The Treatment Action Campaign's First Decade: Success Achieved?

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<th>Abbreviation</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired immune deficiency syndrome</td>
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<tr>
<td>ALP</td>
<td>AIDS Law Project</td>
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<td>ARV</td>
<td>Anti-retroviral</td>
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<td>COSATU</td>
<td>Congress of South African Trade Unions</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>MSD</td>
<td>Merck Sharp and Dohme</td>
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<td>MSF</td>
<td>Medicines Sans Frontieres (Doctors without Borders)</td>
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<td>PMA</td>
<td>Pharmaceutical Manufacturers' Association</td>
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<td>PMTCT</td>
<td>Prevention of Mother-to-Child-Transmission</td>
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<td>SANAC</td>
<td>South African National AIDS Council</td>
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<td>SMO</td>
<td>Social Movement Organization</td>
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<td>TAC</td>
<td>Treatment Action Campaign</td>
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<td>TL</td>
<td>Treatment Literacy</td>
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<tr>
<td>TRC</td>
<td>Truth and Reconciliation Commission</td>
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<td>UN</td>
<td>United Nations</td>
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<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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INTRODUCTION

South Africa is known to have the largest HIV epidemic in the world with 5.7 million people currently living with HIV (UNAIDS). In view of the scope of the HIV/AIDS crisis, South Africa’s Treatment Action Campaign (TAC) has led a broader social movement to increase access to HIV/AIDS treatments. As a leading social movement organization (SMO), TAC addresses the HIV/AIDS epidemic in South Africa through multiple means. Identifying the government as a key actor, TAC has fought for health programs and policies, as well as adherence to the policies put in place. Next, realizing the need for drug therapy TAC has targeted pharmaceutical companies to make HIV treatment more accessible. Thirdly, recognizing the needs of various groups impacted by the disease, TAC has implemented programs to address the needs of especially vulnerable communities such as pregnant women with HIV, youth, and immigrant and refugee populations.

Since the founding of the organization a decade ago, the Treatment Action Campaign has been highly acclaimed within the country and sub-Saharan region as a model organization within the HIV/AIDS social movement. TAC has been recognized for the success it has achieved in 2003 as the recipient of the Nelson Mandela Award for Health and Human Rights and prides itself as a 2004 Nobel Peace Prize nominee.

Now, I seek to investigate whether or not the Treatment Action Campaign is truly successful. First I will define the parameters within which to measure success. I will grapple with questions such as: what defines success and how can it be measured? By what criteria can TAC’s performance be measured? What conditions are necessary to achieve success?
Moreover, given that TAC is a highly recognized and celebrated group, one might wonder why TAC has not achieved more. Provided that TAC fits the criteria for possessing the qualities of a potentially “successful” group, could it be discovered that it has not achieved the success that is expected of this sort of organization? Through this paper, I will set up a framework to measure TAC’s success and then use it to assess its political and social/cultural outcomes. TAC’s political strategies are well-known and seem to be successful at first glance. On the other hand, measuring social and cultural outcome will be much more difficult due to the subjectivity of the matter.

Overall measuring the political outcome (i.e. the creation of treatment programs and health policies) has been straightforward, but I have found that measuring the social and cultural outcome of the social movement on HIV/AIDS is more complex. There is much more ambiguity in the measurement of social and cultural outcomes. Nevertheless, I will attempt to determine whether or not TAC has met its potential and if TAC is truly a successful social movement organization.

**LITERATURE ON THE ASSESSMENT OF SOCIAL MOVEMENT SUCCESS**

The Treatment Action Campaign of South Africa is well known in the sub-Saharan region and highly acclaimed for its efforts to thwart progression of the HIV/AIDS epidemic. It is my aim to examine TAC within the social movement discourse in order to determine its success. Many scholars have theorized about what is necessary for a social movement to thrive given the political and social climate. Scholars often examine collective action through theories such as the political process theory and resource mobilization theory, distinguishing what is necessary in order for a social
movement to generate successful collective action. Within the discussion of the evolution of social movements, there is an ongoing debate as to how to measure success. The dialogue of what constitutes success and what measures are appropriate for determining success has yet to come to conclusion. The units of analysis explored by social movement scholars vary. Some scholars focus on political impacts while others examine cultural or social impacts of the social movement. There is disagreement over which indicators should be considered in order to determine social movement success and a gamut of possibilities has been explored.

The emergence of collective behavior gave rise to theories which guide social movement research such as the political process model. Scholars of political process theory present the case that mobilization takes place in the wake of specific political opportunities, placing emphasis on the external political environment being conducive to the movement’s goals and initiatives (Bernstein 2003, 358). According to the political process model, movements are likely to develop and emerge during times of favorable external political conditions which present opportunities to groups in weak social positions the incentive to be potential challengers (Morris 2000, 446). Morris (2000) claims that in order for groups to engage in successful collective action, they must be exposed to an external political opportunity which is advantageous for the challenging group.

Another social movement theory stresses the aggregation of resources, which includes but is not limited to resources such as money and labor. This approach, known as resource mobilization theory, is at the core of Giugni’s (2004) study of organizational variables and success of social movements. Resource mobilization theory places social
organization as a precondition for collective action, while also emphasizing the ability to mobilize appropriate resources for collective action to take place. Giugni follows the central argument of Gamson in *Strategy of Social Protest*, referring to Gamson’s work as the most systematic inquiry of social movement impact and effectiveness. Gamson (1990) examined the trends and tactics of social movements that achieved success. His study of social movement theory included organizational structure, external crises, and the movement’s use of violence and then finally correlated these features with the movement’s overall success.

Another scholar on resource mobilization theory, Jenkins (1983) expands on social movement theory, adding that resources can be accumulated in not only tangible, but also intangible forms. Tangible resources are those such as money, facilities, and means of communication, whereas intangible resources are those of “human” assets such as organizing and legal skills of participants, and unspecialized labor from supporters (Jenkins 1983, 533). Both sets of resources are vital to operating towards a movement’s goals.

Furthermore, Jenkins explains that resource mobilization theorists view social movements as extensions of institutionalized actions. These theorists argue that social movements can attempt to influence the elements of social structure and organize groups that have previously been unorganized against the institutional elite for example, through legal reform. As a result, social movements must carry out clearly defined, rational actions in order to pursue their specified interests and fixed goals.

These theories, while looking at the conditions in which social movements arise, hint at the ways in which success of social movements can be determined. Each theory,
examining the political backdrop or the ability to mobilize resources, shows what elements may be necessary to achieve success. Scholars have utilized these theories in order to identify indicators of social movement success. Some have targeted political and legislative outcomes as the key indicators of success while others argue that consideration of social and cultural outcomes are also relevant. These are primarily external indicators of success, meaning that the results occur within the external targeted group such as the institutional elite or specific governmental policies.

Meanwhile, other scholars examine internal indicators of success, which are the internal results and benefits that are experienced by the participants of the social movement. Internal factors themselves may play a significant role in affecting the mobilization potential of the movement.

Scholars Tilly and Tarrow (2007) look at three other effects of social movements, examining both external and internal impacts. First, they examine the direct external impact of social movement campaigns on public policies. Second, they examine the internal impact on the lives of activists by observing the effects of participation in claim-making campaigns. And thirdly, they examine the effect of outside campaigns on the social movement itself. Their work primarily involves campaigns that organize public efforts to make collective claims on those in authority. This approach incorporates external as well as internal impacts of a social movement’s actions while also considering the effects of involvement within the social movement as a whole.

Giugni (2004) also examines the external impact on public policy, although he stresses the importance of internal variables and resource mobilization as contributing factors in the determination of the group’s success. Following Gamson’s foundational
work, Giugni (2004) proposes the following areas of movement success: policy change, change in policy process, and changes in social values. Giugni’s determination of success is dependent upon changes seen externally rather than internally within the social movement.

Providing another alternative, Brown (2005) turns to a different set of categories to assess movement impact and success. Brown measures the success of social movement organizations through the assessment of what he calls “outcome success”, “legislative success,” and “perceived success”. The first measure, outcome success, requires examination of the collective benefits and actual changes for the members of the group. Brown argues that this is the ultimate measure of success. Outcome success, as described by Brown, depends on the combination of the context in which the organization works and the specific demands and tactics implemented by the group in order to achieve their goals. Other variables can also influence the attainment of outcome success, such as the influence of the national government, public opinion, and policy changes.

Next on Brown’s set of categories is legislative or policy success, which is “typically measured in terms of policy gains through changes in laws and allocation of money” (Brown 2005, 12). Political change, an external impact, is often cited by various social movement scholars as previously noted. In the same vein, Brown explains legislative success as the changes seen within the government’s legislative body through which the social movement’s goals are realized. The implementation of policy change or new programs does not guarantee that the group’s goals will be realized. But Brown sees legislative change as “benchmarks on the road to real change” (2005, 11).
And lastly, perceived success is the internal perception of success. This means that the organization and its leaders determine the extent to which they believe they have been successful. This measure is very subjective and depends on the goals and expectations the group has of itself. This measure of success will be heavily reliant upon internal operations of the group, which can greatly influence the group’s ability to achieve outcome and legislative success. Brown notes that the greater the degree of radicalism of the group’s goals, the lower the rate of achievement (Brown 2005, 17). These categories of success measurement take into account internal and external factors that influence a group’s operation and results of their campaigns.

