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South Africa's Treatment Action Campaign: Combining Law and Social Mobilization to Realize the Right to Health

MARK HEYWOOD

Abstract

This article summarizes the experience and results of a campaign for access to medicines for HIV in South Africa, led by the Treatment Action Campaign (TAC) between 1998 and 2008. It illustrates how the TAC mobilized people to campaign for the right to health using a combination of human rights education, HIV treatment literacy, demonstration, and litigation. As a result of these campaigns, the TAC was able to reduce the price of medicines, prevent hundreds of thousands of HIV-related deaths, but also to force significant additional resources into the health system and towards the poor. The article asks whether the method of the TAC has a wider application for human rights campaigns and, particularly, whether the protection of the right to health in law, and the obligation that it be progressively realized by the State, provides an opportunity to advance human rights practice.

Keywords: AIDS; health; law; rights

Introduction

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 (London, 2006: 12).

Southern Africa is the region of the world most affected by the HIV/AIDS epidemic. In South Africa, a national survey in 2007 estimated that approximately 5.4 million people are infected with HIV. The gravity of this epidemic is linked directly to social and sexual inequality, including the disempowerment of women, labour and refugee migration within South and Southern Africa, and ultimately the region's poverty. By 2008, an estimated half a million people was receiving anti-retroviral (ARV) therapy in South Africa, but despite this the number of annual AIDS-related deaths is estimated to be between 300,000 and 400,000 – nearly a thousand deaths a day. At least half of the people living with HIV who require treatment are not receiving it. But even with access to medication, or knowledge of how to protect oneself from HIV infection, under the circumstances of economic and social disadvantage that characterize the lives of many women and young people in the nation, many people continue to be infected and to get ill.

The HIV epidemic is taking its toll on South African society. Death and disease caused by HIV has profound implications for human rights that

are recognized in the South African Constitution, including rights to equality, dignity, access to healthcare service and education. The governmental response to HIV has also been one of the greatest tests of South Africa's democracy and law. But despite the depressing down-side of AIDS, this article aims to illustrate how South Africa's growing ARV programme, estimated to be the largest in the world, and the half a million people who now have access to life saving medicine, in many ways owes its existence to a campaign for the human right to health. The AIDS epidemic catalyzed the formation of the TAC, an organization that started in 1998 with a handful of people and, with the assistance of the human rights framework, has grown in a decade into an internationally recognized movement.

The aim is to demonstrate that there can be successful campaigns for better health (and other socio-economic rights) that are driven by human rights demands and that take advantage of legal systems and the law. However, the article also analyses whether there are contextual prerequisites that will either facilitate or frustrate the use of human rights. What ingredients are required for the successful utilization of demands for the right to health by a social movement?

To try to answer these questions, I examine the experience of the TAC in South Africa and attempt to draw out the approaches behind and factors influencing its activity.

Beginnings

TAC was launched in South Africa on 10 December 1998, International Human Rights Day, 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 leaders of TAC appreciated that HIV, albeit a virus, is symptomatic of the deeper social and political crisis that faces poor people, and that the growth of HIV to pandemic proportions is because HIV transmission is often via social fault lines created by poverty, inequality, and social injustice (Heywood, 2000). The intention of the founders of TAC was to popularize and enforce what was loosely described as 'the right of access to treatment' through a combination of protest, mobilization, and legal action. TAC's Constitution describes its objectives as being to:

Challenge by means of litigation, lobbying, advocacy and all forms of legitimate social mobilization, any barrier or obstacle, including unfair discrimination, that limits access to treatment for HIV/AIDS in the private and public sector.

In so doing, TAC acquired moral and legal strength from the South African Constitution, which entrenches rights to equality, life, dignity and says:

Everyone has the right to have access to –
 (a) health care services, including reproductive health care (SA Constitution, Section 27).

The founders of TAC had little prior understanding of public health or its politics. Initially, TAC regarded the primary obstacle to the realization of the right to health in the context of HIV to be privately owned pharmaceutical companies, whose excessive pricing of (and profiteering from) essential ARV drugs had placed these medicines out of reach of the poor in developing countries (Cameron and Berger, 2005).

Therefore, TAC's starting point was to insist that the excessive pricing of essential medicines by multi-national pharmaceutical companies violated a range of the human rights that had, since 1996, been entrenched in the South African Constitution. It argued that intellectual property and patents, whose protection in law had been strengthened under the World Trade Organization's 1995 TRIPS agreement, was not an inherent human right, but a device granted by the state for a public purpose.

However, over the coming years, TAC's experience in campaigning for the right to health demonstrated that health rights, when seriously pursued, cannot be narrowly contained or their violation blamed solely on profiteering from medicines. The responsibility to protect and promote human rights in countries that have made them justiciable has implications for the conduct of government in most spheres of life. The rights to dignity and equality, for example, impact (positively or negatively) upon almost every sphere of social life and political governance. TAC also learned in developing countries that governmental neglect of public health, even by democratic pro-poor governments such as the African National Congress (ANC) in South Africa, can be as much of a barrier to the right to health as profiteering by pharmaceutical companies or the consequences of some aspects of economic globalization (Myburgh, 2007).

