

'Finding the right ingredients to cook the perfect pot of rice'<sup>1</sup>

Politics, power and activism<sup>2</sup>

Fatima Hassan<sup>3</sup>

*While some argue that 13 years is a short time during which to have corrected the legacy of 300 years of colonial and apartheid rule, for people who have no homes, no job and no hope, 13 years is a very long time [Nozizwe Madlala-Routledge, 13 September 2007].*

## Introduction

On 13 September 2007, the former deputy minister of health in South Africa (SA) Nozizwe Madlala-Routledge addressed students and faculty at a University in Durban, SA. In her talk entitled 'A tradition of activism', Madlala-Routledge an anti-apartheid activist, Quaker and senior member of the South African Communist Party (SACP) spoke about the historical traditions of activism in SA with a focus on the African National Congress (ANC) which culminated in democratic multi party elections in 1994.<sup>4</sup>

Ironically, she gave this address a few weeks after she was dismissed by South African President, Thabo Mbeki<sup>5</sup>. In my view, Madlala-Routledge's dismissal as deputy Minister of Health, among other events, is characteristic of the schizophrenic response to AIDS by the SA state in the last 13 years.

Unlike several other countries with a massive AIDS epidemic, denialism has been a significant aspect of the politics and policy response to AIDS in SA. Pseudo-science and attacks on evidence have in turn shaped the response of people living with HIV/AIDS, activists, scientists, doctors, nurses, economists, actuaries, donors, faith based organizations, trade unions, business and the private sector. More especially, denialism has influenced the type, form and brand of activist strategies used by civil society since 1998 to force policy changes.

For this reason, in her talk, Madlala-Routledge used the metaphor of the 'fire, pot and rice'. She said:

For our purposes here, perhaps what we can say is that the perfectly cooked rice is the society we want, and in order for that rice to be perfectly cooked, we all have to do our part to light the fire, to keep the temperature right and to ensure that the right ingredients go into the pot. The African National Congress, elected by the majority today, and probably for the foreseeable future, is consequently, the pot. For any of you who have cooked rice before, you will know that it is easy to spoil it - take your eye off it for too long and it will overcook or throw the water out too quickly and it is underdone. My point is really simple, if you want to see the rice perfectly cooked, you cannot avoid the pot. Standing on the sidelines and toyi-toying will not help that rice cook properly. And neither will leaving the tasks to anyone else. There are many important tasks associated with cooking the rice, and I don't want to overkill the metaphor! Most recently, it seems I have got myself in trouble for saying that the rice is not looking good. I am sorry for the trouble, but my hope is that we use this as an opportunity to improve the cooking of the rice.

...

Over the years the TAC [Treatment Action Campaign] has campaigned for and impacted upon the adoption of a progressive legislative framework protecting HIV positive citizens, national distribution of condoms to improve prevention, the roll-out of mother to child transmission prevention and the subsequent decision to provide treatment to all AIDS sufferers. Now we have a national strategic plan, a groundbreaking document, which aims to halve HIV infections in five years and provide medicines to 80% of those that need them, and TAC leaders sit with Government Ministers on the South African National Aids Council. *If you want to know how to cook rice in a pot - that's how.* (Emphasis added).

There are of course many ingredients that have to be used to cook the perfect pot of rice. Here, the pot represents government or state power, the rice represents a society that is free and open, and the ingredients represent multiple strategies that are used to bring about that society. The fire represents the activism, alertness and awareness needed by the cook - civil society.

**Activism for change**

Madlala-Routledge draws two important lessons when cooking the rice:

1. The need for critical engagement even when democracy exists to ensure that democratic traditions are bolstered.
2. The need for real engagement amidst critical engagement. In other words, unless civil society engages with government, pro poor policies will not be introduced or implemented automatically. This is especially relevant where policy reform without regime change is the ultimate goal.

These two aspects of activism, namely critical and real engagement are playing themselves out in several countries with fascinating outcomes. This paper will focus on how it is doing so in SA, as well as three other countries- Brazil, Thailand and Uganda. The latter three countries are reviewed because they are ordinarily regarded as best practice models for HIV prevention and treatment and/or political commitment leadership, either by activists or international agencies such as UNAIDS and other governments. This paper will examine to what extent this is a true characterization.