On the other hand, Bernstein (2003) presents another set of categories through which to determine social movement success. The categories, originally framed by Staggenborg (1995), include political and policy outcomes, mobilization outcomes and cultural outcomes. Bernstein focuses on the relationship between various strategies and outcomes used by activists, usually finding that the political opportunities highly influence strategic choices and in turn, the results achieved. Scholars of political process theory argue that mobilization takes place in light of specific political opportunities, placing emphasis on the external political environment being conducive to the movement’s goals and initiatives. Although true, Bernstein also emphasizes that the strategic choices of activists are a result of how they understand the relationship between mobilization, political, and cultural effects.

As many scholars examine political impacts as determinants of success, powerful political actors usually dominate the spotlight. However, Morris (2000) urges consideration of the impact of human agency, not only from powerful political actors but
also challengers in less powerful positions. Morris argues that the importance of non-elite players, such as grassroots volunteers, is often overlooked in the success of social movements. As mentioned earlier, these grassroots actors serve as internal resources to the social movement.

In order to assess the success of the Treatment Action Campaign, it will be necessary to examine resource mobilization and political opportunity as explained by Giugni and Bernstein. Jenkin’s offers insight into the internal and external resources involved in resource mobilization. Morris highlights the importance of non-elite players, who are crucial to TAC’s grassroots operation to recruit members. Consideration of non-elite actors is instrumental to TAC’s ability to mobilize human resources.

Indeed, social movement scholars have provided a plethora of ways in which to measure success. My study of the Treatment Action Campaign, using the political process model and resource mobilization model, will allow for examination of both internal and external factors influencing the organization’s effectiveness in the HIV/AIDS epidemic in South Africa. Given South Africa’s unique political history and scope of the HIV/AIDS epidemic, examination of the political opportunity structure will be necessary. And since TAC is highly praised for its success in mobilizing hundreds to thousands of people, I will examine TAC’s mobilization potential as well as framing within the South African cultural and social context.

**RESEARCH DESIGN**

I will assess social movement success by examining the Treatment Action Campaign, an advocacy organization in South Africa. The very name of this organization
often perplexes the observer. If the Treatment Action Campaign is a non-profit non-governmental organization, why do they call themselves the Treatment Action Campaign? The term “campaign” signifies a far different meaning than would a name such as the Treatment Action Organization. Although TAC’s name incorporates the term campaign rather than organization, it is nevertheless a non-governmental organization, meaning that it operates separate from the government. TAC does not accept government funding in an effort to maintain its independence.

In order to study social movement success, we must clarify what social movements are. For our purposes, social movements are collective challenges identified by a group with a shared purpose and social solidarity, engaged in the effort of sustained interaction with elites, opponents, and authorities (Tarrow 1998). They mount claims against their opponents after identifying common or overlapping interests and values. However, in order to launch a social movement they must be able to maintain their challenge. Social movement scholar, Della Porta (2006) notes social movements are fluid, adjusting to the political and social contexts from which they emerge.

Organizations that function within social movements can be referred to as “professional” social movement organizations (SMO). In some cases, a single organization will drive a movement (Della Porta 2006). These organizations are more rigid and hierarchical in structure and usually exert a higher degree of social control over their members. We will find that the Treatment Action Campaign functions as a lead social movement organization.

Although the Treatment Action Campaign is a social movement organization, they include campaign in their organization title. A campaign is defined as a collection of
strategically connected activities which are explicitly organized by a group of network members in pursuit of a common goal and usually against a specific target (Keck and Sikkink 1998, 6). In a campaign, the core network actors are able to create a common frame of meaning which is then used to mobilize people and organizations. This process occurs as the network actors negotiate within and among the groups in the network and connect the groups to each other. They also seek out resources such as information, leadership, and symbolic or material capital while also proposing activities and conducting public relations (Keck and Sikkink 1998, 7). Activists identify problems, specifying the cause of such problems, and then propose solutions. Here, the activists keep in mind that their goal is to not only solve the issue but also seek to produce procedural, normative, and substantive change in the broader area of concern (Keck and Sikkink 1998, 8). In this study, a number of TAC’s campaigns will be examined.

**How to Measure Success**

The goal of this study is to create a framework to analyze social movement organizations and apply it to the case of TAC. Using the success framework I will determine whether or not TAC is a successful social movement organization. Therefore, it is first necessary to identify the key variables of this study, as well as how they will be measured.

The assessment of TAC’s success will be based on examination of the independent variables and dependent variables. Here the independent variables are the factors influencing success: mobilization potential, external political opportunity structure, and framing and social context of the issues (See Figure 1). The dependent
variable is success which will be measured through the examination of political and cultural/social outcomes. (See Figure 2).

In this study, the independent variables are the factors that influence the success of the SMO. Before attempting to evaluate the success of TAC, I will explore the independent variables by looking at three dynamics that influence success. These include:

(1) the mobilization potential of the SMO, (2) the external political opportunity structure in which the SMO operates, and (3) the framing and social context of the issues the SMO tackles. I recognize that these variables are often intermingled and compliment one another. For example, mobilization potential and political opportunity structure often go hand in hand. However, for my purposes of identifying the factors that influence success I will separate these variables and examine them separately.

For the specific case of the Treatment Action Campaign, I will examine the first independent variable, mobilization potential of the SMO, the exploration of TAC’s accrual of both internal and external resources. An internal resource like human capital is
generated by the involvement of high profile players, skilled professionals, and members of the local community who fill staff and volunteers roles within the organization. External resources include financial funding, facilities, and material goods. Other elements that contribute to the mobilization potential include the SMO’s collaboration and connection to the media, other civil society organizations, international affiliates and financial donors. These internal and external resources shape the mobilization potential of the SMO, which then influences the success of the social movement. In order to grasp the size of TAC’s mobilization potential I will look at the human capital of the organization and its network of donors and other civil society organizations.

I will explore the second independent variable, political opportunity structure, by examining the creation of the post-apartheid Constitution and how this new Constitution provides an enabling environment in which TAC can make claims on issues surrounding HIV/AIDS. Other components of the political structure include the operation of the Court system and whether or not it allows the SMO to take legal action against the government. In conjunction with the examination of the South African Constitution and court system, I will discuss the atmosphere of post-apartheid civil society which provided the momentum for the creation of TAC as a leading social movement organization.

The third independent variable to be explored is the framing of issues within the society. The framing of issues is vital to the organization’s ability not only to gain members but also to give the community at large insight into why the issues proposed by the social movement are important and how the issues should be confronted. The social context can determine what issues the organization chooses to take up. Therefore, I will look at public perceptions of the severity of the HIV/AIDS epidemic and the issues
related to it using data from public opinion surveys known as the Afrobarometer. I will also explore the presence of counter-messages such as AIDS denialism, supported by former President Thabo Mbeki, the Health Minister, and traditional healers, and how that has played a role in framing issues with the social movement.

Now I am ready to begin assessment of the dependent variable of success (refer to Figure 2). Since the impact of social movements is multidimensional, success will be conceptualized as a function of two outcomes: (1) political outcome, (2) cultural/social outcome. Political outcome is the change in the government or legislative level which includes changes or creation of government policies. Cultural/social outcomes, which can also be referred to as social outcomes, are the changes in social norms, beliefs, and behaviors. I contend that a positive outcome in both areas is necessary for the success of a SMO, because each outcome has a domino effect on the next outcome. For example, a positive political outcome will allow for a positive cultural/social outcome. Positive achievement in both outcomes is necessary for success of the SMO. A positive political outcome must translate into a positive social/cultural outcome for the SMO to be considered successful. In the end, a positive political and social/cultural outcome will constitute success of the Treatment Action Campaign.
The political outcome of the Treatment Action Campaign will be measured by counting the number of policies changed or created, whether the goals within policies are met, and the number of victories in cases in which TAC takes the South African government or international pharmaceutical companies to court. It will be concluded that the political outcome is positive if the organization is successful in creating or changing policies in accordance with their targeted goals. Certainly, winning court cases in favor of TAC’s position will constitute a positive outcome. However, the inability to successfully alter policy or government denial of the creation of policy will be considered as a negative political outcome, as well as losing court cases. TAC’s involvement in the creation of the National Strategic Plan on HIV/AIDS and the SMO’s pressure on the government for the creation of a policy on the prevention of mother to child transmission of HIV will be closely examined. TAC is known to exert pressure on the government and has even sued the government and taken it to court for failure to comply with national policies and legislation. The results of pivotal cases such as Minister of Health v. TAC (2002) will be assessed to see if a positive political outcome is achieved.
But, TAC’s court involvement is not limited to targeting the government. TAC’s struggle to increase access to treatment has led it to target pharmaceutical companies as well. Hence, I will examine the results of the case TAC v. MSD and Merck. A court ruling in favor of TAC’s position will be considered to be a positive outcome as opposed to a court ruling in favor of the pharmaceutical companies being considered as a negative outcome. Therefore, the change and creation of policy in addition to winning court cases will add up to a positive political outcome, leading the organization in the direction of success.

The second outcome to be examined to determine if the Treatment Action Campaign is successful is the cultural and social outcome. Cultural outcomes can occur in shifting belief systems and practices. As I examine the role of AIDS denialism by both the former Health Minister and the former President, I will explore whether or not TAC has exerted a positive influence to counter-act and reduce AIDS denialism. Also, the use of traditional healers and cures will be examined. For example, the case of Matthias Rath, a self-proclaimed traditional healer who provides vitamins as AIDS cures, will be studied. I will examine how the TAC has tackled the case of Rath’s so-called AIDS cure and how this has or has not altered cultural beliefs about the disease and its treatment. The cultural outcome of TAC’s efforts will be determined by whether or not TAC has influenced society enough to lead the public to deny Rath’s claims. This will be assessed through data from newspapers’ documentation of public opinion. If TAC’s effort reduces AIDS denialism, it will be counted as positive. Also, decreased stigma of HIV positive status as well as greater understanding and adherence to treatment will contribute to a
positive social outcome. This is to be assessed through analysis of the efforts in TAC’s Cool Youth and Treatment Literacy campaigns at the grassroots level.

