

## **Chapter 13.**

### **Justice and the Treatment Action Campaign**

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#### **Introduction**

It is a terrible irony that the need for an effective and ongoing response to the AIDS epidemic will be one of the defining legacies left to the ANC by a President who tried to deny the existence of HIV. It is also ironic that the Treatment Action Campaign (TAC), an organization that Mbeki once branded as 'flag carrier for pharmaceutical companies', is heralded one of the few organizations that was able to force a complete overturn policy in an area defined and defended by himself, during his Presidency. However, rather than looking back, this chapter attempts to draw some lessons from TAC and the Mbeki era. It aims to inform how both government and civil society (hopefully together) approach AIDS, as well as health more broadly, during the Zuma government.

There is no question that, in the last decade, the health of millions of South Africans has deteriorated. Over 5.5 million people live with HIV. An estimated 2.5 million people have died of AIDS since the mid 1990s. Tuberculosis (TB) has exploded and multi-drug and extremely drug resistant TB have assumed epidemic proportions. There has been a growth in non-communicable disease among the poor. Malnutrition is rife. Infant and maternal mortality have risen.<sup>1</sup>

There is both a social and political explanation for the crisis in public health. In general the importance of health promotion and disease prevention not just to the individual, but to national development was not understood by the ANC or the government. Symptomatic of this was the trusting of health to an incompetent Minister.

But this chapter argues that health is also about politics and the health crisis grew in the places where post-apartheid democracy failed: in the patronage and protection of an inefficient Minister of Health, in the failures of internal democracy in the ANC and the inability to admit and overcome AIDS denialism, in the blurring of lines between the views of the party (or its President) and the duties of the state. But whilst the declining health of the poor people, and particularly the scale of the AIDS epidemic, can be attributed to political negligence, it was not its only cause. As important has been the growth of socio-economic inequalities – and their impact on both health and development.

By the time of its 52<sup>nd</sup> National Conference in late 2007, the ANC had recognized the disastrous consequences of its political omissions on health. It adopted resolutions that promised that 'education and health must be prioritized as the core elements of social transformation'.<sup>2</sup> In 2008, this was carried into several ANC-led initiatives to develop new policy for health reform, a process which culminated with the adoption by the ANC of a 'road map for health reform', including the introduction of a system of National Health Insurance (NHI). The result is a health plan that foregrounds AIDS, TB and the resuscitation of health systems. However, what remains unclear is whether there is sufficient will to finance the reorganisation of health care. It is also unclear whether the ANC understands that arresting and reversing the health crisis also means tackling inequality. Both require massive social investment -- in a period when global and national economic forces will cause more pronounced inequality.

Civil society will once more have a major role to play in ensuring implementation of health policy. During its first decade, 1998 to 2008, TAC made a name as an organization fighting for health. But its actual campaign has been less for health, than for health goods, particularly medicines, for the poor. The strategy of the TAC was shaped by the political context, largely made by President Mbeki, and defended acolytes such as Essop Pahad, Manto Tshabalala-Msimang, Smuts Ngonyama, Ngoako Ramathlodi and the late Peter Mokaba. TAC had no choice other than to mobilize people to challenge and overcome AIDS denialism and to reduce medicine prices. Both campaigns had demonstrable success. In early 2002 the price of first line anti-retroviral medicines fell dramatically, making them affordable in South Africa. AIDS denialism ended with the appointment of Barbara Hogan as Minister of Health in October 2008.

But with Mbeki gone, and access to ARV medicine guaranteed to the extent that the health system has the capacity to provide it and the government can afford it, the next decade will contain different challenges, for both government and civil society. A balance will have to be found between sustaining campaigns for access to ARV treatment and health care services, and robust political advocacy and action against inequality. Campaigns for health goods will be self-defeating if they ignore the link between social and economic inequality and poor health. In the words of Daniel Becker, a Brazilian health activist: 'How much good does it do to treat people's illnesses, only to send them back to the conditions that made them sick?'<sup>3</sup> Similarly, Dr Paul Farmer, asks whether it is possible to practice medicine effectively 'without addressing social forces, including racism, pollution, poor housing, and poverty, that shape [the course of ill health] in both individuals and populations?'<sup>4</sup>

This chapter considers the implications of the changing political and economic environment for continuing efforts by civil society to ensure the right of 'everyone' to have access to health care services, and for conditions that make for health.<sup>5</sup> It questions whether the government will have the will to take all measures that are available to it in law to advance health. The 'road to health' will require that TAC and its allies unite more effectively to directly challenge governmental policies which cause and reinforce inequality. It will also require that pro-poor organizations of civil society, including political parties, better understand and act on the relationship between health and development.

Finally, in the context of ongoing global economic pressure towards austerity, it will almost certainly necessitate compelling the government to use of the state's legal power and moral legitimacy to ensure it can carry out its positive constitutional duties to protect and promote health. This requires an intention to defend the Constitution and sustain community mobilisation in order to utilize the national state as an instrument of democracy that can deliver on poor people's needs.

### **What did TAC achieve?**

The work and achievements of TAC have been extensively documented and analysed, including by myself.<sup>6</sup> This chapter looks at TAC, and the struggle for AIDS treatment, in a broader political and social context. It frames TAC's achievements in gaining access to medicines in a longer term perspective of health and development. TAC was launched on 10 December 1998, the 50<sup>th</sup> anniversary of the Universal Declaration of Human Rights. The ideal was the realization of the right to equality, specifically in relation to poor people's right of access to life saving medicines for the treatment of HIV, and the belief that the South African constitution could advance this right.

In the late 1990s it seemed as if AIDS would follow the course of other diseases of the third world: treatable if you were rich and life-threatening and invariably fatal if you were poor. However, TAC and AIDS activists globally were able to change that course. By late 2008 it was estimated that 500,000 people were receiving ARV treatment in the public sector in South Africa, and over three million world-wide.<sup>7</sup> In terms of absolute numbers South Africa has the largest ARV treatment programme in the world, achieving some of the best results in terms of drug-adherence. In late 2008 it was estimated by the Treasury that every month 20,000 additional people were being initiated onto treatment every month. But this is still only meeting less than 50 per cent of the existing need for treatment.

