions, convincing the Congress of South African Trade Unions to jointly convene a national event on the issue of HIV/AIDS. At that event, the TAC called together labor and business leaders and government officials to discuss a possible national treatment program. This maneuver kept government in the talks but moved the issue of HIV/AIDS treatment beyond the exclusive control of the Ministry of Health.

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. The second analysis included a budget-based costing exercise, which demonstrated that the cost of providing comprehensive

ARV treatment would rise from US\$31.8 million in 2002 to a potential peak of US\$2.4 billion by 2015. The researchers noted, however, that actual costs were likely to be even lower because the price of the medicines was expected to fall, and because of additional savings to the state from a reduction in the number of AIDS orphans who would need public support. Other cost savings not included were those related to the economic impact of HIV/AIDS-related sick leave and mortality among ordinary South Africans.



TACTICS FOR DEMANDING HIV/AIDS PREVENTION AND TREATMENT PROGRAMS

Advocacy

- Commissioning research and proposing program design
- Grassroots AIDS awareness and treatment literacy programs
- Hosting public events and using mass media to raise awareness
- Building alliances with global organizations to increase international pressure
- Garnering support from private-sector leaders and trade unions
- Civil disobedience

Cost and budget analysis

- Carrying out long-term, holistic estimates of cost
- Identifying underspent budget items

Litigation

- Using cost and budget to counter the affordability argument
- Keeping open the option for collaboration when it presents itself

The TAC thus acknowledged that the NTP had serious cost implications but argued that within five years there would be measurable cost savings. Refusing to provide antiretroviral treatment to people with AIDS does not reduce expenditure, it argued, because the failure to act would ultimately drain government coffers in other ways.

At the end of 2002 government rejected a draft agreement for a national treatment plan that had been accepted by business and labor leaders. In response, the TAC announced a civil disobedience campaign and threatened to take legal action.

Before the TAC could file a motion in the courts, however, it landed a break: a leaked copy of a report from the government's Joint Treasury and Health Task Team, which demonstrated that an ARV treatment plan was affordable and would save hundreds of thousands of lives. Shortly after the TAC released this information to the public, 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 finally approved by the cabinet in November 2003.

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 US\$6 billion on HIV and AIDS prevention and treatment over a five-year period. Creating one of the most comprehensive AIDS treatment programs in the world, the bill anticipated that 1.625 million people would receive ARV treatment by 2011.

WERE THE CHANGES DUE TO THE CAMPAIGN?

The TAC's advocacy and lawsuit directly forced the South African government to implement a program to prevent mother-to-child transmission of HIV. The TAC's precise contribution to the passage of a national treatment program, however, is less clear because a number of other factors also added pressure on the South African government to formulate a large-scale response to the epidemic.

Political commentators have pointed out that the African National Congress (ANC), South Africa's ruling party, was vulnerable to attack on the HIV/AIDS issue by opposition parties in the 2004 elections. While the party's overwhelming national majority was not under threat, it was likely to face a substantial challenge in some of the provincial elections. The timing of its announcement to launch a national ARV program may have been motivated by political expediency. Nonetheless, the TAC's advocacy efforts could be attributed with bringing HIV/AIDS issues to the political fore in the first place. 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."

By 2003 South Africa had also come under intense criticism both from the domestic and international scientific communities for President Mbeki's dissident views on the link between HIV and AIDS. In one of the most embarrassing moments for the South African government, in 2006 the United Nations Special Envoy for AIDS in Africa commented that AIDS policies being pursued by the ANC government were "worthy of a lunatic fringe." However, while preserving its international reputation may have been a motivating factor, it is unlikely to have been the driving force behind the government's reversal.

Another factor that clearly assisted the TAC in its struggle for access to treatment was the constant decline in drug prices during the same period. This, however, can also be partly attributed to the TAC's efforts. One of the TAC's greatest successes on drug prices came in 2003 when the Competition Commission of South Africa found in favor of the TAC and a number of partner organizations that had filed a complaint with the Commission about excessive ARV prices. This decision prompted several drug companies to provide licenses to generic manufacturers, dramatically slashing the price of yearly treatment for AIDS from US\$10,439 per person in 2000 to US\$182 by May 2005.