For the Treatment Action Campaign to be a successful social movement organization, it must be found that it has achieved a positive political outcome and positive cultural/social outcome. The mobilization potential will affect the political outcome. If positive outcomes are accomplished, I will deem TAC successful.

A case study of the Treatment Action Campaign of South Africa will be valuable for several reasons. The HIV/AIDS crisis across the sub-Saharan region affects two-thirds of all people suffering with AIDS globally. According to UNAIDS, South Africa has the largest HIV epidemic in the world. In the depths of this epidemic, the Treatment Action Campaign has emerged with the goal of increasing access to treatment for those living with HIV/AIDS. TAC has served as a model social movement for groups in other countries on the continent also experiencing the HIV/AIDS epidemic. Observers often ponder why they are not able to mobilize and launch a movement like that of the Treatment Action Campaign.

Not only has the Treatment Action Campaign been recognized nationally and within the region, it has also been in the international spotlight. In addition to its Nobel nomination, TAC has also been featured in the New York Times on several occasions as well as in Time Europe, where journalist Peter Hawthorne referred to TAC as the “country's leading AIDS activist movement.” Other international organizations such as OXFAM and the Ford Foundation have supported and funded TAC in their efforts in the fight against the epidemic.
Certainly, TAC’s international, regional and domestic popularity as well as publicity have increased over the past decade. But is TAC truly as successful as it is perceived to be? This study seeks to analyze the true success of TAC by engaging social movement theory.

Organizational Structure of TAC

In order to do so, we must explore the organization on multiple levels. TAC operates as four levels – national, provincial, district and branch levels. The National Office, located in Cape Town, is the political arm of the organization. Staff and volunteers often deal with representatives of government and seek to influence health policies while also drawing attention to government noncompliance with its own legislation.

TAC has six provincial offices in nine of South Africa’s provinces. I will focus on the Western Cape Provincial office in order to see how it manages the multiple district offices within the province. The Western Cape Provincial office, where I was able to work for four weeks in January and February 2008, is mainly responsible for administrative tasks and organization of district-level activities, including thousands of community members in order to protest for various causes.

Next are the district offices. The Khayelitsha District office in Site B is the largest district in TAC and serves as the model district. I will examine the Khayelitsha district office and the multiple campaigns run through this office. The district offices are primarily the ones responsible for the branches within their district. The Khayelitsha district office manages 14 branches within the area, which together mobilize existing
members and recruit new members. The district and branch levels are the social arms of the organization. They play an enormous role in mobilizing members of the community.

Data Sources

The case study of the Treatment Action Campaign will be developed through data gathered from multiple primary and secondary sources. My trip to South Africa (through the UConn Honors in Cape Town program in 2008) allowed me to carry out participant observation of the inner workings of the Treatment Action Campaign in Cape Town. Observations of the organization were collected from January to April 2008, during which time I served as an intern in several TAC offices. I began in TAC’s Western Cape Provincial Office working for 21 hours per week, from January to February 2008. Most of this time was spent preparing for TAC’s Western Cape Provincial Congress, attended by TAC delegates from 14 branches within the Western Cape along with staff and volunteers from the TAC National Office. In preparation for the Congress, I worked under the supervision of the Western Cape Coordinator Fredalene Booysen. My responsibilities included database management of over 1000 TAC members and volunteers; drafting letters and invitations for the Congress; and preparing packets to be distributed at the Congress.

After attending the Western Cape Provincial Congress from February 8-10, 2008, I transferred to the Khayelitsha District office, where I interned for 24 hours per week for a period of 10 weeks. During this time I was given administrative duties as the interim Administrator of the office, often dealing with the finances of the office as well as re-organizing TAC archives and records of the organization’s various campaigns. I participated in weekly staff meetings and worked closely with staff members as well as
volunteers within the Khayelitsha office. I also attended court cases in the Khayelitsha Magistrate Court and the Cape Town High Court and also protested and marched alongside TAC members for various causes within the HIV/AIDS community. I attended branch meetings within the Khayelitsha District and other events connected with their various campaigns for youth and treatment literacy.

Though my experience with TAC is not limited to what has been described above, it afforded me the opportunity to gather data through participant observation. I will supplement this with archival data from the organization as well as internal documents and publications such as TAC’s Congressional Reports and *Equal Treatment*, TAC’s magazine publication. In addition, other primary source data will include South African government policies outlined in the National Strategic Plan on HIV/AIDS and documentation from relevant court cases available through the South African Government website. In addition, I will use statistical data from the United Nations available through UNAIDS and the World Health Organization (WHO).

Additionally, I will use secondary sources such as scholarly articles and books both to deepen my assessment of TAC and to assess the campaign in relation to broader social movement theory. The work of key authors in social movement literature, such as Tilly and Tarrow (2007), McAdam, McCarthy and Zald (1996), Giugni (2004) and others will be closely examined. Articles from scholarly journals such as *Social Policy* and *Politics & Society* have analyzed the Treatment Action Campaign. Several books will be utilized to further assess TAC’s activities and the political arena in which TAC operates, such as Alex de Waal’s *AIDS and Power: Why There is No Political Crisis - Yet* (2006) and Pieter Fourie’s *The Political Management of HIV and AIDS in South Africa* (2006).
This combination of sources will provide me with ample data for answering the central question at stake: whether or not the “success” of the Treatment Action Campaign is a fitting reality or an inaccurate impression.

History and Establishment of the Treatment Action Campaign

The Constitution of South African is known to be one of the most progressive in the world. It includes many of the core human rights central to the Universal Declaration of Human Rights, including a range of economic rights.

The Treatment Action Campaign was founded as the next major threat emerged in the post-apartheid era: the HIV/AIDS epidemic. This epidemic menaces the progression of the reconstruction and development of the new South Africa, not only impeding the evolution of economic and political transformation, but also social and cultural growth.

TAC was founded on International Human Rights Day, the 10th of December, 1998. The emergence of a ‘rights based’, ‘patient-driven’ civil society organization was the result of a fusion of the gay-rights movement during and post-apartheid. The gay-rights movement and newly declared Constitution of South Africa allowed for the germination of such an organization to sprout on firm ground.

During the 1990s the stage was set for the formation of the Treatment Action Campaign. The distinct democratic culture of the post-apartheid government gave way for civil society to test its right to freedom of speech, right of assembly and right to information. Even more, the culture of rights provided a language which would be significantly utilized by TAC in order to push towards greater access to HIV treatment. By identifying the potential power of human rights, TAC comrades created an enabling environment in which to birth a new social movement and fight for socio-economic
justice through equal treatment for HIV. In order to provide an explanation of the political environment in which TAC arose, it is necessary to dive into the history that led to its establishment.

It was not until 1982 that AIDS had surfaced in South Africa. Into the mid-1980s it was estimated that somewhere between 10 and 15 percent of gay men in Johannesburg were infected with HIV. Soon thereafter, the gay rights movement quickly added HIV/AIDS activism to its agenda. Gay rights activists such as Zackie Achmat and Edwin Cameron, persons who will be further elaborated upon later, were great contributors to the formation of the Treatment Action Campaign, in addition to the influences of other groups and people. One notable influence on TAC was the AIDS Coalition to Unleash Power, also known as ACT UP, established in the United States in the 1980s. This radical group targeted pharmaceutical companies and AIDS researchers as well as to the US government for inadequate attempts to develop an effective HIV Treatment within the first decade of the epidemic. ACT UP was known for its loud presence, staged ‘lie-ins’ (as opposed to “sit-ins”) and powerful political slogans, all tactics that have influenced TAC’s activism strategies.

Another significant catalyst to the formation of the TAC was the life and death of ANC leader and gay-rights/AIDS activist Simon Nkoli. This led Achmat to vow to drive forward “Nkoli’s struggle for openness and the protection of the rights of people living with HIV, especially their right to treatment access” (Mbali 2005, 10). Achmat wrote in a letter to HIV/AIDS activists in 1998 following Nkoli’s death,

“On Friday night at Simon’s funeral I made a call for ten people with HIV/AIDS, their families and friends and allies to start a symbolic fast for access to treatment on 10 December 1998… Openness and treatment are two pivotal issues…A campaign for ‘Openness’ is in reality a call for activism and the assertion of identity. People with HIV/AIDS are on our own (whether in or out of the closet)
– while we should seek love, compassion and care – we should also demand treatment.”

This call for the creation of the TAC was a call for a movement led by HIV positive activists who are open about their status. Since then, openness about HIV status has been a pivotal benchmark of the organization’s political and social strategy. Achmat’s call was met with a mix of thousands of both HIV positive and HIV negative activists wearing t-shirts boldly displaying the image ‘HIV POSITIVE.’ This strategy of openness transformed the HIV epidemic from one that was silent and invisible to one that is politically loud and vocal with a large visible constituency, which provides leverage to the equal treatment movement led by the TAC. The promotion of openness proved to be a powerful political tool.