That so many people are on treatment has a great deal to do with TAC's social, political and legal mobilisation. For over a decade it was able to develop and sustain a cadre of activists, at its peak numbering over 20,000, who confronted both government policy and private health sector profiteering from medicines. TAC's volunteers were mostly marginalized young women and men from poor communities, many of them living with HIV and in need of treatment. They were assisted to organize and unleash their power as rights-bearing citizens of the democratic South Africa, through utilizing Constitutionally entrenched rights to demonstrate, organize, educate and have resort to the courts to promote and fulfill rights. In many ways TAC developed as a model of how human rights, law and mobilization can be combined to further the interests of poor people.

TAC's achievements are real. The course it followed in overcoming the obstacles to access to treatment was unavoidable. Guaranteeing access to life-saving medicines was, after all, its primary mission. But TAC has grown into more than just a limited campaign for ARV treatment. Delegates at its fourth national congress in 2008 amended its constitution to reflect its aspirations to protect human rights more broadly and sustain access to treatment through transformation and improvement of the state health system. This therefore requires us to examine TAC in the broader context of the social and political factors, which (as I argued in the introduction to this chapter) determine health, including HIV.

In its first decade, TAC became very much a creature of the context of President Mbeki's AIDS denialism.<sup>8</sup> The contest with AIDS denialism was the backdrop to the struggle for access to treatment. Every major breakthrough in the struggle for treatment access -- whether in relation to the prevention of mother-to-child HIV transmission (2002), a national treatment plan (2003), the implementation of the treatment plan (2004), access to treatment for prisoners (2006), an ambitious National Strategic Plan on HIV, AIDS and STIs (2007), and the battle against state-encouraged quackery (2008) - was also a victory over AIDS denialism. Against this constant, the question of profiteering from medicines by multi-national pharmaceutical companies was an issue taken on by TAC successfully, but only sporadically. Similarly, the critical issues of access to a quality health care system and HIV prevention, received scant attention. In fact, it could be argued that the malign shadow cast by AIDS denialism, and the relentless campaign that had to be waged to overcome it, largely eclipsed other factors that were driving the HIV epidemic, factors that suddenly loom large with the defeat of AIDS denialism.

### **The next challenges**

Two issues can be postponed no longer:

- preventing new HIV infections and
- resuscitating South Africa's health system.

The sustainability of access to treatment for people with AIDS is dependent on both. Unless the tap of new infections is turned off it will be impossible to meet the demand for treatment. Unless, the health system is sorted out, it will be impossible to supply the demand.

Successful HIV prevention on a large scale has thus far proved elusive and intractable. It cannot be undertaken without challenging the socio-economic drivers of HIV infections, drivers have become more pronounced in the last decade. Similarly, unleashing the potential quality of South Africa's *total* health system means challenging the inequalities within it, and the systems for its governance, particularly its financing. These issues necessitate a new approach to AIDS by civil society as a whole and TAC in particular. In this respect the end of AIDS denialism may not mean the end of conflicts with the ANC or the next government.

In late 2008 it was still estimated that over 1,500 people daily were being newly infected with HIV.<sup>10</sup> However, these 1,500 people are not random innocent bystanders who happened to be in the path of a virulent virus. They have at least one and sometimes a combination of the following characteristics: being black and poor, women, young, unemployed, living in rural areas and being without formal homes. In other words, they are people who live in a country where although 'all people are equal under the law',<sup>11</sup> millions of people are less equal than others and do not have 'the full and equal enjoyment of all rights and freedoms'.

This requires an examination of inequality and its relationship to HIV and AIDS. It is a reasonable supposition that that it is inequality, rather than just 'extreme poverty' - as was claimed many times by Mbeki<sup>12</sup> - that has become the major driver of declining ill health generally and rising rates of HIV infection particularly. For example, research conducted in a number of developed countries has demonstrated that inequality, rather than just wealth, is a major social determinant of health. This is the case even when the inequality is between people who, comparable to developing country standards of living, are socially secure. Thus, Daniels et al point out that: 'the relationship between economic development and health is not fixed, and that the health achievement of nations is mediated by processes other than wealth.'<sup>13</sup> Put simply, a country may simultaneously be gaining in wealth, and failing in health.

This would suggest that a social and economic strategy which promotes narrow economic growth (measured primarily by GDP, FDI etc), whilst at the same time

using a parallel strategy to alleviate poverty primarily through selective cash transfers to a segment of the poor (child support grants, foster grants etc), will increase inequality even whilst it mitigates poverty. Such a policy was followed by the Mbeki government. But it is contrary to the method of government required by the South African constitution, which must progressively reduce inequality. It will also not assist HIV prevention. If HIV cannot be prevented it will be hard to improve public health generally or make progress against specific Millennium Development Goals (MDGs).

Put another way, economic policies that widen inequality, both between classes and within classes, fuel both disease and ill health. This makes public policy questions such as access to social security, sufficient food and fair labour practices integral to HIV prevention and treatment.

### **Inequality and HIV**

There may be dispute about the depth and breadth of poverty there is no doubt that inequality has grown. Fewer people are classified as living in absolute poverty. But more very poor people live side-by-side with less poor people in urban formal and informal settlements all over the country. The growth in proximal inequality creates an immediate vulnerability to disease, however distant its political causes.