The Tools of a Human Rights Movement

Many civil society organizations internationally locate their activities in the international human rights framework, particularly, in the vision of the Universal Declaration of Human Rights. In the early 2000s, the value of asserting human rights to demand a normative international standard seems to have grown in currency in the field of HIV/AIDS. For example, in 1998, the United Nation's Joint Program on AIDS (UNAIDS) and the UN Office of the High Commissioner for Human Rights (OHCHR) published *International Guidelines on HIV/AIDS and Human Rights*. Although documents such as this have no formal legal standing, they can assist in exposing the governments that violate these standards and can be incorporated into advocacy. Multi-national NGOs such as Human Rights Watch, Amnesty International, and Oxfam International confront different issues, but attempt

to do so from different points on the axis of human rights. The re-articulation of political and social issues as human rights issues by NGOs has, to some extent, contributed to what has been described as the 'reshaping' of the state as new technologies 'have created new sources of power: through the flow of ideas, information, alliances, strategies and money' (Reich, 2002).

Many of these human rights organizations are very effective at shaming and exposing violator governments, and shaping international public opinion. However, in their day-to-day work, they base themselves on advocacy for ideas via an apparatus and a handful of professionals, gaining their strength from their media reach and modern communications – rather than working with a social movement where poor people becomes their own advocates.

TAC adopted a different approach. From the outset it sought to build a capacity to pursue human rights entitlements directly among 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', which often seems part of the global industry spawned by the epidemic, articulate but ineffective. In addition, unlike academics or professionals who take up human rights issues out of conscience, for poor people human rights are a personal necessity. These needs do not disappear when NGO employees change jobs, or NGOs change priorities.

But to do this required that community-based activists acquired not only an understanding of how to articulate human rights, but also of how to apply them as demands in relation to specific social and political issues. The right to health, for example, may be recognized in international covenants, national constitutions, and jurisprudence. But it cannot be effectively utilized by community activists unless health itself is better understood; nor can the right to health be pursued without connecting it to issues of law, politics, or governance.

In South Africa, this capability had to be built from scratch. Although there had been movements based on health and human rights in the 1980s and early 1990s, these had become emasculated by the late 1990s. The model that was adopted came from the United States, where AIDS activists, led by people with HIV, had pioneered the idea of 'treatment literacy' among people with HIV. Treatment literacy recognizes that in order to fight for rights effectively, people also are required to understand the science of HIV, what it was doing to their body, the medicines that might work against it, the research that was needed etc. Emulating this model, TAC became the first AIDS activist organization to pioneer the concept and practice of HIV 'treatment literacy' in a developing country. Links were made with groups such as the Gay Men's Health Crisis (GMHC) and ACT-UP, who in 1999 came to South Africa to provide training to the first cadre of TAC treatment literacy activists.

Treatment literacy involves 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 promote treatment literacy among its members and in poor communities, TAC developed a range of simple educational materials (including posters, booklets and videos) and combined these with an extensive training programme. 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.

TAC volunteers who have been trained and have passed an examination are called 'Treatment Literacy Practitioners' (known as TLPs). They are given a small bursary for a year and then assigned to clinics, hospitals, and community organizations where they conduct further training and agitation for the right to treatment. They are also linked to TAC's community branches, the nerve centre for TAC's local organizing, and the treatment literacy programme has an administrative infrastructure that can double up as a means for mobilization and local organization.

The centrality of treatment literacy, and the way in which it is the foundation of community-based human rights advocacy, has been overlooked by most researchers and writers on TAC. And yet it is the largest part of TAC's apparatus. In 2007, over 200 people were trained and deployed as 'TLPs' throughout South Africa. According to TAC Deputy General Secretary, Zackie Achmat, the TLPs provided information to over 100,000 people per month. It is also the largest part of TAC's budget, approximately \$1.5 million in 2007 (Achmat, 2008).

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

Treatment literacy is the base for both self-help and social mobilization. Armed with proper knowledge about HIV, poor people can become their own advocates, personally and socially empowered. For example, in interviews conducted during an evaluation of TAC, its volunteers are quoted as saying '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' (Boulle and Avafia, 2005).

In the communities where TAC organized, treatment literacy agitators fuelled the demand for access to ARV 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 personal necessity of gaining access to healthcare services (because most of TAC's members are infected with

HIV), a new generation of human rights activists came into being. Aided by the trademark 'HIV positive' T-shirt, an organizational coherence began to form and people with AIDS ceased being silent victims and became political agitators for their human right to treatment.