Whereas in the early 1990s, human rights-focused AIDS activists were directing their efforts to sustain greater respect for the right to patient confidentiality, in the late 1990s human rights-focused AIDS activists utilized openness and HIV status as a way to demand greater respect for the socio-economic right to access to health care. This led to so-called “patient-activism”, driven by people living with HIV/AIDS. This is an attribute of the TAC which is widely reflected within the organization to this day. Furthermore, HIV/AIDS discussions were no longer held in the third person, as if speaking of an abstracted third party, but now taken place in the first person, giving a human face to the epidemic.

In addition to the creation of an atmosphere of openness, the political arena in the post-apartheid nature fostered an environment in which an organization such as TAC could be created. The emergence of TAC was influenced significantly by two historical developments post 1994: the development of antiretroviral drug therapy, and the adoption
of the new South African Constitution, which specifically outlined socio-economic rights. Mobilization was crucial for the former due to two blockages in access to HIV treatment. The first was the protection of patent monopolies, utilized by the pharmaceutical industry’s, and the second was AIDS denialism within the government. Several key government officials, such as President Mbeki and the Health Minister, rejected the efficacy and safety of HIV treatment due to their AIDS denialist ideologies. Needless to say, this had resoundingly negative consequences on the HIV/AIDS community.

Before concluding the history and establishment overview, several other notable persons must be mentioned. As noted earlier, the death of Simon Nkoli spurred Achmat to carry out Nkoli’s struggle for openness and access to treatment. But near this time, Gugu Dlamini, a 36 year old woman, openly pronounced her HIV positive status on the radio at a World AIDS Day ceremony. Three short weeks later, Gugu was murdered by men in her community because of her HIV positive status. In remembrance of her life and protest against her needless death, 100 shirts were printed with the logo ‘HIV POSITIVE.’ Hence, “TAC’s struggle for social justice and the rights of people with HIV and AIDS had begun” (TAC Diary, 2008).

Since the formation of the TAC, numerous campaigns and court cases have generated vast media publicity. This has allowed for greater awareness surrounding HIV/AIDS rights and discrimination as well as mobilizing greater numbers within civil society. TAC has battled the South African Government and international pharmaceutical companies in order to press forward for equal treatment for all people. And as TAC prepares for the future, its members continue to strive for health equality, while remembering those who they have lost and celebrating those who remain with them.
ANALYSIS OF TAC SUCCESS

Analysis of TAC’s success will be assessed in two steps. First, I will thoroughly examine all the independent variables and its multiple components. Then, I will examine the dependent variable, success, by measuring positive political, cultural, and social outcomes (refer to Figures 1 and 2).

INDEPENDENT VARIABLE

Now I am ready to assess TAC’s success by first examining the independent variables of political opportunity structure which involves components including the Court system and the Constitution among others.

Political Opportunity Structure

Anti-apartheid struggle and post-apartheid civil society

From 1945 to the late 1980s, the majority of South Africans experienced displacement, deprivation and discrimination to the fullest extent through the apartheid policies set in place by the National Party. Segregation and racial discrimination were codified in law, which led to the dislocation of black and “colored” South Africans into homelands or Bantustans, the outskirts of urban areas. To this day, millions of black and colored South Africans reside in the townships that were created as a result of apartheid, many of which are still without electricity or running water.

The legalization of racial discrimination led to the deprivation of citizenship for all but the small white minority. This resulted in poverty and disease among the displaced black and colored population. The race ideology of black inferiority was repeatedly
confirmed through law and practice, resulting in segregation realities that ravaged the quality of living in every way possible for black and colored people (London 2004, 8). The segregation policies were implemented to the fullest extent possible, especially in the quality of health care afforded to each group.

Dislocation and segregation plunged the black and colored communities into extreme poverty. Poverty then manifested itself in violence and disease throughout their communities. During the dismantling of apartheid, which began in the 1980s, health became a large concern to anti-apartheid activists.

The end of apartheid was largely achieved by the anti-apartheid movement. The anti-apartheid struggle was fought through utilization of the courts and the media, in addition to local and transnational advocacy networks, along with grassroots mobilization and skillful negotiations (Robins and von Lieres 2004, 582). Activism within this time period gave TAC a greater political understanding of fighting oppression and creating a movement. TAC situated itself within anti-apartheid politics, a result of the experience of TAC’s founding leadership, “who cut their activist teeth during the anti-apartheid struggles of the 1980s” (ibid). The anti-apartheid struggle provided the political opportunity for the formulation and growth of TAC.

It was also during this time that the movement to realize the right to health as a human right began, immediately following the death of Steve Biko. In 1977 Biko, a political activist, was detained and tortured to death. Apolitical health professionals found the complicity of Biko’s medical doctors to be unethical and deeply offensive. In an effort to address this injustice, these health professionals signed petitions, wrote letters, marched holding placards, and even joined organizations that would spur change.
In addition to Biko’s death and the dismantling of apartheid’s segregationist policies, the post-apartheid reality of the socioeconomic status of black and colored South Africans continued to have its racial divide. Black and colored South Africans still experience higher prevalence of disease and mortality in contrast to the white minority. It was easy to see the crippling ramifications of apartheid policies on those who lived in homelands in terms of poor quality of living and health. Not surprisingly, in the post-apartheid era TAC and others focused on the right to health, largely in response to the devastation of the physical well-being of the majority of the population.

The political opportunity was made clear after 1994. With the defeat of the apartheid regime, the former opponents were now obliged to implement policies and programs advocated for in the anti-apartheid struggle. Thus, the health ministers at the national and provincial levels began to implement pro-poor policies in the health and social service sectors (London 2004, 8). This, coupled with the human rights discourse developed in the anti-apartheid struggle, led to an emerging partnership between civil society and the new government in the development and implementation of new health policies. TAC took advantage of this political opportunity and made an effort to shape public policy for the health and equity of marginalized groups.

South African Constitution and Court System

South Africa’s newly adopted post-apartheid Constitution was adopted in 1996 and is now known to be the most progressive Constitution in the world. Chapter 2 of the South African Constitution features a Bill of Rights in which Articles 7 through 39 specify various civil and political rights in addition to socioeconomic rights. Article 27
states, “Everyone has the right to have access to health care services, including reproductive health care; The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights” (South African Constitution). The inclusion of the socioeconomic right to health makes this a very progressive Constitution, thus allowing citizens direct access to make claims to such rights as human rights.

Even more, the South African Constitution states rights of citizens to have remedies for the enforcement of their rights. Article 38 specifies this right stating, “Anyone listed in this section has the right to approach a competent court, alleging that a right in the Bill of Rights has been infringed or threatened, and the court may grant appropriate relief, including a declaration of rights.” This article furthermore elaborates that a person can approach the court seeking not only their own interest, but also on behalf of the public interest. Article 34 ensures citizens the right to access the courts. This opens the door for TAC to access the courts and make the claims it does.

The South African court system is similar to the U.S. court system. From top to bottom the court system is composed of the Constitutional Court, Supreme Court of Appeals, High Courts of South Africa (ten provincial divisions and three local divisions), Circuit Courts, and nine specialized courts. The specialized courts consist of a court on taxes, labor, divorce, land claims, a water tribunal, the Truth and Reconciliation Commission (TRC), magistrates, small claims and community courts (Constitutional Court of South Africa).

A case can go to the Constitutional court through various means, but only two methods are relevant for the work of TAC. A case can go to the Constitutional Court
“as the result of an appeal from a judgment of the High Court or the Supreme Court of Appeal or as a direct application to the Court, asking it to sit as a court of first and last instance because of the urgency of the matter” (CITE Const. Ct website)

I will explore a few of TAC’s most pivotal cases, one of which was heard in the Cape Town High Court and another in the Constitutional Court.

**Mobilization Potential**

**Internal Resources**

Internal resources of SMOs are human capital, which consists of professional staff, high profile players, organization members, and local community members. I will examine each of these components as they relate to TAC and contribute to its mobilization potential (refer to Figure 1).

**Staff and Membership**

Today, TAC has an elaborate management system, composed of a two-tier governing body and offices at the national, provincial and district levels (refer to Figure 1). These offices allow the organization to function at the political level alongside the South African government, and also recruit and provide serves at the grassroots level. TAC’s many campaigns, events, and activities are all made possible through the coordinated efforts of paid staff and volunteers.

However, the present-day management system of the organization and the sheer number of staff and volunteers that allow for the operation of TAC did not exist a decade ago. In 2000, just two years after the birth of TAC, the organization’s staff consisted of three individuals and 800 members. Four years later, in 2004, TAC’s paid staff grew to
46. Then in 2006, the organization’s staff expanded to 67 and an estimated 16,000 members. Within the same year, TAC also attracted 350 interns (CITE).

TAC’s founders, South African native Zackie Achmat and Mark Heywood, originally from London, continue to play a large role within the organization even ten years after it was established. Achmat and Heywood are currently placed among the top positions within the organization. Achmat and Heywood serve in the National Executive Committee (NEC), the highest authority and decision making body of TAC, respectively as chairperson and treasurer. Achmat became the international face of the organization early on in the development of TAC (Robins 2004, 663). Heywood not only plays an active role in TAC but has simultaneously been involved with the AIDS Law Project in South Africa since 1994 and now serves as the project head. He is also the Deputy Chair of the South African National AIDS Council (SANAC). Heywood’s participation in these organizations and activism in the anti-apartheid movement since the 1980s makes him a knowledgeable and valuable resource to the organization. Both Achmat and Heywood have advanced degrees, adding to the professional staff in the organization.