In the words of the report of the Commission on the Social Determinants of Health (CSDH):

The poor health of the poor, the social gradient of health within countries, and the marked health inequities between countries are caused by the unequal distribution of power, income, good, and services .... This unequal distribution of health-damaging experiences is not in any sense a 'natural' phenomenon but is the result of a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics.<sup>14</sup>

What is meant by this in South Africa? The vast majority of people in South Africa are poor. But people's experience of poverty is not uniform. Poverty (like wealth) is layered, with sex and disability in particular being associated with deeper degrees of inequality.<sup>15</sup> In South Africa the fact that women and girls experience deeper social and economic disadvantage than men and boys, is thought to explain their earlier and higher rates of HIV infection and mortality. Girls and young women, who are the least equal of poor people, adopt survival strategies that are not necessary for boys and men.<sup>16</sup> For some, sex becomes a commodity they can exchange in return for a degree of social security (or greater equality).<sup>17</sup> This is obtained from men who may be only slightly less poor (after

all, they often live in the same community), but whose access to income is linked to their sex, limited access to the economy and often slightly older age.

In the past (before the emergence of HIV) the migrant labour system, and its enforcement by apartheid laws, penned millions of women into rural areas, and hundreds of thousands of men in soulless hostels. This shaped a demographic of sexually transmitted disease, particularly syphilis.<sup>18</sup>

Fifteen years after the end of apartheid, internal migrancy driven by economic rather than political factors, remains a major risk for disease.<sup>19</sup> According to some research, in the post apartheid years changes to the South African economy have created 'a changing political economy of sex' and 'most African women today are no longer waiting in rural areas to be infected by their migrant partners'.<sup>20</sup> Women are as poor as they were under apartheid but more mobile, making them much more the active agents of their own vulnerability. But in this changed socio-economic context one particular area of state failure has been glaring and has added to the risks of HIV infection: that is the failure to invest in gender equality and to protect women and girls from sexual violence. This is an issue that TAC has also attempted to tackle, but one on which it has not been able to make the same social imprint with its ideas, as it has for example on access to ARV treatment. In a number of communities, particularly Khayelitsha, TAC showed that it is possible to mobilize against domestic violence and ensure that the legal system fulfills its responsibilities towards women. But these campaigns have remained localized.

The result of social insecurity and inequality is that if awareness of HIV is not accompanied by access to income, or a dependable justice system that can prosecute domestic violence and rape, or support services for women and girls, it will be insufficient to reduce risk behaviour. But although women have a particular vulnerability, poor men are also not immune to behaviors that are directly influenced by their marginalization and inequality. Catherine Campbell has drawn attention to how:

Frequent and unprotected sex with multiple partners may often be one of the few ways in which men can act out their masculinity. This might be the case particularly in situations where men, at best, work in difficult conditions over which they have little control or, at worst, have little access to jobs and money.<sup>21</sup>

This analysis helps us to understand how, during the Mbeki years, inequality, migration and sex coalesced into a risk vector to health and well-being. The theatre where this risk is acted out is poor residential communities where people live their 'private lives'. But the factors that influence people's behaviours (or

choices) are being heavily influenced by the social, economic and political policies of government.

The vicious circle that fuels HIV infections can be summarized as follows. For people who are poor, vulnerability to HIV starts by being driven by external factors, particularly inherited disadvantage in access to education and employment. However, once greater risk has become actual HIV infection, then illness that is caused by HIV provides a further motor to the cycle of inequality. Unless people with HIV have access to health care services that provide treatment and care, illness deepens pre-existing deprivation: it incapacitates people, creates new needs and diverts household resources. HIV infection becomes not just the symptom, but an agent, of inequality.

For these reasons, if HIV prevention is to succeed it requires that organizations such as TAC campaign on two levels: *directly* through a social mobilization to diagnose, prevent and treat HIV and *politically* through challenges to the policies that create, or fail to alleviate, inequality.

### **Health systems decline**

Because of the lack of competition from the public sector and because good health is essential to life and well being, health services have become a site of ruthless profiteering by private companies and of growing inequality in access to health care services. Tragically, in the post apartheid period two processes, until recently both largely unchecked, have made the national health system worse and more unequal.

On the one hand, the public health system has been gravely underfunded and subject to constantly growing demand. It has been placed under the tutelage of mostly incompetent and sometimes corrupt politicians. In the mid 2000s, despite the mounting evidence of the near collapse of this system in many districts, ANC politicians protected each others' backs and claimed that health systems were improving. Those who spoke out, most notably Nozizwe Madlala-Routledge, the Deputy Minister of Health from 2004 to 2007, were ganged up against. Routledge was eventually dismissed in August 2007.

As public health services deteriorated, the private health system became more necessary for access to health care both for those with money and those without – the diametric opposite of the intention of the ANC's 1994 National Health Plan and the 1997 White Paper on Health. For example, it is estimated by the Health Roadmap that nearly 50 per cent of poor people first seek primary care from private doctors when they are ill 'despite having access to free care', paying out of pocket, and accounting for nearly 20 per cent of total national health

expenditure. Approximately 15 million people use private health services of one kind or another for out of hospital care. But, because of its expense, private hospital care can be afforded by only 7.5 million people.

Profits in the private health sector soared because firms were relatively free from legal regulation and oversight in most areas of operation (with the exception of medicine pricing and medical schemes<sup>22</sup>). Netcare, for example, made post tax profits of R1bn in 2007.<sup>23</sup> In this respect it is also important to note that TAC's focus on private profiteering from medicines, albeit necessary, obscured the fact that profiteering was also taking place in other parts of the health system as well, particularly by the large hospital groups.

When it came to the public sector, TAC initially concentrated its fire on public health skeptics who claimed that the public health system would 'collapse' if ARV treatment was introduced, overlooking the deeper processes that were taking place in health provision. As a result of TAC's campaign, health services for AIDS treatment were one of the only areas in the health system that experienced consistent investment and strengthening. Unfortunately, under less pressure and scrutiny, most other areas of health care suffered an unchecked decline.

In 2004, after TAC's pressure on the government finally secured a National Treatment Plan, the movement began campaigning for a People's Health Service, aiming to draw attention to the crisis of health systems. However, TAC's calls for investment in the public sector and regulation of the private sector were inconsistent. Pressure for health reform could not be sustained, not only because of the continual re-surfacing of AIDS denialism, but because the demand was much more complex than the call for AIDS treatment and needed a new alliance to be built.