From the outset, TAC's national campaigns attracted media attention. Much of this focused on one or two individuals, against images of TAC's growing volunteer base. What was missed, however, were the campaigns being mounted in communities and their outcomes. In many villages and townships TAC activists, empowered by treatment literacy and confident that they had both law and human rights behind them, fought for the right to health care. The role and impact of a TAC branch in the rural community of Lusikisiki in the Eastern Cape is described by Jonny Steinberg in his 2008 book about AIDS in South Africa, *Three Letter Plague*. In Queenstown, another small town of the Eastern Cape, the police opened fire with rubber bullets on TAC marchers after they had occupied the local hospital to demand that it should speed up its ARV programme. In Khayelitsha, a large township outside Cape Town, TAC branches transformed the approach to HIV in the local clinics and have also taken up issues such as crime and violence against women. At its best the TAC model did two things: it created a national social mobilization capable of unifying people to demand the right to health from government and pharmaceutical companies and it created an empowered citizenry at a local level who assisted and demanded the delivery of healthcare services within poor communities as a matter of right and law.

Focusing on Real Needs and Getting Governments to do Their Duties

TAC was sometimes criticized for having a 'narrow' focus on the right of access to ARV medicines (Heywood, 2003a). Responding to this criticism allows us to segue into a discussion of the strategies that will (or will not) legitimate human rights advocacy as a means to pursue claims for social justice.

TAC is a campaign for the right to health and social justice. Ultimately, the two are co-determinant. However, TAC's 'narrow' demands for access to ARVs was grounded in the reality of the AIDS epidemic, rather than public health or social justice theory. Pregnant women infected with HIV needed ARV drugs to reduce the risk of HIV transmission 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. Without saving the lives of activists with HIV it would be impossible to establish a movement led by people with HIV. Broader questions about health systems would follow, as they did.

Thus, rather than reflecting a narrow approach, 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 was demonstrated by the huge international wave of concern unleashed in 2001 as a result of the attempt by 41 multi-national pharmaceutical companies to block South Africa's amended Medicines Act, global pressure around the right to health is more likely to be catalyzed by real community and national mobilization that is driven by people actually needing health care, than from abstract denunciations of injustice, however true these may be (Heywood 2001).

TAC's first campaign, launched on 10 December 1998, was intended to be tangible, understandable, emotive, and life saving. It was to demand that the South African Government introduce a national programme to prevent mother-to-child HIV transmission (PMTCT). TAC called for pregnant women's right of access to a simple medical intervention (a short course of the drug AZT), that could significantly reduce the risk of HIV infection from pregnant mother to baby during and after birth. The response of the South African Government was that the primary barrier to the use of AZT was the drug's high price. (At the time it was not known that the real reason was the embrace of AIDS denialism by President Mbeki, as well as the efforts by the ANC to finalize the development of a drug that it imagined would be a lucrative alternative to AZT). In response, TAC argued that profiteering by GlaxoSmithKline (GSK), the patent holder of AZT, from an essential medicine was a violation of the right to life – and demanded a price reduction.

This campaign caught the attention of young women with HIV and – for the first time in Africa – began to galvanize a social movement that was made up of people who were predominantly poor, black, and living with HIV. It also garnered substantial media coverage, which assisted TAC to amplify stories of the human cost of denial of HIV medication to a national and international audience. The violation of the human right of access to treatment for HIV was made into 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 drug company profiteering as a rights violation and challenging it with reference to the South African Constitution, TAC made it an issue that demanded a legal remedy. This campaign (and future ones), therefore, began to focus on the positive duties on the South African Government that arise from the human rights that are entrenched in South Africa's supreme law.

Using Constitutional Law

TAC's focus has been on the right to health. But the determinants of health are also in access to education, food, clean water, and housing. Fortunately, in its Bill of Rights, the South African Constitution recognizes these as rights that are measurable and justiciable. For example:

- Section 24 says people have a right 'to have the environment protected';
- Section 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';
- Section 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';
- Section 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, and social security'.

TAC made a study of law and worked closely with progressive lawyers, many of whom developed their skills in using the law to undermine apartheid. TAC argued that the Constitution created a legal duty on the government to fulfil its human rights provisions. Therefore, with regards to the right of access to health care services, TAC argued that the government was obliged to take steps to overcome the unaffordability of medicines, especially when it has a legal means to do so. The legal means are the threat of compulsory licensing (where the government forces a patent holder to grant a license to the state or general public) or parallel importation (where a patented medicine is imported from a country where it is priced lower without the permission of the patent holder). Ironically, although the government had vigorously defended these legal measures, which it has built into its amended Medicines Act, the pressures exerted by both the US Government and pharmaceutical companies have made it reluctant to use them (Heywood, 2001).

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 abstract legal obligations. It also worked with scientists and researchers to develop plans and alternative policy proposals that would meet the requirements of 'reasonableness' that jurisprudence of the Constitutional Court has said repeatedly the government must comply with (Berger, 2008).¹

1 The concept and definition of what constitutes a 'reasonable plan' for the delivery of socio-economic rights has acquired great importance in South African jurisprudence. According to the Constitutional Court, a 'reasonable plan' must be context-specific and dependant on the facts and circumstances of any particular matter, and include the following elements:

- Sufficient flexibility to deal with emergency, short, medium, and long-term needs;
- Making appropriate financial and human resources available for the implementation of the plan and
- National government assuming responsibility for ensuring the adequacy of laws, policies, and programmes; clearly allocating responsibilities and tasks; and retaining oversight of programmes implemented at provincial and local government level.