While a number of other factors may have helped to push South Africa toward action, many of those factors can also be

attributed, at least partly, to the efforts of the TAC, and none seem to have provided sufficient impetus alone.



OUTCOMES RELATED TO THE CAMPAIGN

- A program to prevent mother-to-child transmission of HIV anticipated to cover 95 percent of all pregnant women receiving care within the public health sector by 2012
- A public antiretroviral treatment program that now serves 1.2 million South Africans living with HIV/AIDS and is expanding
- The HIV & AIDS and STI (sexually transmitted infections) Strategic Plan for South Africa (2007-2011), which commits US\$6 billion on HIV and AIDS prevention and treatment over a five years

Perhaps the clearest indication of the TAC's influence, however, is that the final spending plan was drawn up with substantial consultation from the organization. Indeed, the TAC's advocacy is now seen globally as an inspiring model for how to win a human rights victory.

CONCLUSION

The TAC is itself an extraordinary organization, with features that are easier to describe than to replicate. It benefited tremendously from the dynamic leadership of its first chairperson, Zackie Achmat, who famously demonstrated his commitment to the political and moral legitimacy of the TAC by refusing to take ARV drugs, even as he became very ill from AIDS. His principled stand earned him international humanitarian awards, including a nomination for the Nobel Peace Prize. This high-profile attention bolstered the TAC.

A number of political analysts note that the TAC's success also stems from its reimagining of anti-apartheid activist strategies. The TAC had socio-political roots in various kinds of anti-apartheid activism in the 1980s and early 1990s, and so it naturally found inspiration in these prior movements. The TAC's civil disobedience campaign, for example, clearly made reference to the ANC's 1950s Defiance Campaign. The consequence of this, in the minds of many South Africans, was to associate the struggle for the right to healthcare with the anti-apartheid struggle for freedom.

Another of the TAC's strengths was its sophisticated use of strategies that positioned it alternatively as both constructive proponent and radical activist, and as ally and adversary of the government. It formulated technical solutions and often evoked the South African Constitution but also was prepared to break the law during its civil disobedience campaign. These multiple and even contradictory roles evolved over time. The TAC's mission was initially 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. It was only during the fight for access to Nevirapine and ARVs that the relationship between the TAC and the government was strained. However, the TAC always remained open to collaboration with the government.

The TAC also was exceptional at both mobilizing grassroots support for its objectives while concurrently courting international solidarity. At the local level, the TAC creatively used local political symbols and songs and the familiar style of the anti-apartheid movement. It courted schools, churches, union meetings, football matches, and community centers, and went door-to-door to encourage community members to support its objectives. Meanwhile, the TAC forged international alliances with civil society organizations like Act Up and the Stop Aids Campaign, which organized solidarity events all over the world in support of the TAC.

Finally, the TAC is distinguished by its extensive use of mass media opportunities during its struggle for access to treatment; through radio, newsprint, television and the Internet, it communicated its messages relentlessly. Some attribute its media success to its networking skills, while others point to an adept framing of its struggle that portrayed AIDS as a human rights agenda that resonated even with those who had no direct concern for HIV/AIDS issues.

All of this suggests that the TAC is endowed with many skills — and that all of its diverse talents have contributed in some way to its success. The case study, however, also makes clear that the TAC's use of budget analysis was critical for overcoming the government's inertia on HIV/AIDS. By creating its own cost estimates and by pointing to the government's record on health expenditure, the TAC was able to dismantle the technical and de-politicizing defense the government had constructed around cost and affordability.

¹ 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, pg. 290.

² www.tac.org.za/documents/MTCTCourtCase/ConCourtJudgmentOrderingMTCTP-5July2002.pdf.

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