TAC's campaign was eventually overtaken by a process launched by the ANC in mid-2008, following up on resolutions taken on health at the Polokwane Congress. This process, facilitated by the ANC's Health and Education committee, recognized both the crisis of disease and the crisis of health systems and made proposals to address both. In its early stages Manto Tshabalala-Msimang, the then Minister of Health, had almost nothing to do with it. But a new era began with the appointment of Barbara Hogan from October 2008 through May 2009, and Aaron Motsoaledi from May 2009. The report and its recommendations appear to have largely been adopted by both the government and the ANC, even if progress on the National Health Insurance component is not yet visible.<sup>24</sup>

The 'health road map' appears to be consistent with the constitutional duties of the state in relation to health, and has therefore been welcomed by activists. It recognises the importance of establishing health budgets based on needs assessment, on resolving the human resources crisis, and on prioritising the reduction of AIDS, TB and infant mortality. But the roadmap is silent on the crucial questions of cost, how it will be financed and how it will be implemented in the context of government's fiscal constraints. For example, in late 2008, reports began to surface of massive, uncontrolled over-expenditure on the health budget, and the running out of funds for the purchase of ARVs four months before the end of the financial year in several provinces.<sup>25</sup> In addition, the government must address powerful private sector resistance to fundamental reform and a depleted and demoralized health workforce.

The political will may be there, but the political how is uncertain. One thing we may be certain of: without the external pressure of civil society, the ANC's ambitious goals will not be implemented.

### **Duties of government and uses of the state**

The final report of the CSDH points out that 'the structural determinants and conditions of daily life constitute the social determinants of health'. In keeping with this, the analysis I have offered in this chapter of how social inequality influences *state of health (including relative risk of HIV infection)*, as well of how inequality influences the *degree of access to health care services* begs the question of what is likely happen to health and health services under South Africa's next government.

If the ANC's 2009 Election Manifesto is to be believed, it will: 'aim to reduce inequalities in our health system, improve quality of care and public facilities, and boost our human resources and step up the fight against HIV and AIDS and other diseases. Health reforms will involve mobilisation of available resources in both private and public health sectors to ensure improved health outcomes for all South Africans.'<sup>26</sup>

Should this aspirational statement be trusted? There is certainly a qualitative difference between Motsoaledi and Tshabalala-Msimang, and between the Mbeki and Zuma governments more generally. But at this stage it is not possible to say yet whether the left rhetoric emanating from the new ANC leadership is mere posturing and positioning in the quest for leadership or whether it will translate into a genuine concern for the poor. If it is the latter, it is also not clear whether the ANC will operate by means of populism or constitutionalism. But whatever happens there is no doubt that in its first few years at least, the next government will find itself even more restricted than its predecessor. How will it deliver

costly and necessary social reforms in a turbulent global economy drifting from deficit-spending to austerity? How will it calculate and apportion its 'available resources'? How will it justify decisions to invest in social services, such as health, to the financial markets which judge the value of SA state securities?

Regardless of the pressures, the health crisis will not pause while these questions are answered, or wait for a more expansive fiscal outlook. If the health crisis is not arrested in coming years the damage may end up being beyond repair. As a result, there is now a need for AIDS and health activism to become enmeshed with political activism and vice versa. But, this will require a mind shift.

Up to this point, health has been marginal in campaigns for equality and justice. In the words of a group of authors, including the former UN Special Rapporteur on the Right to Health, writing in the *Lancet*: 'until recently, the right to health was only dimly understood and attracted little support from civil society or any other sector.'<sup>27</sup>

There are many ways in which the right to health can be used to mobilize around other social ills, and improve other aspects of the lives of poor people, even if these are still largely overlooked.<sup>28</sup> Ill health seems to be regarded by many in social movements primarily as the *consequence* of poverty and inequality, rather than equally as a *contributor* to it. As a result, it is rare to find health advocacy at the centre of the campaigns and programmes of pro-poor and social justice organizations. Internationally, socialist parties, trade unions and social movements have rarely shown any sign that they appreciate how integral health is to dignity and development. Consequently very few have prioritized and aggressively implemented health programmes and platforms – and the duties of the state in this regard have been forgotten.

Compounding this problem is the way in which many activists and analysts seize too quickly on explanations for poor health that are nearest to hand and which offer grist to their mill about the 'inherent evils' of neoliberalism and globalization. Of course, there have been good reasons to draw attention to the negative consequences for health of IMF-led structural adjustment programmes, debt repayment and World Trade Organisation (WTO) agreements, particularly the Agreement on Trade Related Aspects of Intellectual Property (TRIPS).

But globalization and neoliberalism are an insufficient explanation for state failure on health, and when it is offered as the main explanation it is disarming. Decline in health indicators is not caused by globalization alone, but by the *voluntary* retreat of governments from their social responsibilities – sometimes citing 'globalization' as a feint for its own omissions.

South Africa is an example. Between 1994 and 2003, South Africa reduced its external debt as a per cent of GDP, and avoided taking loans from the IMF<sup>29</sup>. This changed in 2003 as the country's rising current account deficit required inflows of funds not covered by other financial capital. But although there were 14 World Bank loans, including hospital refurbishment, South Africa was not under the direct thumb of global finance the way many other African countries were. The debt burden did not impede increases in social spending. But despite this, between 1996 and 2000, under the Growth Employment and Redistribution Strategy (GEAR), the ANC government voluntarily imposed arbitrary limits on public spending on health with profound consequences for the capacity to meet health needs and it was only in the mid-2000s that per capita state spending on healthcare began to rise (after inflation is discounted). In some ways, the subsequent increases were wasted, because by then, nursing colleges were closed, scarce skills had migrated, and hospitals fell into disrepair.