Consequently, what has distinguished TAC from other South African campaigns, such as for a People's Budget or a Basic Income Grant, is that it framed its demands not simply as 'better pro-poor policy' but as policy alternatives based on legal entitlement – and therefore as positive duties that rest with national governments and, where relevant, the multi-national corporations and multi-lateral institutions.

To enforce these duties, TAC developed the capacity to combine negotiation, litigation, and mobilization. Thus, since 1999, TAC has undertaken successful constitutional litigation on at least five occasions:

- in 2001–2002, for a national programme to prevent PMTCT (Heywood, 2003b);
- in 2004, for access to the implementation plan for the ARV roll out (known as the Operational Plan on Comprehensive Treatment Care and Support) (TAC, 2004);
- in 2006–2007, for access to ARV treatment for prisoners at Westville prison in KwaZulu Natal province (Hassim, 2006);
- on an ongoing basis to challenge the profiteering by multi-national pharmaceutical companies, notably GSK, Boehringer Ingelheim (AIDS Law Project, 2003; TAC, 2003b), and Merk Sharp and Dohme (TAC, 2008);
- and finally to defend the Medicines Act against individuals such as Matthias Rath, a wealthy German industrialist, who has denounced ARV treatment and instead marketed his vitamin pills as therapy for HIV/AIDS (TAC, 2008).

But in each of these cases, the litigation was not left to lawyers, but used to strengthen and empower a social movement and backed up by marches, media, legal education, and social mobilization. Without an accompanying social mobilization, the use of the courts may deliver little more than pieces of paper, with a latent untapped potential. For example, one of South Africa's most ground-breaking socio-economic rights judgments (*Government of the RSA and Others v Grootboom and Others*, 2001) concerns the right to housing. It was delivered by the Constitutional Court in 2001. But in 2008, when Irene Grootboom, the first applicant, died she was still without a house (Marcus and Budlender, 2008).

Some writers (such as Johnson, 2006), suggested that this combination of human rights advocacy and litigation will reveal its limitations when it comes up against defenses based on arguments about resource constraints and 'available resources'. However, TAC argues that in a system of governance in which rights are supposed to be pivotal to policy making, decisions on resource allocations must be subject to what Pius Langa, the South African Chief Justice, calls for the 'culture of justification' (Langa, 2007). This means that decisions on spending on crucial socio-economic rights

should not be determined only by what state treasuries (in their own wisdom) decide 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'. This is evident from the Constitution's connection of 'available resources' with everyone's right to access to information (Section 32) and to just administrative action (Section 33), as well as the explicit requirement that 'public administration be development-oriented', that 'people's needs must be responded to' and that there is 'efficient, economic and effective' use of public resources (Section 195).

In a developing country like South Africa, with enormous poverty, inequality, and unmet need, there is no dispute that the state faces legitimate budgetary constraints that may limit rights. This is why the Constitution requires only the progressive realization of rights. But there is a second string to TAC's argument. Where there are genuine affordability issues, a further duty then falls upon the state. Consideration must be given as to how costs might be reduced, for example, by licensing generic medicines; or further resources acquired, by taking over essential property or facilities.

Inequality is inherent to capitalism and its growth is one of the consequences of the globalization of the world economy. But, despite this, TAC operates from the political conviction that significant resources for social reform do exist in most countries of the world and that progressive policy shifts *can* be achieved within the current economic-legal framework – but only if they are fought for, described as rights, and linked to a more refined and legally developed argument about the positive obligations of the state.

The Redistributive Effects of TAC's Human Rights Campaigns

At its 2008 National Congress, TAC defined 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 (TAC National Executive Discussion document, 2007).

This vision is very broad and ambitious. Achieving it will not be possible without a significant shift of resources to the poor (or what Richardson (2007) calls a ‘wealth transfer’) from both the state and the private business sectors. In reality, it requires an economic policy that prioritizes meeting social need as much as foreign investment.

The question is: are these not political issues, rather than issues of human rights, and would TAC not be better off to recognize them as such?

Trying to answer this question leads us to the heart of the redistributive potential that, I would argue, lies within a consistent approach to the realization of human rights. For example, in the early 2000s, the combined campaigns of TAC, and international NGOs such as Médecins Sans Frontières, Oxfam International, and Health-Gap put the pharmaceutical industry under a harsh spotlight that led to big drops in the prices of ARV medicines. In my view, a campaign that successfully brings down the price of a medicine redistributes to poor communities a value that would otherwise have been claimed as profit by shareholders. Similarly, TAC’s successful litigation to force the 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 which goes beyond the direct benefit received by the people in need of treatment.

Analyzing these wealth transfers provides a novel way to assess the outcomes of TAC’s campaigns for the right to health. Through price reductions, the cost of care averted and increases in budgetary allocations it is possible to reveal the tangible benefits of a mobilization for human rights. 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. TAC does not claim sole credit for these outcomes. However, either through litigation or through mobilization or both it provided the initial impetus for each of these breakthroughs and then sustained pressure to ensure their implementation.