TAC also has a group of lawyers who have facilitated in numerous court cases, some of which will be examined later. These lawyers provide countless hours of service on behalf of the organization. TAC attracts the services of lawyers from the Legal Resource Centre (LRC), South Africa’s largest public interest law center founded in 1979. In addition to these legal professionals, many middle-class business and health professionals, as well as scientists have volunteered their services for TAC’s initiatives (Robin 2004, 665).
Over the years, the increasing number of staff and members is reflected in the growth and creation of new districts and branches. TAC now has 10 districts with 49 active branches. The district offices organize events within the district in addition to facilitating meetings at the branch level. The district offices employ paid staff and volunteers, whereas the branches are solely composed of unpaid volunteers and local community members. The districts and branches create the backbone of the organization since they are the predominant recruiting bodied within the organization.

Currently, Khayelitsha (which is in the Western Cape Province) is the largest district in TAC, with 14 active branches. As the largest growing district within the organization, Khayelitsha serves as a model district. The organization strives to develop all the other districts to be comparable not just in size but also in terms of the functional abilities of the Khayelitsha model.

**External Resources**

**Funding**

Since its founding, TAC has increased in its size in staff and membership as well as the scope of its campaigns and activities. This is made possible through the increase in human resources outlined above, as well as through the significant increase in funding the organization has experienced over the years. TAC does not receive any funding from the African National Congress, South Africa’s governing political party since apartheid, and thus relies heavily on donations.

At the onset of the organization, TAC’s generated revenue amounted to little over R200,000, about US$32,000. In 2004, TAC’s income increased to about R14.5 million, about US$1.9 million. At the end of 2008, the organization reported an income of R36.7
million, about US$5.1 million (see Appendix A for full budget figures). Most of the income was generated through international donations from various organizations and individuals. In the fiscal year of 2007-08, the largest donors were the Swedish International Development Agency and Atlantic Philanthropies, a U.S. based private foundation. Other large donors include Medecins San Fronteieres (MSF or Doctors without Borders), OXFAM Australia, and the Royal Netherlands Foundation.

The Treatment Action Campaign does not receive any funding from USAID because “it is seen to promote the interests of the US Government,” or pharmaceutical companies (Friedman and Mottiar 2005, 517).

Facilities

In order for the organization to operate, offices were set up for each province and district. Only one office exists for the national level, which was recently relocated to Cape Town from Muizenberg. Each of the districts within TAC has its own office and set of paid staff. TAC’s income allows for each office to be equipped with computers and full internet and phone services. Each province and district office is allocated funds for paid staff positions and material resources according to the district’s size and functional capacity, which is determined by the national office. The largest district, Khayelitsha has office space thanks to MSF’s generous offer to provide office space for them across from its own.

Media

TAC’s presence within the media is considerable. Due to TAC’s highly politicized events such as campaigns, marches, protests and court cases, newspaper
consistently showcase these events. The organization tackles so many issues related to HIV/AIDS and is entrenched so deeply in the political and social dimensions of the disease that TAC is visible in multiple arenas. The set up of the organizational structure demonstrates how TAC is able to operate on so many different levels.

The organization’s media connections are not limited to newspapers. When planning protests, marches or other high profile events, TAC often calls upon local and national radio and news stations to cover their event. This is often done through a media coverage request faxed to the various media stations.

Networking

From the founding of the organization TAC has utilized networking and partnerships as a vital tool to achieve their objectives. Realizing that HIV/AIDS has many political and socioeconomic dimensions it was not difficult to cultivate alliances with other movements or organizations. In the immediate post-apartheid transition in 1994, TAC allied itself with the Trade Union Movement (London 2004, 10). TAC also developed long-standing relationships with the Congress of South African Trade Unions (COSATU), a partner in the Tri-partite Alliance with the African National Congress and the South African Communist Party, as well as Medecins Sans Frontieres (MSF). Positioning itself with COSATU has proven to be critical for TAC’s political engagements. Although, it is unknown whether if this was intentional, the Western Cape Provincial office is in Salt River, Cape Town, with their office sharing the floor of a building with COSATU.

Framing and Social Context
My study focuses on the decade of 1998-2008, the first decade of the Treatment Action Campaign takes place during a pivotal time in South African history. The birth of TAC took place in the post-apartheid era in which new rights were asserted during a time of economic redistribution. The early 1990s also mark the onset of the HIV/AIDS epidemic. Being aware of the social context in which TAC arose will allow for examination of TAC’s strategic framing. I will examine how TAC maneuvered the political environment and social context of AIDS to strategically create frames in which to work. This exploration will show interplay between political opportunity, mobilization, and framing as well as a dynamic interchange between TAC’s frames and other counter frames. The process is an interactive dialogue where one side presents an argument and the other a counter argument.

Given the social and political context of South African history, we will see three main time periods in which TAC implemented different frames. First, I will look at the period of 1998 to 2000, the early years of setting the rights debate; second, the period of 2000 to 2003, the rise of the AIDS denialism and pseudoscience; and lastly, the period of 2003-2008, when TAC seeks to see government action and treatment roll-out.

As noted by Zald, cultural context and historical events provide opportunities for framing (1996, 261). In this case, the struggle out of apartheid and the formation of the post-apartheid South African Constitution set the framework for people to assert their rights. The new Constitution, not only gave HIV-positive people the authority to claim their right to health but to equal citizenship and access to treatment. It was during this time that TAC framed their initiatives in terms of claiming their rights and therefore obliging the government to provide life saving medications for HIV-positive people.
TAC created the movement as an assertion to their right to treatment, pressing the government for more affordable drug treatments and policies to implement a nation-wide treatment plan.

Initially TAC gained momentum in their mobilization capacity and exercising their demands against the government. But in 2000, President Thabo Mbeki began to outwardly support AIDS dissident science, speaking out against the intellectual foundations of AIDS health science and policy (Butler 2005, 594). It was during this time that Mbeki discredited AIDS science, denying the causal link between HIV and AIDS and positing that antiretrovirals (ARVs) may be poisonous and lethal. Facing public critics, such as academics, opposition parties, AIDS activists, and health professionals who all spoke out against dissident AIDS science, Mbeki created his own AIDS advisory panel. Mbeki established the President’s Select Advisory Panel of AIDS Experts (see Figure 3), composed of ‘established scientists’ and AIDS dissidents (Robins 2004, 658).

With the rise of AIDS dissident science, the use of traditional healers and medicine became an increasing norm amongst the South African community. With dissident science being supported by the President, existing myths about AIDS gained momentum as well. Common myths about AIDS included that it was the product of witch-craft, a punishment from God, a disease created by the United States, CIA to deplete the African population or created by drug companies to create drug markets. Even more, some believed that lubricants in condoms were the source of HIV, sex with infants of virgins would cure AIDS or ARVs were toxic. Alongside this plethora of myths and conspiracy theories stood President Mbeki flirting with dissident science, creating a government of policy makers and politicians that sustained AIDS denialism.
The government support of AIDS denialism was also shared with some traditional healers. One traditional healer, Matthias Rath, a German national, received much attention from TAC for his distribution of vitamins as an AIDS cure and clinical trials on HIV-positive individuals, eventually leading to the death of two clinical trial participants. Matthias Rath, a self-proclaimed traditional healer, is not alone in developing concoctions as AIDS cures and treatments. Others in township areas of the Cape Flats have advertised their home-grown herb supplements and drink mixtures that would cure the symptoms of AIDS. These traditional healers related to the link between body and spirit, targeting that as the source of AIDS.

Figure 3. President Mbeki’s Select Advisory Panel of International AIDS Experts
With AIDS dissident science within the government, the spread of AIDS-related myths and conspiracy theories and practice of traditional healers, conventional science regarding AIDS was severely undermined. Therefore, TAC sought to counter these frames with another intellectual frame. This was done through a strategic approach in which TAC created an intellectual campaign in the early 2000s, relying on the expert and professional training for TAC members. More on this will be discussed later.

Initially, TAC used a rights claiming frame in response to the political opportunity created by the post-apartheid Constitution. Mobilization was possible given the continued strength of the post-apartheid civil society. Then TAC shifted its frame from a rights discourse to an intellectual campaign as a counter argument to AIDS dissident science. In later years, the mid to late 2000s, TAC had to re-focus itself after victories in cases against the government and pharmaceutical companies. TAC re-framed its strategy to largely focus on pressing the government for implementation of policies and treatment plans they had promised.

DEPENDENT VARIABLE: MEASURING SUCCESS

Now that I have examined the independent variables that affect success, I am ready to assess the success of TAC by examining political and cultural/social outcomes. Examining each outcome requires determining whether or not the outcome is positive as mentioned previously. Positive outcomes will contribute to success.

The strategies used by the Treatment Action Campaign will now be examined to assess whether this social movement organization has achieved success. This will be done by examining the dependent variable, success, as a composite of two parts: the
political outcome and social outcome of TAC’s activities (refer to Figure 2). The first part to be measured is its political outcome, which has four indicators: 1) the number of legal cases won by TAC; 2) the creation of new public policy on HIV/AIDS; 3) the reform of existing policy; and finally 4) the implementation of new and existing policies overall. Then the social outcome will be measured, also with four indicators, as follows: 1) TAC’s strategies in countering AIDS denialism; 2) the creation of policies to counter the work of traditional healers; 3) the increase of treatment adherence; and 4) the overall decrease of HIV/AIDS stigma and misperceptions.

Political Outcome

Firstly, I will examine what TAC has achieved given the political structure developed throughout the anti-apartheid era, specifically by examining TAC’s strategies within the democratization process of South Africa. This exploration will focus on TAC’s use of the new South African Constitution and court system in which new rights were asserted. Then I will look at the effects of TAC’s political victories have had on the social dimension, by examining TAC’s strategies at the local and grassroots levels which allowed for the overturning of AIDS denialism and greater education surrounding the disease.