The Health Roadmap suggests that to achieve staffing ratios similar to a decade ago and to take into account population growth and added disease would require an additional R12 billion to be spent per annum. Despite the health system's desperate need for funds, Tshabalala-Msimang refused to calculate the country's health needs and properly quantify its human resource or budgetary deficits. For example, in 2007 she belligerently asked the SA Human Rights Commission why:

we need to get into an exercise, which will be very expensive and costly, of determining for all these areas and others the extent and the resource requirements of the backlogs, in order to determine needs based budget for the realisation of the rights in the Constitution?'<sup>30</sup>

Similarly, although Mbeki and the ANC occasionally engaged in fierce rhetoric against pharmaceutical company profiteering, his government did not take advantage of the flexibilities negotiated by developing countries at the WTO Ministerial meeting in Doha, in November 2001, under the TRIPS agreement.<sup>31</sup> These flexibilities permit developing countries to issue compulsory licenses on essential medicines under conditions that they consider constitutes a 'national emergency or other circumstances of extreme urgency' including HIV/AIDS, TB 'and other epidemics'. Hence the political determinants of the health crisis lie in large part with the refusal of developing country governments (particularly the so-called emerging economies that have available resources) to use state resources or legal authority to prioritise health in public policy. In the current context of a global financial turbulence and competing demands for huge social investment which will be deemed 'unaffordable' in the current economic climate, the health system may not receive the political attention or financial and other resources that it urgently require. What can be done about this?

## Stand up for your rights

One of TAC's most valuable contributions to post apartheid democracy has been its demonstration of the supremacy of South Africa's constitution, which encompasses both human rights and rules of government. This makes it possible to combine law with mobilization in order to improve social conditions. TAC has given practical demonstration of the role that courts can play in protecting rights, ensuring democratic practice, political accountability and insisting on openness and ethics in government. Its legal challenge to government in the PMTCT has been described as 'a new form of political trial.'<sup>32</sup>

Invoking and utilizing the Constitution, and all the rights it gives people in relation to government, is going to become more rather than less necessary in the years ahead. In addition, the demand for constitutional government, policy making and the fulfillment of duties needs to be directed at more than just issues of AIDS or housing. Such an approach is also relevant to some of the most fundamental inequalities in South Africa, including access to food and education – both rights in the Constitution.

But here too there is a hurdle to be overcome. The legalization of socio-economic rights by many countries, including South Africa, represents an important advance in the quest for social justice. However, many academic writers on health still appear to be in a quandary on this issue and activists are skeptical of the value of this development, largely because of a distrust of law and suspicion of 'liberal values' such as human rights. David Fidler, for example, worries whether human rights will become 'a morally compelling but politically ignored mantra'.<sup>33</sup> Aginam says we should 'de-emphasise justiciability and stress human dignity, indivisibility and the interdependence of all human rights.'<sup>34</sup> From a different perspective, *The Economist* tried to pour cold water on a human rights approach to challenging inequality:

Food, jobs and housing are certainly necessities. But no useful purpose is served by calling them 'rights'. When a government locks someone up without a fair trial, the victim, perpetrator and remedy are fairly clear. This clarity seldom applies to social and economic 'rights'. It is hard enough to determine whether such a right has been infringed, let alone who should provide a remedy or how.<sup>35</sup>

*The Economist* is not alone in its thinking, although some progressive academics come to the same conclusion through different arguments. In 2003 Patrick Bond questioned TAC's ability to use a rights-based campaign to compel the SA Government to introduce a national anti-retroviral treatment programme,

something that happened later in the same year. In a mea culpa he nonetheless concludes:

Such socio-economic human rights can be won, in my view, only through deglobalisation, namely the delinking of countries and regions of the world from the bureaucratic straightjackets designed in Washington and Geneva-structural adjustment, TRIPs, etc-on behalf of corporate interests. <sup>36</sup>

These writers are correct insofar as they think that the recognition of human rights in themselves will make a difference in the struggle against inequality. But they are mistaken insofar as they overlook the value that rights can play in social mobilization that aims to compel governments to carry out their duties. They are also mistaken in underestimating how rights can be utilized to reshape public policy and resource allocations. In a December 2007 issue of *the Lancet*, dedicated to the right to health, various writers assert that 'an equitable health system is a core social institution, no less than a fair court system or democratic political system.'<sup>37</sup> But they also point out, 'The right to the highest attainable standard of health encompasses medical care, access to safe drinking water, adequate sanitation, education, health-related information, and other underlying determinants of health.'<sup>38</sup>

In the same issue Amartya Sen states that human rights are necessary as not as 'the children of law' but as the 'parents of law': that is, as aspirations that law must find means to advance and protect: 'The right to health has similarly broad demands that go well beyond legislating good health care (important as that is). There are political, social, economic, scientific, and cultural actions that we can take for advancing the cause of good health for all.'<sup>39</sup>

Thus the wheel comes full circle, and we are back at the confluence of health, inequality, the duties of government to fulfill the right to health and the necessity for sustained and organized pressure on government from civil society. In this context let us look again at how law may assist the campaign for the right to health in South Africa and internationally. Today there is a growing body of domestic law on the right to health and state duties. More than 150 countries have become State parties to the International Covenant on Economic Social and Cultural Rights (ICESCR) which recognizes state's duties to take steps to achieve 'the highest attainable standard of physical and mental health' for their populations.<sup>40</sup> Fully 83 have signed regional treaties which recognize the right to health. And, more than 100 countries have incorporated the right to health in their national constitution.'<sup>41</sup>

*The Economist* and fellow rights-skeptics<sup>42</sup> would not dispute that a wrong is committed when people starve in a country that has a grain surplus (like India)

or die of AIDS within proximity of under-utilised private health care facilities (as they do in South Africa). But they would argue that such a finding is essentially moral rather than legal, and therefore of little remedial value. There was a time when this was true. However in the last few decades human rights have become more than just 'pious wishes'. Since 1990, there have been 71 documented court cases concerning the right to medical treatment, 59 of them successful.<sup>43</sup> Therefore the justiciability of the right to health no longer seems to be an issue. Rather, the problem revolves around how a court can meaningfully remedy its infringements and ensure the enforcement of its orders. It is also about how to persuade governments to take into account in all policy-making and resource allocations the positive duties that they have assented to. The international human rights Covenants, Treaties and Declarations such as the 2001 UNGASS Declaration of Commitment on HIV should all have bearing on what the state must do in relation to health. These are political issues as much as they are legal duties.