Price reductions

When TAC was founded in late 1998, the price of the traditional first-line regimen of ARV medicines (AZT, 3TC, NVP, DDI, and D4T) was approximately R450 (\$64) per month.² 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, led these prices to begin to drop significantly. By 2007, the first-line regimen cost less than R300 (\$42) per month.

2 The exchange rate of the South African rand has fluctuated greatly during this period and is currently at R10/\$1. However, an exchange rate of R7/\$ is used here.

In early 2004, TAC's legal challenge of excessive pricing through 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 (AIDS Law Project, 2003). The reduction in drug prices were a huge cost saving to the government by the time it launched its national ARV treatment programme in early 2004 (TAC, 2003b).

Similarly, in 2000, the anti-fungal Fluconazole, patented under the name Diflucan by Pfizer in South Africa, cost over R100 per tablet. This excessive cost was unaffordable to either the government or individuals and was leading to painful and preventable deaths among people with HIV. TAC announced a 'defiance campaign' in the name of Christopher Moraka, one of its volunteers who had died from cryptococcal meningitis and openly imported a generic from Thailand. This combined with the threat of legal action led Pfizer to announce its Diflucan donation programme to the South African Government in May 2000. This programme was welcomed by TAC but criticized for its restrictiveness. 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 than \$50 million (R350) worth of Diflucan (Department of Health Press Statement, 2000).

Finally, in a number of cases the mere threat of legal action by TAC and the AIDS Law Project was enough to bring about a reduction in the price of several essential medicines for HIV-related opportunistic infections, including Amphotericin B (Berger, 2008a).

Costs of care

The savings on the cost of medicines benefited both the government and the private health sector and permitted wider access. But in addition to the monies saved it should also be possible to calculate savings to the health system that arose from preventing illnesses as a result of providing people with effective medicines. For example, through its mobilization and litigation to compel the government to have a reasonable PMTCT programme, the government was saved the costs of medical care for tens of thousands of infants who would otherwise have been infected with HIV. According to statistics provided by the health department in 2006, 19,758 babies born to mothers living with HIV were tested for HIV. A total of 16,288 babies tested HIV-negative while 3,470 babies tested HIV-positive.

The PMTCT programme has also brought about the expansion of health infrastructures and services to poor people, constituting both a cost and cost saving to government. In March 2007, the South African Government claimed that 'more than 80% of government clinics' were providing PMTCT

services and that 'at least 580,880 pregnant women' accessed these services during 2006.

TAC had from the outset campaigned for a national ARV 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 (TAC, 2003a). But after 2004, South Africa established the fastest growing ARV treatment programme in the world. By early 2008, it was estimated that over 420,000 people were receiving treatment through the public health system (DOH Annual Report 2007/2008). However, as with the Diflucan programme, TAC remained vigilant after the programme was started. Mobilizations, now targeting the roll-out of the service at a provincial and facility level, continued. In addition, TAC helped to establish the Joint Civil Society Monitoring Forum (JCSMF), a network that closely monitored and reported publicly on the expansion of access to ARV treatment and the primarily political obstacles it was encountering. Close monitoring of the programme required the government to constantly account for its omissions and weaknesses and maintained pressure for ongoing investment and expansion.

As a result of the ARV programme, at least 400,000 people are alive who would have died. From this, it should be possible to calculate the costs of needs for medical care that are averted as a result of fewer people dying of AIDS and a reduction in the numbers of opportunistic infections requiring admission and treatment through the public health system. Another important dimension to consider would be the social and economic costs of caring for orphans that will be avoided as their parents remain alive as a result of having access to medication.

All of the campaigns described in this article have received extensive coverage in the media. This has led to a better public awareness of HIV treatment. It could be argued, therefore, that in addition TAC could claim to have contributed to the high levels (so far) of adherence to ARV 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 healthcare workers to improve their patient's 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 5 years of expansion. 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' (National Treasury, 2007). In the 2008 budget, expenditure was revised upwards to R6.5 billion a year by 2010/11. According to the budget review:

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 programs (National Treasury 2007: 45–47).

Most significantly of all, in May 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.

TAC was closely involved in writing the NSP. After the debacle caused by South Africa’s Health Minister at the 2006 International AIDS Conference in Toronto, where the country exhibition had highlighted the Minister’s infamous penchant for garlic and lemons as treatment for HIV, the South African Government responded to the outcry by muzzling the Minister. In this new context, TAC made the finalization of an ambitious HIV treatment and prevention plan one of the conditions for its willingness to trust and work with the government.