Success will be determined by reviewing TAC’s strategies and victories over time. Political outcomes will be measured by assessing whether or not TAC achieved a positive or negative outcome in terms of the goals it pursued. A positive outcome is one in which TAC’s specific goal was achieved whereas a negative outcome is one where TAC’s goal was not achieved. For example, did TAC win the court cases it brought to the
High Court or Constitutional Court of South Africa? Did TAC successfully press the South African government to put HIV/AIDS and treatment access on the political agenda through the creation of specific public policies? And now, is TAC successfully pushing the government to implement the policies to the fullest extent possible. In the pursuit of each of these goals, I will show how TAC’s advocacy draw on historic repertoires of contention honed in during the anti-apartheid struggle.


From 1998, when TAC was first founded, to 2003 the organization heavily focused on campaigning for wider access to HIV/AIDS treatment. TAC created this goal because the organization identified the dangers presented by the rejection of the safety and efficacy of HIV treatments promoted by dissident scientists (Mbali 2005, 19). Consequently, TAC sought to battle the South African government and multinational pharmaceutical companies to provide greater access to HIV drugs for people.

By the end of 1998, TAC had already initiated a campaign for the Prevention of Mother-to-Child Transmission of HIV (PMTCT). In this campaign TAC demanded that the government provide access to azathioprine (AZT), a drug that would help prevent HIV-positive pregnant women from transmitting the virus to their unborn children. Some government members argued that the drug was too costly while others outwardly denied the effectiveness of the drug. The Minister of Health would not allow for a program on PMTCT or dispersal of the drug due to skepticism regarding the efficacy of the drug (Minister of Health v TAC, 2002). Meanwhile, President Thabo Mbeki outwardly proclaimed that AZT was poisonous and life-threatening, not life-saving. For the next five years, TAC demonstrated and marched throughout South Africa in protest of the
government and pharmaceutical companies. The case was later presented to the Court in 2002, which will be explored in further detail.

As previously discussed, the anti-apartheid struggle presented new forms of civil society action. Echoing the anti-*dompas* (pass law) defiance campaigns of the apartheid era, TAC created the “Christopher Moraka Defiance Campaign against Patent Abuse” in 2000 (Robins 2004). This civil disobedience campaign aimed to uncover the excessive profiteering on patented drugs by illegally importing generic drugs from Thailand.

The campaign was named after a TAC volunteer Christopher Moraka who has died in July 2000 from AIDS-related oral thrush. TAC’s spokespersons claimed that fluconazole, a drug not available to the public health system due to its exorbitant costs, would have eased his suffering and pain. TAC publicly announced its intentions to defy pharmaceutical patents on drugs at a conference in July 2000, while also calling upon other organizations and individuals to join their campaign. This immediately brought immense international attention, intensifying the outcry against pharmaceutical giant Pfizer. After Achmat purchased 5,000 capsules of fluconazole in Thailand, TAC exposed the profiteering and patent abuse by Pfizer. A 200mg capsule of fluconazole cost R28.57 in the South African public sector and an astonishing R80.24 in the private sector, whereas in Thailand one capsule cost R1.78. It became clear that Pfizer had inflated prices of name-brand medications. This critical identification of pricing differences, in addition to Pfizer’s unwillingness to reveal their investment and pricing policies, left Pfizer in a very vulnerable position among international and activist pressure (Bloom 2000).
Not long after in March 2001, Pfizer finally lowered drug prices. The public pressure built up through TAC’s protests in the form of fasts and rallies throughout Cape Town and Durban, forced the company to reduce the prizes of their products (Thomas and Dorono 2004). In state clinics, Pfizer made its drugs available free of charge. This put TAC on the international forefront with their “David and the Goliath” victory against a pharmaceutical giant, catapulting the organization into the global arena (Robins 2004). This victory can obviously be counted as a positive political outcome for TAC.

Though TAC experienced a huge victory against Pfizer, the battle against pharmaceutical giants was not over. While TAC was also confronting the South African government in its PMTCT campaign, it was working alongside the government in a court case initiated by pharmaceutical companies. In March 2001, thirty-nine pharmaceutical companies, represented through the Pharmaceuticals Manufacturing Association of South Africa (PMA), brought the South African government to court (OXFAM Policy Report, April 2001). The PMA claimed that certain amendments to the 1997 Medicines and Related Substances Act were unconstitutional. The proposed amendments would enable the government to make drugs more affordable in South Africa by decreasing the prices of the PMA’s drugs (TAC Diary 2008). The law allowed less expensive generic drugs to be imported or made in South Africa. Though TAC was not initially involved in the case, TAC incorporated itself into the court case as a “friend of the court,” or amicus curiae, to provide evidence relevant to the government's argument. Here is an example of how TAC balanced its tactics of conflict and co-operation in its relationship with the government. In this case, TAC actually acted as an ally to the government rather than acting in opposition of it.
This was a political opportunity that allowed TAC to insert itself not simply because the government’s goal mirrored TAC’s, but also to demonstrate that TAC is willing to work with the government. Whereas, in the PMTCT campaign the organization was mainly battling the government, this case presented an opportunity for TAC to work cooperatively with the government. In many situations we will see that TAC launches action as a challenger of the government, thus creating a relationship of conflict. However in the legal case with the PMA, TAC leaders immediately saw the opportunity to show that its goal is not to create hostility with government, but to win greater access to treatment. In the long run this was a conscientious strategic maneuver to dispel beliefs that the organization was an enemy to the newly formed democratic government.

Figure 4. Zapiro cartoon featured in The Mail & Guardian on March 6, 2001.

Throughout the involvement of this case, a legal battle which actually began in 1998, the organization assembled and participated in numerous protests and demonstrations. Between December 1998 and February 2001, TAC organized seven
public demonstrations in the form of protests and marches (TAC Newsletter March 2001). During this period, TAC’s “Global March for Access to HIV/AIDS Treatment” in July 2000, involved more than 6000 people. While members, volunteers, and sympathizers of TAC congregated in protests and marches, its leaders were hard at work. TAC representatives met with government policy makers and the PMA nine times before the case was concluded.

In April 2001, the PMA conceded to the numerous national and international pressures to withdraw its case against the South African government. This was mainly the result of negative media publicity against the pharmaceutical companies involved such as Pfizer and Glaxo Wellcome for drug profiteering (Robins and von Lieres 2004). Since TAC’s marches and protests occurred all over the country, it received much media attention as well, both domestically and internationally. This also helped cast a negative light on the pharmaceutical companies and won international sympathy for South Africa and TAC’s claim against the PMA.

Overall, TAC’s involvement in the PMA case was crucial to the government’s success against the international pharmaceutical industry. Mobilization and collective action brought international and national attention to the issue, which then shamed the pharmaceutical companies into withdrawing the case. While thousands gathered for public protests in South Africa, TAC also implemented a highly successful global media campaign, convincing international public opinion that pharmaceutical companies had a moral obligation to make drugs affordable (Robins 2004). If the numerous protests and marches and international media campaign had not occurred, the pharmaceutical companies may not have wanted to retract the case. This ending can be counted as
another positive outcome. TAC’s goal was to further government efforts to make drugs more affordable to South Africans. Dismissal of the PMA case opened the stage for the implementation of the legal framework created through the Medicines Act to be finalized, thus allowing for cheap and effective drugs to reach the people. Finally, South Africa was able to have more affordable drugs and manufacture generics within the country.

Though a long and protracted court case with the PMA was avoided, TAC’s break from the courts amounted to only a brief intermission. In 2001, after years of government lethargy and disregard for the creation of a national PMTCT program, TAC took advantage of a political opportunity to take the Minister of Health to court. The case of the Minister of Health v. Treatment Action Campaign (2002) arose out of years of struggle to pressure the government to implement a PMTCT program but more specifically in response to discriminatory legislation created by the South African government. In August 2001, a government policy was made outlining the distribution of the drug Nevirapine (NVP) in public health institutions. This drug helps to prevent mother-to-child HIV transmission at birth. A few pharmaceutical companies had offered Nevirapine to South Africa at no cost for a period of five years. However, the government did not allow for wide disbursement of this drug, claiming that it must be subject to tests and research before being distributed to the public. The government did allow the drug to be made available in two sites, but not to the public at large. TAC challenged this policy since the Medicine Control Council, a specialist body responsible for testing drug safety, had registered NVP as a safe drug. TAC argued that the government’s concern about the drug’s safety was baseless. The government policy
allowed for a small number of people with the financial means to access private health facilities to have access to this drug.

When the Constitutional Court heard the case, they agreed with TAC’s claim to assert the right to health and the rights of children. It was found that Sections 27 and 28 of the South African Constitution create a positive obligation on the State to promote access to health care (Robins and von Lieres 2004). The Court went even further and determined that the government has a constitutional obligation to provide a comprehensive policy to combat mother-to-child HIV transmission and thus far has failed to meet that obligation. The outcome of this case asserted that the government does have a constitutional obligation to meet the positive duties stipulated in the Constitution in regards to access to health care. In the end, TAC received a positive outcome in the case of the Minister of Health v. TAC (2002) when the Court ruled in its favor. However, the outcome of the case could not have been possible without the provisions in the South African Constitution on health and child rights and the precedent case *Grootbroom* (2000). Once again, we see that democratization of South Africa paved the way for these rights to be asserted.