For those who are committed to social justice (including justice in health), the growing recognition (if not respect) for fundamental human rights in national and international law<sup>44</sup> provides an opportunity to mobilize poor people to compel their governments to fulfill the duties they have accepted on paper. But, it is also incumbent on civil society to better define the content and duties arising from crucial socio-economic rights. It is necessary to be able to state 'when a right has been infringed' and what a state must do to fulfill it. As the *Lancet* says: 'the right to health is not just a slogan, it has a concise and constructive contribution to make to health policy and practice.'

What are the duties that arise from the Constitution's recognition of the right of 'everyone' to 'sufficient food', 'appropriate social assistance'<sup>45</sup> and of children to 'basic nutrition' and 'basic education'? How will government be monitored to ensure that it is under constant pressure to fulfill these rights? Linked to this, is the necessity for civil society to demand that legal systems are made more affordable and accessible to people to assist them to 'remedy' violations of human rights.<sup>46</sup>

Looking at the years ahead, we can say that we have a policy framework rooted in the right to health, particularly the National Strategic Plan on HIV, AIDS and STIs and the Health Roadmap. Both documents create legal duties on government generally and the Minister of Health in particular. However, whether these duties are fulfilled will depend upon an active and effective civil society; the precise contours of the struggle for the realization of the right to health will depend upon how the Ministry sets about implementation of policy.

### **Towards a politics of rights**

In the same article in which it denounces the notion of socio-economic rights, *The Economist* states: 'For people in the poor world, as for people everywhere, the most reliable method yet invented to ensure that governments provide people with social and economic necessities is called politics.'<sup>47</sup>

The denial of health is political. Health (or the lack of it) has an impact on human capability, dignity, and the right to life, in a similar fashion to whether people have access to sufficient food or not. The denial of the right to health has been described by Paul Farmer as a form of 'structural violence' against the poor. That is, not just a violence of omission, but the predictable result of political neglect of poor people's socio-economic rights. Health is described as a socio-economic right, and a positive obligation that must be acted upon by the state. By contrast, protection against torture is described as a civil right, and a negative injunction. But the effect of a violation of either is the same: pain, indignity, incapacitation and often death. Both are preventable.

But whilst a growing acceptance of civil and political rights protects people in many countries of the world (although by no means all) from torture, the lack of respect for the right to health blights lives across the globe, but overwhelmingly the lives of the poor.<sup>48</sup> The outcry about the AIDS epidemic has contributed to a new focus on health and justice, which has exposed the whittling away of public health systems to a point where there are few doctors, few medicines and, with the exception of South Africa, a huge dependency on donor aid. It is estimated that AIDS has caused the death of 25 million people since the 1980s. Most of these deaths are in Africa. But, despite the social and humanitarian crisis this has caused, according to Alex de Waal: 'HIV/AIDS has turned out to pose a political threat no greater than familiar pathologies such as hunger and homelessness. AIDS has been politically domesticated. Anti-retroviral treatment has become the central mechanism for managing AIDS,..'<sup>49</sup>

What does de Waal mean? In many African countries AIDS has led to the emergence of independent civil society organizations, such as the AIDS and Rights Alliance of Southern Africa (ARASA)<sup>50</sup>. These organizations have begun to examine and challenge governmental conduct, including resource allocations and commitment to health. They have exposed gap between pledges and practice, such as the AU's 2002 Abuja commitment to spending 15 per cent of government expenditure on health.<sup>51</sup> In South Africa, AIDS spawned one of the most successful social mobilizations post apartheid. AIDS was a political running sore of the Mbeki government and contributed to the readiness of the ANC to dismiss him as President.

De Waal's conclusion may ultimately prove correct, but it is premature. AIDS activism has won access to treatment for many people who, in the past, governments would quietly have let die, believing that nobody would notice their deaths. However, if AIDS activism does not extend beyond the campaign for ARVs, then it may well end up being 'politically domesticated'. AIDS has exposed the fault lines of inequality in society. Ultimately it is these fault lines that must be attended to.

This chapter has tried to illustrate how health heavily influenced by the political choices made by government. Promoting and demanding the fulfillment of human rights is a political response to health that measures these choices against nationally and internationally agreed standards. In South Africa TAC pioneered a political campaign for health that was founded in human rights. However TAC's method has a potential not only for health, but also for mobilizations to demand delivery by government of housing, sufficient food, social security, education and employment – all ultimately determinants of health.

But what will it take to realize this potential? A cohesive civil society is essential. But unfortunately, it is arguable that in the drawn out politics of the succession battle for the ANC leadership, civil society, whilst not becoming more divided, has become more fragmented, and thus weakened. There are deep fissures that divide civil society over the approach adopted by the Alliance in its justifiable quest to unseat Mbeki, but its unprincipled quest to promote Jacob Zuma. The trade union movement in particular has encouraged the belief that a Zuma, however tainted, will be the foundation for policies that are more sympathetic to the poor and to equitable and sustainable development. As was evident from the ANC's 2009 election manifesto, new policies have been thrown up, but much less thought seems to have been given to how to implement these plans.

It seems probable that the next ANC government, whilst more sympathetic to the poor in its outlook, will not find itself in a position to better deliver on basic rights (or needs). What George Orwell termed 'doublespeak' in 1984 will become the order of politics. Already, for example, the promise to create jobs is being redefined as a promise to protect jobs.