As is evident from its ‘Guiding Principles’, the NSP is explicitly couched in rights language. One of its four ‘key priority areas’ for intervention is described as ‘Human Rights and Access to Justice’. This section sets out activities and targets that aim both to combat and educate vulnerable groups about human rights violations, but also to increase people’s access to legal services in order to challenge them. The NSP prioritizes fighting violence against women and children. It also sets an example for what TAC describes as ‘needs-based budgeting’ by being the first health programme in South Africa to simultaneously model its costs, based on the actual interventions that are needed, rather than to set interventions within predetermined costs. Whether the South African Government can be persuaded to fully fund this programme, particularly in a period of economic recession and financial instability, is an as yet unwritten chapter of this history. However, its approval by the Cabinet and the work that has been done since 2007 to embed the NSP in society sows the seeds of future human rights campaigns demanding its fulfilment.

Developing a New Model for the Use of Law and Legal Systems to Campaign for Human Rights

The approach to the pursuit of human rights described in this article has relevance beyond health and AIDS. Human rights campaigns also exist that demand that governments improve access to quality education, housing, and ensure sufficient food and water and employment for all. But they would probably be more successful and sustainable if they began by empowering disadvantaged communities to lead these struggles.

The essence of my argument is that in the current global political conjuncture, despite the fact that the odds seem heavily stacked against the poor,

there is an opportunity for human rights approaches to issues of poverty. The global process of democratization that took place in the 1990s, however shallow and cynical it may be in some countries, has given unprecedented recognition to rights, and linked them to principles of state accountability, state duty, and the rule of law. 'The role and reach of law is increasing, a trend that reflects broader global forces' (Rhode, 2004) and in the last 20 years, there has been a historically unprecedented shift towards law and legalism in government. According to Klug (2000), over 56 percent of members of the United Nations made major amendments to their Constitutions between 1989 and 1999, and of these at least 70 percent adopted entirely new Constitutions.

Some argue that embedding the 'rule of law' was one of the largest frauds perpetrated by the IMF and World Bank on peoples breaking free from a variety of tyrannies after the global balance of power shifted following the collapse of the USSR. They argue that, although full of the sound and symbols of democracy, and couched in human rights and constitutionalism, in reality the advance of rule of law was intended to restore balance to the exercise of power after the instabilities created by the collapse of a range of hybrid Cold War governments. Radical political movements that had fought for democracy in the old client states of the USSR, whether in Eastern Europe or Africa, were to get its clothes, but not necessarily what they hoped of its content. The scale of this strategy is illustrated by the fact that 'in the first half of the 1990s well over a billion dollars was spent on rule of law projects in every conceivable corner of the globe' (Klug, 2000, p. 2).

In his analysis of the South African constitution-making process, Heinz Klug examines the international pressures that were brought to bear on the question of rights. However, he shows that because of the strength of civil society, attempts to prescribe models based on 'the liberal paradigm of individual human rights and multi-party democracy' (Klug, 2000, p. 24) could not preclude the 'simultaneous inclusion of a range of alternative constitutional elements, including socio-economic and cultural rights...' (Klug, 2000, p. 24). Looking at developing countries more broadly he finds that 'the two trends having the most direct impact on processes of post Cold War state reconstruction are those emphasizing liberty and equality'.

However, even while we must recognize the ulterior motive on the part of the 'advanced democratic states', it is also important to appreciate that the spread of democracy, and the pretence of democratic governance, has created a legal space for the human rights movement. Yes, the promotion of individual 'liberty' may be a catch phrase associated with neo-liberal attacks on welfare states but, in my view, the question that ought to be asked, particularly by the poor, is 'liberty from what?' If the liberty people seek most desperately is from poverty and inequality, and if this is central to their ability to lead their lives with dignity and autonomy, then the role of the

state – and its ability to respect, protect, promote and fulfil human rights – comes very much to the fore.³

The potential for reconstructing human rights as state duties is argued for by Allan, who suggests that in constitutional democracies such as South Africa civil society should view the democratic state as a mechanism of enablement, rather than constraint, and subject it to pressure aimed at ensuring the progressive realization of human rights. According to Allan:

the purpose of the democratic state, ... is to provide a mechanism for ensuring the accountable use of public resources for purposes of progressively realising peoples' human rights (Allan, 2007).

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 countries, such as India and Brazil, and even transitional economies, such as China, where such a space either does exist or can begin to be created.

Rights can be the basis for a new politics that may enhance community struggles for development. They also allow civil society to create a new space for engagement with the state in emerging democracies. Because rights demands are couched in international law and can claim the legitimacy of Conventions signed by governments in Geneva and New York (which they rarely intend to fulfil) the state may feel compelled to engage with them. As described, TAC operated in an ideal legal framework. But its campaign was at heart a political one, against the policies of an ANC government that was hugely popular – having brought political liberation to South Africa in 1994. This was a difficult space to occupy. TAC's campaigns, particularly the 2003 civil disobedience campaign, always stayed within the law, but pushed the envelope of politics and tested the depth and durability of the new democracy. At times the President of the ANC, Thabo Mbeki, even attempted to cast TAC as foreign funded and 'counter-revolutionary'. At one point, it was suggested that it is a Trojan Horse for a new 'anti-ANC' political party. However, these accusations did not stick because TAC's consistent counter was that it was only fighting for rights recognized and entrenched in the South African Constitution, rights the government was under an obligation to provide (Heywood, 2005).