While this case was in the court, TAC mobilized over five thousand TAC supporters to march outside the Constitutional Court, and also conducted a series of “Stand Up for Your Rights” marches all over South Africa. On February 14, 2003, TAC held its largest march to date, with over 20,000 participants supporting TAC’s demand for a treatment plan. After all the victories TAC had experienced in its litigation against government and pharmaceutical companies, activism was fueled against perceived failure of government to address treatment access. This led to another civil disobedience
campaign in 2003. During this campaign, TAC made the claim that the Minister of Health and the South African government more generally were culpable for the deaths of the people who died from AIDS without treatment (TAC Diary 2008).

The government responded to TAC’s numerous demands for a treatment program with an announcement of extra budget appropriations for HIV/AIDS medical treatment. It was now time for the government to support ARV treatment and create a national treatment plan. But the government refused to sign an agreement with the National Economic Development and Labor Council (NEDLAC) agreeing to an AIDS treatment plan and failed to fulfill their promises. TAC could not take this lightly and thus initiated another civil disobedience campaign.

This was a difficult maneuver for TAC to make, since civil disobedience is typically utilized against governments that the people do not support. The TAC agenda was one of “reform, not revolution” (De Waal 2007). Though danger of being viewed as anti-government was present, “TAC leadership judged that the campaign could be defended and conducted in a way which would not lose it the moral high ground” (Friedman and Mottiar 2004). Seriously taking into consideration public support and key organizational allies, TAC initiated non-violent civil disobedience.

Finally in August 2003, the government agreed to a public ARV roll-out program, a more comprehensive national plan. In November 2003, the government presented the Operational Plan for Comprehensive Treatment and Care for HIV and AIDS Care, Management and Treatment for South Africa (the Operational Plan). Up until this point, TAC had fought relentlessly to force the government to create a treatment plan. Now that TAC had achieved this goal, a new goal was necessary. TAC shifted its focus from the
creation of a treatment plan to the implementation of the plan. From 2004 onward, TAC focused its political efforts on ensuring that the treatment plan was implemented. In addition to this political goal, TAC made more social goals: to campaign for expanded treatment literacy and public education and to mobilize for HIV prevention (TAC Diary 2008).

**Shifting Focus: Policy Implementation and Prevention (2004 to 2008)**

Recognizing all of its political victories, TAC decided to shift focus from the assertion of human rights to the implementation of the policies that were created through the victories in court. From 1998 to 2004, TAC spent much of its efforts fighting the political system that disenfranchised the HIV positive community by demanding affordable treatments and health policies for treatment programs. Now that these goals were achieved, TAC shifted gears to see that the programs were effective, providing treatment to those who need it.

Into the year 2004, TAC kept a close eye on government progress of the ARV roll-out. Understanding the significance of the roll-out program, TAC helped establish a joint civil society forum to monitor the government’s implementation of the Operational Plan. At this point, TAC had already created a number of partnerships with other organizations. These organizations teamed up with TAC to create the Joint Civil Society Monitoring and Evaluation Forum (the Forum). The civil society organizations involved included the AIDS Law Project (ALP), Centre for Health Policy (CHP), Médecins Sans Frontières (MSF), and the Institute for Democracy in South Africa (IDASA), just to name a few.
For purposes of evaluating TAC’s overall “success,” I consider the creation of the Operational Plan as a positive outcome, as it helped TAC’s goal of ensuring that the government created a treatment plan. The Operational Plan is the result of the efforts of TAC in protests, resistance, and litigation. Now TAC’s goal is to see sufficient implementation of the treatment plan. Although, TAC’s focus has shifted from policy creation to policy implementation, their tactics have remained largely the same. Also, the creation of the forum demonstrates how TAC is altering its focus and implementing new strategies to achieve its goals.

Since February 2004, TAC began pressing the Minister of Health to release “Annex A,” which prescribes goals for the implementation of the plan, including dates, sites and targets for the ARV treatment roll-out. By October 2004, the Minister of Health still refused to disclose the information, even after the Annex was revised. At one point, the Minister denied it even existed. Without knowledge of the government’s plans and targets for the Operational Plan, TAC could not hold the government accountable to its promises. The information was key in order for TAC to assess the implementation of the policy. TAC launched the Access to Information Campaign and a court case to demand that the people have a right to know and that the government must release the information. TAC pointed to Section 32 of the South African Bill of Rights which states, “Everyone has the right of access to any information held by the state... that is required for the exercise or protection of any rights.”

In a pamphlet, “Right to Know, Right to Live,” TAC argued that the “access to information helps communities work with government to improve service delivery” (TAC 2004). By informing the public about their right to know, TAC once again used a
rights discourse to achieve its goal. In this campaign TAC conducted marches, demonstrations, consultations with civil society organizations, and ultimately legal action against the Minister of Health in the “Annex A Case” (Heywood 2009). In November 2004, the Pretoria High ruled in favor of TAC’s right to access information and ordered the minister to pay punitive costs for misleading the public. Again, TAC scored another positive political outcome.

From here on, TAC continued to monitor implementation of the program, demanding better roll-out in places like Mpumalanga. Much effort was taken to document progress and produce reports on the roll-out program. This timely research was vital to ensure that the government was implementing the program in all provinces and servicing as many people as possible.

In 2006, TAC was in Court again, but this time against the Department of Correctional Services and the Ministry of Health for denying ARV treatment to prisoners in Westville Prison. In a September 2006, TAC’s Newsletter disclosed statistics on the number of deaths in South African prisons. The number of prisoners who have died in custody from natural causes has risen dramatically from 211 in 1996 to over 1500 in 2005. TAC claimed that this increase in the prison mortality rate was directly attributable to HIV/AIDS and its intersection with tuberculosis (TB) (TAC 2006).

Again, the Court agreed with TAC in that the rights guaranteed in the South African Constitution applied to all South Africans. The Court ordered the government both to provide ARV treatment to prisoners and to submit a treatment plan for the prisoners. This victory, another positive outcome for TAC, again relied on the South African Constitution and the assertion of rights to win its claim.
In 2007, continuing its emphasis on prevention and implementation of treatment programs, TAC worked alongside the government to draft a National Strategic Plan for 2007-2011 for HIV/AIDS and Sexually Transmitted Infections (NSP). This policy promised to reduce new HIV infections by 50% and to extend treatment to 80% of people living with HIV. The government quickly adopted the plan. TAC’s resources and research were crucial to developing a strategic plan for treatment and prevention. Without the help of TAC, the NSP would not have been created. Here, TAC achieved another positive outcome.

Overall, TAC had many political successes, demonstrated by all the positive outcomes discussed above. This was a long process, in which TAC developed a complex relationship with the South African Government. The evolving relationship between the government and TAC shows a repertoire of tactics. While TAC worked alongside the government in the ARV roll-out and creation of the NSP, it also remained critical of the program’s implementation. TAC was always careful not to act as an ally to the government or to be too anti-government, understanding the importance of balancing cooperation and conflict in order to retain public support. I will show the interplay between the government and TAC to be even more dynamic later, in my discussion of AIDS denialism and government supported dissident science.

Over the years, TAC has realized that mass mobilization and networking are key tools in their success, which in turn has created political space for the assertion of health rights and citizenship. Mass mobilization of women, unemployed people, and HIV-positive individuals showed the government that its promises and obligations within the
Constitution must be met. Mobilization was the backbone to TAC’s success, a sentiment often reiterated by TAC co-founder, Nathan Geffen (Friedman and Mottiar 2004).

These varied positive political outcomes are largely a result of the political opportunity structure. TAC, in turn framed its issues and goals in a manner that helped it capitalize on the favorable context in order to achieve positive outcomes. The institutional channels to make political demands were set in place post-apartheid, through the democratization of South Africa. The Courts provided direct and immediate means of engagement by TAC leaders, while public civil disobedience, protests, and marches allowed for involvement of thousands of South African citizens. The political opportunity provided by the new post-apartheid Constitution and South Africa’s strong human rights frame work informed the movement’s decision to create a rights frame. For TAC, the framing process was made possible by the existing political opportunity structure. The rights frame was vital to TAC’s political success. The continued reliance on claiming and fulfilling rights led TAC to employ litigation, marches, and protests, all of which had positive outcomes.

**Cultural and Social Outcome**

TAC’s first decade was filled with numerous political victories. But as a social movement, TAC strived not only to influence policy making, but also to make sure that these policies were translated into practice in the social realm. While the political aspect of TAC’s work evolved around claiming and asserting rights, the social aspect involved battling stigma, discrimination, and AIDS denialism within society. Assessment of the social/cultural outcome will include intensive discussion of government-sponsored dissident AIDS science, including support of traditional healer Matthias Rath. I will also
examine TAC’s efforts to influence cultural perceptions and education on HIV/AIDS. TAC played a large role not only in the political realm of the HIV/AIDS pandemic in South Africa, but also in prioritizing the social aspects of the pandemic.

In measuring whether success was achieved in the social and cultural spheres, I will examine the changes in common myths about AIDS and especially the effects of AIDS denialism. I will also examine TAC’s response to the commonly used medicines provided by traditional healers, closely exploring TAC’s relationship with Matthias Rath. An in-depth discussion of Rath will not only expose common beliefs about the disease, but also show what measures TAC took to combat false information. Furthermore, assessing the social outcome will require exploration of TAC’s initiatives at the grassroots level by examining the strategies and programs TAC implemented. We will see how TAC implemented grassroots meetings, training, and educational programs in order to combat HIV/AIDS stigma, misinformation, and discrimination.