As important as civil society coherence, is its ability to work strategically, building on legal principles and institutions that exist to ensure social progress. In the health arena, for example, TAC's advocacy has led to the fleshing out and empowerment of institutions of co-governance between civil society and government departments, such as the South African National AIDS Council (SANAC).<sup>52</sup> With regard to health more broadly, civil society should recognize and act upon the opportunities that have been created by the National Health Act, which sanctions the creation of Hospital Boards, district health committees

and national and provincial health consultative forums.<sup>53</sup> However both of these are ultimately dependent upon encouraging and building active citizenship, based upon a knowledge of rights and the responsibilities of government. In the context of the complexity of markets, political and legal reform, there seems little value in resuscitating the hackneyed mantra of political 'alternatives' that have been superseded by modern history.

In this context, the South African Constitution - and how it obliges government to use its resources - could be the ally of a government that genuinely seeks social betterment. It could be used to justify policy choices that may not be considered 'wise' by international financial institutions, but which can be framed as reasonable and legally binding state duties. In the advent of precedents that spent trillions of dollars bailing out failed companies in order to restore market stability, there is a strong legal and moral case to be made that this recession should not take its normal toll on poor people. But taking advantage of the Constitution in the years ahead, means protecting the Constitution and its institutions now, something the ANC is flagrantly not doing. To protect its President, it must perforce cast aspersions on the rule of law and its institutions.

If South Africa's leading political party and liberation movement will not protect the totality of the Constitution that it gave birth to, then this will be one of the most immediate and pressing responsibilities of civil society. South Africa is deeply divided in its inequality. In many areas (not surprisingly after 300 years where the majority of the population was legally disadvantaged), government is weak. As has been evident from the tender-fest of the South African government at all levels, the opportunities for corruption and self-enrichment are great. Social reform and, in the context of this chapter, reform of health systems, depends upon active democracy, continual engagement in policy making, monitoring of implementation and the unrelenting external and independent pressure of the poor on the government that owes a legal duty to improve their lives.

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<sup>1</sup> See *South African Health Review*, 2008, Chapter 16, Health and Related Indicators, Health Systems Trust.

<sup>2</sup> ANC, 52nd National Conference, Resolutions, available at:

<http://www.anc.org.za/ancdocs/history/conf/conference52/resolutions-f.html>

<sup>3</sup> Daniel Becker, Centro de Promoção da Saúde (CEDAPS) Health, Equity and Social Determinants, presentation to the University of Nijmegen, 23 May 2007.

<sup>4</sup> P Farmer, 'Structural Violence and Clinical Medicine', *Plos Medicine*, October 2006, Vol 3.

<sup>5</sup> The Constitution of the Republic of South Africa states that: 'Everyone has the right to have access to health care services, including reproductive health care' and that the 'the state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of these rights.' (s 27)

<sup>6</sup> Heywood M, 'South Africa's Treatment Action Campaign: Combining Law and Social Mobilisation to Realise the Right to Health', *Journal of Human Rights Practice*, Issue 1, Vol 1, 2009.

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<sup>7</sup> UNAIDS, *2008 Report on the Global AIDS Epidemic*, available at: [http://www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2008/2008\\_Global\\_report](http://www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2008/2008_Global_report).

<sup>8</sup> See: N Nattrass, *Mortal Combat, AIDS Denialism and the Struggle for Antiretrovirals in South Africa*, University of KwaZulu Natal Press, 2007.

<sup>9</sup> The South African health system is divided between a privately financed system, accessible to wealthy and employed people via medical aid schemes, and a tax-funded public system, used by the poor. Although poor people utilize the private system when they can afford it, rich people do not use the public system because of its disrepair. They two systems do not work together or share the same vision. In order to meet South Africa's health needs it will be necessary for the two to complement each other.

<sup>10</sup> T Rehle and others, National HIV Incidence Measures – New Insights into the South African Epidemic, *South African Medical Journal*, March 2007, Vol 97, No. 3, 194-199.

<sup>11</sup> S9 (1) and (2) of the South African Constitution.

<sup>12</sup> See T Mbeki, Speech at the Opening Session of the Thirteenth International AIDS Conference, July 2000, [www.anc.org.za/show.php?doc=ancdocs/history/mbeki/2000/tm0709.html](http://www.anc.org.za/show.php?doc=ancdocs/history/mbeki/2000/tm0709.html) : 'The world's biggest killer and the greatest cause of ill health and suffering across the globe, including South Africa, is extreme poverty.'

<sup>13</sup> Daniels N, Kennedy B, Kawachi I. 'Health and Inequality, or, Why Justice is Good for Our Health' (p 67) in S Anand, F Peter, A Sen, *Public Health, Ethics and Equity*, Oxford University Press, 2004.

<sup>14</sup> WHO, *Closing the Gap in a Generation, Health Equity Through Action on the Social Determinants of Health*, Final Report of the Commission on Social Determinants of Health, Executive Summary, 2008.

<sup>15</sup> The association between disability and poverty has not been properly studied or quantified in South Africa.

<sup>16</sup> It is important to note that by 'survival' I do not mean solely ensuring access to food, but also access to other commodities and resources that define modern living, and which very poor people see all around them, but lack money to acquire. In the words of *King Lear*: 'Allow not nature more than nature needs, man's life is cheap as beasts.'

<sup>17</sup> Research conducted in Swaziland and Botswana bears this out. Weiser SD, Leiter K, Bangsberg DR, Butler LM, Percy-de Korte F, et al, '[Food Insufficiency Is Associated with High-Risk Sexual Behavior among Women in Botswana and Swaziland](#)' *PLoS Medicine* Vol. 4, No. 10, e260 doi:10.1371/journal.pmed.0040260

<sup>18</sup> K Jochelson, *The Color of Disease, Syphilis and Racism in South Africa, 1850-1950*, 2001, Palgrave Macmillan.

<sup>19</sup> M Lurie, 'Migration and HIV/AIDS in Southern Africa: A Review' *South African Journal of Science* 96 (2000).

<sup>20</sup> M Hunter, 'The Changing Political Economy of Sex in South Africa: The Significance of Unemployment and Inequalities to the Scale of the AIDS pandemic', *Social Science and Medicine* 64 (2007) 689-700.