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), that is

3 Although I am not going to explore it here, it is important to point out that a strong developmental state is not inimical to individual liberties.

similar to the AIDS denialism that was embraced by the South African Government, under its former President Thabo Mbeki (Heywood, 2004). 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. Denialism leads to violations of a range of human rights. It is best overcome by human rights activism.

Conclusion

Throughout this article I have tried to illustrate how combining human rights advocacy with litigation and legal argument about a state's duties towards health can bring about tangible improvements in people's lives. However, I have made a number of large assumptions about the rule and role of law: these include the need for a genuine separation of powers and the willingness of the executive to respect orders of the courts; guarantees that the courts themselves are politically impartial and will genuinely abide by the dictates of the Constitution; and the possibility that human rights organizations may utilize the courts. These assumptions may hold in South Africa at this point in time. But, as was seen in Pakistan in late 2007, when judges and activists were imprisoned and the Supreme Court effectively dissolved, they are far from immutable. Social movements can and should use law to achieve human rights, but 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 idea of the rule of law, in the current global political environment, therefore requires further analysis and elaboration from a human rights perspective.

There is, however, one final issue. Ultimately, individual human rights must be something that ordinary people are themselves capable of protecting. It is well and good for a skilled social movement, such as the TAC, to use the law to assist the poor to obtain their right to health, but can the poor protect themselves in the absence of an organization like TAC? Answering this question requires that we understand the full continuum of rights struggles and the activities that should underpin them, particularly, as I have argued in this article, human rights education and localization. The ultimate objective of human rights campaigners is a more and more empowered citizenry, living in a context of globally agreed and nationally accepted rights, and within reach of a broad range of legal systems to enforce them.

Appendix

The structure of the TAC

At its first Congress, held in Soweto in 2000, the TAC adopted a constitution, setting out its objectives, structures as well as the rights of its

members. The TAC Constitution was amended in 2004 and is available at www.tac.org.za/Documents/Constitution/tac_constitution_24_feb_2006.pdf (TAC, 2004)

At its heart, TAC is a member/volunteer-based organization, recruiting its volunteers primarily from the urban and rural poor. However, from the outset, the TAC also sought affiliation and active support from other mass-based organizations within civil society, such as the Congress of South African Trade Unions (COSATU) and the South Africa Council of Churches (SACC), both organizations that were at the forefront of the fight against apartheid. As a result TAC's structures sought to include representation from both its members and affiliating 'sectors' such as the trade unions. TAC has also been fortunate, and unusual in post-apartheid South Africa, because it has been able to attract volunteers of different races and class backgrounds. Organizationally, the TAC operates on three levels:

- At a community level through 'branches', which have been established in over 100 poor communities. Branches are composed of its activist volunteers, TLPs and other local supporters. Branches meet monthly and are responsible for the implementation of TAC campaigns and programmes in poor and marginalized communities, as well as for education and treatment literacy. Branches are led mainly by people living with HIV and women.
- At a provincial level, in six out of nine of South Africa's provinces. A Provincial Executive Committee (PEC) brings together branch leaders and provides a vehicle for leadership training and information sharing. Branches elect members to the PEC, which meets quarterly. Provincial TAC offices co-ordinate training, mobilization, and TAC programmes and also target advocacy at provincial governments.
- At a national level through a National Executive Committee (NEC), made up of elected provincial representatives and sector representatives as well as through a 'secretariat' (its five key office bearers) that is directly elected by delegates at the TAC National Congress. The NEC is re-elected every 2–3 years at the TAC National Congress.

TAC is a voluntary organization. However, as it grew it was necessary to establish a professional infrastructure to support its programmes and campaigns. Within 10 years, TAC's full-time staff grew from none to over 100; its annual budget from less than \$20,000 to approximately \$5 million in 2007. This growth has implications for TAC's sustainability.

A chronology of the TAC

10 December 1998 – TAC launched on International Human Rights day in Cape Town, with a small demonstration for the right to treatment.

21 March 1999 – Human Rights Day, South Africa. TAC holds first demonstrations of people with HIV to demand a national PMTCT programme in three cities.

24 March 1999 – TAC holds its first meeting with ANC Minister of Health, Dr Nkosazana Dlamini Zuma, and issues statement on the need to reduce ARV drug prices. Although the meeting was positive, soon after this relations between the TAC and the government began to deteriorate.

1999 – Thabo Mbeki replaces Nelson Mandela as South Africa's second president. Dr Manto Tshabalala-Msimang is appointed as Health Minister.

January 2000 – TAC files papers to join as *amicus curiae* on the side of the South African (SA) Government in the litigation concerning the challenge to South Africa's Medicines Act by international pharmaceutical companies (the Pharmaceutical Manufacturers' Association – PMA).

5 March 2000 – TAC leads a march of 5,000 people to the Pretoria High Court on the first day of the PMA court case.

19 April 2000 – The PMA withdraws its case against the SA Government under public pressure and after TAC had been admitted to the case by the court.