Countering AIDS Denialism

The realization of the HIV/AIDS epidemic spurred TAC to mobilize for treatment access. As seen in previous sections, TAC endured long battles with the South African government and multinational pharmaceutical companies to increase treatment access and ensure implementation of treatment policy. Yet at the same time, TAC was battling the disastrous effects of dissident AIDS science supported by President Mbeki and others. Moreover, traditional healers openly advertised and distributed various substances as “AIDS cures.” In this section, I will examine how TAC framed and tackled the issue of government supported AIDS denialism.
Although dissident AIDS science began in the late 1980s, it did not gain momentum in South Africa until President Thabo Mbeki began to support it (Vandormael 2007). Mbeki’s argument was rooted in a national ideology to protect the African image from falling victim to Western perceptions that Africans are promiscuous or sexually deviant. Hence, Mbeki created HIV science based on nationalistic grounds, emphasizing an overall fear of being victimized by the West. Mbeki’s denialism in the Western biomedical model began to take drastic turns as he publicly denied the link between HIV/AIDS and deny the effectiveness of ARV treatment (See Figure 6).

![Figure 6. Zapiro cartoon featured in the Mail & Guardian on Nov 8, 1999](image)

TAC was careful in the way it approached AIDS denialism. Throughout rural areas South Africa, little education and knowledge on HIV/AIDS science or treatment was available, the threat of AIDS denialism was much more severe. Therefore, TAC has to delicately frame its opposition to AIDS denialism so as to not fuel arguments that TAC was anti-government. Initially, TAC described the government’s “denial” as reluctance or apathy to see the urgency of the AIDS crisis and immediately respond (Vandormael
Instead of labeling the government as “wrong,” TAC portrayed it as “morally weak” (Ibid).

But with the gravity of the AIDS crisis intensifying and no retraction in AIDS denialism, TAC turned to a more dramatic frame. At first, TAC claimed that public skepticism towards the science of HIV was a function of political, intellectual, and moral weakness. Then, TAC began to describe the President and Minister of Health’s beliefs and actions as “evil” and “murder.” Here a link was made between the contestation of internationally accepted AIDS science and culpability for death.

In order to combat AIDS denialism support by the government, TAC assembled and implemented what Vandormael (2007) refers to as its “Intellectual Campaign.” This campaign was primarily driven by an epistemic community, members of the professional and academic community who contributed their skills and knowledge to counter the unorthodox views of Mbeki and other AIDS denialists (Vandormael 2007). This campaign differed from TAC’s traditional campaigns because it did not involve public protest and other confrontational activities. Rather, the intellectual campaign turned to a high level of expert specialization on AIDS science to counter the rhetoric preached by the denialists.

The intellectual campaign occurred from 2000 through 2004, with the epistemic community playing a key role in pressing the government for a PMTCT program and litigation mentioned earlier. But in 2005, TAC launched the “2BY6 Campaign,” advocating for 200,000 HIV positive people to receive ARVs by 2006 (TAC Diary 2008). This campaign also called on the government to denounce AIDS denialism and its
practitioners such as Matthias Rath. But the government continued to support Rath and allowed him to sell vitamins as AIDS cures (See Figure 7).

As TAC was marching and protesting through the 2BY6 Campaign, Rath accused TAC of receiving funding from pharmaceutical companies. TAC then engaged in a legal battle with Rath for his slanderous accusations and also accused him of experimenting on human subjects. Here, TAC utilized the Medicines Act to support its claim against Rath’s unlawful distribution of unregistered drugs and his experimentation on humans. In 2006, the Court found that Rath had defamed TAC, which TAC considered a victory against AIDS denialism, particularly since the ruling would enhance TAC’s reputation at the grassroots level.

Although, TAC won the case against Rath it can not be counted as a positive outcome unless it had implications in the social realm. In some sense there must have been positive implications on public beliefs on the denialists approach as the Court re-validated TAC’s reputation. This would help TAC in its grassroots programs.

Figure 7. Featured in the Mail & Guardian on Sept 21, 2005.
TAC’s most influential and most prized program is Treatment Literacy. This program is built and run by people at the local level to teach others in their community about HIV science and treatment. This educational program trains locals to be Treatment Literacy instructors who then reach out to people within the community. TAC highly prioritizes education. In order to ensure health citizenship, the people must be educated and knowledgeable.

Stigma and Discrimination

In order to decrease stigma and discrimination, TAC created the “HIV POSITIVE” logo, printed on thousands and thousands of t-shirts which were worn at all of TAC’s protests and marches. TAC created the logo so that onlookers could not differentiate between who had HIV and who did not have HIV. The idea was that no one can know if someone else has HIV, and therefore should not act in a discriminatory manner towards them (personal conversation with Western Cape Provincial Coordinator, Fredalene Booysen 2008). Also, it is an even more powerful visible statement when
thousands of people congregate wearing HIV POSITIVE shirts on the streets of South Africa to demand treatment access.

TAC also regularly publishes newsletters, the magazine *Equal Treatment*, booklets and pamphlets to educate people about HIV/AIDS and related issues. Understanding the complexity of the epidemic and how it affects so many parts of life in addition to personal health, TAC adopts issues such as violence against women, and xenophobia against refugees. TAC also implements door-to-door pamphlet campaigns and “Cool Youth” HIV/AIDS education programs in local schools.

These efforts have helped to make HIV/AIDS a higher priority among South Africans, as reflected by recent public opinion data. Results from the Afrobarometer polls conducted between 1999 and 2004 suggest that HIV/AIDS has moved up the ladder of what the public thinks the government should prioritize. This increase in prioritization may be a reflection of people’s personal experience with the disease. From 2000 to 2004, the percent of the South African population which had experienced personal loss due to AIDS rose from 16 to 31 percent.

Overall, determining the social outcome is not as concrete as determining positive political outcome, owing to the subjectivity of the matter and the lack of public opinion data. Nonetheless, TAC has made significant strides even at the grassroots level. The ability of TAC to mobilize thousands of people for protests and marches shows that its actions at the social level are stirring people to support TAC’s goals. The growth of TAC’s programs also shows that people at the grassroots level are willing to lend their support and services. With some reservation, I would thus conclude that TAC has achieved a positive social outcome.
SUCCESS ACHIEVED?

TAC’s objective to attain treatment access for more South Africans was successful. The numerous positive political outcomes show that TAC was able to press the South African government to create policies and battle multinational pharmaceutical companies for more affordable drugs. However, when it comes to the social outcomes, determining success is less clear. TAC wanted to increase education on HIV/AIDS, which it has done through its Treatment Literacy program. But whether stigma and discrimination decreased can not be quantitatively stated.

My research on TAC’s activities and outcomes leads me to conclude that TAC has been highly successful, particularly in its earlier years. But in the latter years, from 2004 to the present, the ambiguity of its goals makes it much more difficult to determine if success was achieved after the initial political battles were won.

CLOSING REMARKS

TAC has certainly demonstrated a wide variety of tactics and strategies, targeting all aspects of the multi-dimensional issues raised by the HIV/AIDS epidemic in the South Africa. TAC has utilized its institutional structure and networks to affect not only the policy aspect of the epidemic but also the social and grassroots service related aspects of the epidemic. TAC’s well-roundedness helped to mobilize thousands and won international acclaim and support.

Though many of TAC’s events and activities were covered in this paper, many more were left out. Not being able to examine and include analysis of even more of
TAC’s work may have limited the parameters for determining TAC’s success. Also, the unavailability of public opinion data made it difficult to access the social outcome.

However, TAC’s unusual social movement approach may serve as a model for other social movements. The complexity of the HIV/AIDS epidemic has required a well-rounded and comprehensive advocacy approach, which TAC developed. Though TAC has achieved many legal victories, how these victories will translate into action at the social level still remains to be discovered. Considering the range of the epidemic and the thousands who still need treatment, TAC’s work is far from over. Hopefully, its success in the early years will propel TAC to find more success in the future.
# APPENDIX A

## TAC Income (1999-2008)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Income</th>
<th>Expenditure</th>
<th>(Deficit)/ Surplus for the Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000-01</td>
<td>R 1,844,302</td>
<td>R 1,351,434</td>
<td>R 492,868</td>
</tr>
<tr>
<td>2001-02</td>
<td>R 6,433,603</td>
<td>R 3,734,709</td>
<td>R 2,698,894</td>
</tr>
<tr>
<td>2002-03</td>
<td>R 9,397,845</td>
<td>R 10,814,913</td>
<td>R (1,417,068)</td>
</tr>
<tr>
<td>2003-04</td>
<td>R 14,429,363</td>
<td>R 13,567,776</td>
<td>R 861,587</td>
</tr>
<tr>
<td>2004-05</td>
<td>R 22,122,678</td>
<td>R 19,340,525</td>
<td>R 2,782,153</td>
</tr>
<tr>
<td>2005-06</td>
<td>R 27,303,419</td>
<td>R 29,824,479</td>
<td>R (2,521,060)</td>
</tr>
<tr>
<td>2006-07</td>
<td>R 27,641,896</td>
<td>R 29,138,367</td>
<td>R (1,496,471)</td>
</tr>
<tr>
<td>2007-08</td>
<td>R 36,699,997</td>
<td>R 37,268,958</td>
<td>R (568,961)</td>
</tr>
</tbody>
</table>


Figures were converted using exchange rates from:
Timeline of the Treatment Action Campaign and other related events (1998 – 2008)

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).


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.

Source: (Heywood 2009, ) and (TAC Diary 2008)
Bibliography


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