<sup>21</sup> C Campbell, *Letting Them Die, How HIV/AIDS Prevention Programmes Often Fail*, The International African Institute, 2003, 184.

<sup>22</sup> In its first term the ANC amended both the Medical Schemes Act and the Medicines and Related Substances Act, to try to control prices and improve affordability.

<sup>23</sup> A Sore Point, *Financial Mail*, May 9, 2008.

<sup>24</sup> A Roadmap for the Reform of the South African Health System, A Process Convened and Facilitated by the Development Bank of South Africa, 8 November 2000.

<sup>25</sup> See: Opposition Wants MECs Head, Independent Newspapers, 14 November 2008, reporting a budget shortfall of R3.1bn in KwaZulu Natal ; No Money for New ARV patients in the Free State – Health Department, Health-E News, 14 November 2008, reporting that the Free State had

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stopped enlisting new ARV patients because it had run out of money.

<sup>26</sup>ANC 2009 Election Manifesto, Together We Can Do More, available at:

<http://www.anc.org.za/show.php?doc=elections/2009/manifesto/manifesto.html&title=2009+Election+Manifesto>

<sup>27</sup> G Backman and others. 'Health Systems and the Right to Health: an assessment of 194 Countries' *The Lancet*, Vol 372, December 13, 2008, 2047-2085.

<sup>28</sup> In *Public Health, Ethics and Equity* (see footnote 8) Sen et al provide evidence to show how redistributive economic policies have a positive outcome on health. On the other side of the coin, however, successful campaigns for health can also bring about economic and social redistribution.

<sup>29</sup> The Presidency, Republic of South Africa, *Development Indicators Mid Term Review*, 2007, p 10.

<sup>30</sup> See address by the Minister of Health to the SA Human Rights Commission, 30 May 2007.

<sup>31</sup> B Loff, M Heywood 'Patents on Drugs: Manufacturing Scarcity or Advancing Health?' *The Journal of Law Medicine and Ethics*, Vol 30:4, Winter 2002

<sup>32</sup> D Davis, M le Roux, *Precedent and Possibility, The (Ab)use of Law in South Africa*, Double Storey, Books, 2008.

<sup>33</sup> D Fidler, Constitutional Outlines of Public Health's 'New World Order', 77 *Temple L. Rev.* 313 (2004).

<sup>34</sup> O Aginam, *Global Health Governance International Law and Public Health in a Divided World*, University of Toronto Press, 2005, 36.

<sup>35</sup> *The Economist*, March 24, 2007.

<sup>36</sup> Z Net Daily Commentaries, *Can Victory on AIDS Medicines Catalyse Wider Change?*, Dec 1 2003

<sup>37</sup> *Ibid*, *Lancet* 2082.

<sup>38</sup> *Ibid*, *Lancet* 2048.

<sup>39</sup> A Sen, 'Comment: Why and How is Health a Human Right?' *The Lancet*, Vol 272, Issue 9655, 13 Dec 2008.

<sup>40</sup> Articles 2, 11 and 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) deal with duties of States to assist each other and the rights to 'adequate food' and the 'highest attainable standard of physical and mental health' See:

[www.ohchr.org/english/law/index.htm](http://www.ohchr.org/english/law/index.htm)

<sup>41</sup> Hogerzeil, H et al, 'Is Access to Essential Medicines as Part of the Right to Health Enforceable Through the Courts', *The Lancet*, Vol 368 July 22, 2006 [www.thelancet.com](http://www.thelancet.com). These cases were in Argentina, Bolivia, Brazil, Columbia, Costa Rica, Ecuador, India, Nigeria, Panama, San Salvador, South Africa and Venezuela.

<sup>42</sup> See: A Neier, Social and Economic Rights: a Critique:

[www.wcl.american.edu/hrbrief/13/2neier.pdf](http://www.wcl.american.edu/hrbrief/13/2neier.pdf). Neier claims that the socio-economic rights in the SA Constitution and Universal Declaration of Human rights 'get [us] into territory that is unmanageable through the judicial process and that intrudes fundamentally into an area where the democratic process ought to prevail.' But this claim entirely misses the dialectical relationship that should exist in a democracy between legal systems and politics. The two should be part of a continuum and a process for ensuring accountability.

<sup>43</sup> *Ibid*, Hogeril.

<sup>44</sup> H Klug, *Constituting Democracy, Law, Globalism and South Africa's Political Reconstruction*, Cambridge University Press, 2000.

<sup>45</sup> In early 2009 a proposal for Chronic Illness Grant was developed under the auspices of the South African National AIDS Council (SANAC). It arises from the Constitutional duty to provide appropriate social assistance. Predictably it has major cost implications and will be an early struggle to test whether constitutional duties trump fiscal restraint by the next government and how 'available resources' are determined.

<sup>46</sup> A Hassim and M Heywood, 'Remedying the Maladies of 'Lesser Men or Women': The personal, political and Constitutional Imperatives for Improved access to Justice', *South African*

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*Journal on Human Rights*, 2009.

<sup>47</sup> *The Economist*, *Ibid*

<sup>48</sup> In 2006, Lawrence Gostin published an article arguing for the development of a UN Framework Convention on Global Health. See L Gostin. Meeting the Survival Needs of the World's Least Health People, A Proposed Model for Global Health Governance, *JAMA*, July 11 2007, Vol 289, 2, 225-228.

<sup>49</sup> De Wall, A. *AIDS and Power – Why there is No Political Crisis Yet*, Zed Books, 2006, 119.

<sup>50</sup> [www.arasa.info](http://www.arasa.info)

<sup>51</sup> African Union, Abuja Declaration on HIV/AIDS, Tuberculosis and Other Infection Diseases, April 2001.

<sup>52</sup> [www.sanac.org.za](http://www.sanac.org.za)

<sup>53</sup> AIDS Law Project, Siberink. The National Health Act 61 of 2003, A Guide, available at [www.alp.org.za](http://www.alp.org.za)