July 2000 – TAC organizes global march for treatment at the start of the International AIDS conference in Durban. The march is widely understood to have been a turning point in acceptance of the right of access to treatment for people in Africa and other developing countries.

March 2001 – TAC holds its First National Congress in Soweto attended by nearly 500 activists.

July 2001 – TAC launches Christopher Moraka Defiance Campaign to challenge the patenting and pricing of the anti-fungal medicine, Fluconazole. The campaign is named after a TAC member who died as a result of the unaffordability of Fluconazole.

21 August 2001 – TAC files legal papers against the SA Government regarding its failure to provide ARVs to PMTCT.

October 2001 – The Bredell Consensus Statement on Access to ARV treatment is launched by TAC and international scientists after a conference that brought activists and scientists together.

18 December 2001 – The Pretoria High Court rules in favour of TAC on PMTCT and orders the government to roll out a programme on PMTCT. The government appeals the order.

2 May 2002 – 5,000 TAC supporters march past the Constitutional Court on the day of its hearing of the appeal in the PMTCT case.

5 July 2002 – South Africa's Constitutional Court hands down a landmark ruling in favour of TAC and the right of access to healthcare services. One of the Constitutional Court judge reports that he cried after the decision was made public.

September 2002 – TAC files a complaint with the Competition Commission concerning the conduct and excessive pricing by multi-national pharmaceutical giants Boehringer Ingelheim and GSK of three essential ARV medicines.

November/December 2002 – TAC involved in negotiations with business, labour, and government to try to agree on a National Treatment Plan. The negotiations are sabotaged by the government and ultimately unsuccessful.

February 2003 – TAC leads march of 20,000 to the South African Parliament on the day of the Presidential state of the nation address to demand a national treatment programme.

21 March 2003 – TAC launches its civil disobedience campaign against the ANC government to protest at the 600 deaths per day taking place as a result of HIV infection.

April 2003 – The civil disobedience campaign is suspended after hundreds of arrests and an offer by the ANC to begin to talk to TAC again. TAC's suspension of its campaign is made conditional on progress towards a National Treatment Plan.

August 2003 – TAC holds its Second National Congress in Durban and decides to relaunch civil disobedience.

9 August 2003 – The SA Government announces a cabinet decision to develop a national ARV treatment plan. At this point, no people are officially receiving treatment in the public health sector.

10 December 2003 – Out of court settlements are announced between TAC, GSK, and Boehringer Ingelheim regarding TAC's complaint to the Competition Commission. The companies agree to issue seven voluntary licenses for the drugs, increasing competition and bringing down prices.

2 July 2004 – TAC turns its attention to broader issues around health systems and holds a national conference to make demands for a 'People's Health Service'.

November 2004 – Pretoria High Court rules in favour of TAC's right of access to information and awards punitive damages against the Minister of Health (the Annex A case) for withholding information about the implementation plan for ARV treatment.

September 2005 – TAC holds its Third National Congress. By this time less than 100,000 people are on treatment. TAC has 20,000 volunteers.

5 July 2006 – Judgments are handed down in favour of TAC in its case demanding access to ARV treatment for prisoners at Westville prison in Durban, KwaZulu Natal.

August 2006 – TAC protests at the International AIDS Conference in Toronto lead to SA Government muzzling the Minister of Health and seeking a new relationship with TAC.

27–28 October 2006 – TAC and its allies in the trade unions, churches, and NGOs hold a national civil society congress on an HIV prevention and

treatment plan. The Congress is addressed by the Deputy President of South Africa.

1 December 2006, World AIDS Day – TAC and the government announce the creation of a strengthened National AIDS Council (SANAC).

January – May 2007 – TAC closely involved in the drafting of an NSP on HIV/AIDS that proposes to put two million people on treatment by 2011 and cut new HIV infections by 50 percent.

4 May 2007 – The NSP is endorsed by the Cabinet.

7 November 2007 – TAC files a new complaint with the Competition Commission, this time against Merk Sharp and Dohme (MSD) over its refusal to license the ARV drug, Efavirenz, on reasonable terms.

9 November 2007 – TAC organizes mass demonstration to highlight the TB crisis in South Africa.

March 2008 – TAC hold Fourth National Congress. By this time, 450,000 people are on treatment in the public health sector. TAC debates new approaches to campaign for the right to health.

1 June 2008 – TAC announces that MSD has agreed to license Efavirenz on reasonable terms, leading to price reductions.

13 June 2008 – TAC wins its case against Matthias Rath, who is ordered by the Court to stop unregistered ‘clinical trials’ and publishing advertisements claiming that vitamins cure AIDS.

September 2008 – South African President Thabo Mbeki is removed as President of South Africa by the ANC. South Africa’s Health Minister is replaced in a Cabinet reshuffle.

MARK HEYWOOD

AIDS Law Project,

P. O. Box 32361,

Braamfontein 2017, South Africa

heywoodm@alp.org.za

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