### **Changing policy and relations- new activism**

The premise of this paper is that civil society has a role to play in articulating and shaping policy change and implementing it. However, to be effective in bringing about policy changes, there are certain fundamental aspects of effective activism that must be understood and appreciated.

First, unlike traditional or so called 'ultra left' notions of activism, new activism is not dominated by the immediate need to transform structural relations and imbalances among states and /or between the state and non-state actors over time. Second, new activism takes advantage of relations and alliances with the state if it is integral to saving lives and bringing about key policy changes in order to transform structural relations. Third, even where alliances with the state, faith based organizations (FBOs), international agencies and donors as well as the private sector are entered into, it is not at

the expense of integrity. For example, an alliance with the faith based sector does not mean that civil society will refrain from criticizing where necessary. This is true both in SA and Brazil<sup>6</sup>, where FBOs are allies of AIDS activists and assist in implementing programmes that make HIV prevention, care and treatment services available to people in need. However, at the same time, activists have challenged certain faith based doctrines, namely its opposition to contraception, condom use and the availability and provision of termination of pregnancy services. On these aspects, activists in Brazil, South Africa, Thailand Uganda and elsewhere have challenged FBOs directly. This has even led to internal divisions in some FBOs resulting in religious scholars applying liberal interpretations to theological doctrines to promote HIV prevention through condom use and other safer sex practices.<sup>7</sup>

### **But who and what is civil society?**

In my attempt to define civil society I think the following statement best illustrates the futility of that exercise:

“No definition of social movement enjoys scholarly consensus and there probably will never be such a definition because definitions inevitably reflect the theoretical assumptions of the theorists.” (Morris and Herring 1987: 139)<sup>8</sup>

For the purposes of this paper I have chosen to define civil society as anyone doing work in civil space.<sup>9</sup> This includes traditional allies: issue based campaigns and alliances, non governmental organizations (NGOs), FBOs, trade union federations and people and communities most affected by a particular issue or cause that include what are broadly referred to as ‘social movements’. But I want to also include the following non-state actors: scientists, public health care workers particularly doctors and nurses who work in state facilities and the business sector.<sup>10</sup>

However, I do want to distinguish civil society from ‘NGOs’ in general. While the latter may form part of civil society, not all NGOs practically can. This is

why pure service oriented NGOs that exist to carry out state or donor required services rarely advocate or bring about policy change - they implement services.<sup>11</sup> Hopefully this addresses the concerns raised by Seckinelgin about service provider NGOs. He argues that NGOs are increasingly drawn into governance structures by donors and governments to legitimize the role of donor agencies and government power. Further, international agencies are increasingly determining NGO responses to AIDS because NGOs depend on them for continued funding. The latter is increasingly evident where the activities of African NGOs who depend on the US administration for funding through the US President's Emergency Plan for AIDS Relief (PEPFAR) are prescribed by funding conditions and thus limit the provision and promotion of sexual and reproductive health services (see discussion on Uganda below).<sup>12</sup> Seckinelgin therefore warns about the sustainability of NGO interventions and its ability to 'engage with long term issues' in Africa. I agree that the growth in the number of NGOs in any one country is not an 'indicator of efficient work done in reaching to people by which their problems are addressed'. However, in Africa, the most innovative initiatives to address HIV/AIDS have 'been designed and implemented by civil society groups'.<sup>13</sup> Such NGOs are ideally located to deal with issues in the short to long term. Admittedly, those that are funded by donors without minimal conditions are likely to last. In the case of Uganda however, I think Seckinelgin's concerns are accurate. I deal with this in more detail later.

### **Alliances with the state- selling out?**

To social movement 'purists', engagement with the state or state power (even where it is legitimate) is considered inappropriate and misguided. Any reliance on the state or formal state structures such as courts, parliaments, oversight committees are also viewed with suspicion. Purists also argue that engagement on one issue deflects attention from other equally important issues and that this could make civil society less critical of the state and state power.<sup>14</sup>

## Historical use of alliances - illegitimate state power makes activist choices less blurred

Of course in countries where regime change is the ultimate goal (apartheid SA, military junta Brazil) not directly engaging with the state is easier and obvious. Rights movements ordinarily refrain from engaging with illegitimate states. Nor do they rely on state power to bring about or implement social change because such change is fundamentally opposed to the regime's intentions of absolute power. Also, such engagement would be viewed as support for an illegitimate regime and this could make activists less credible to communities that they work with.

But where state power is considered legitimate and regime change is not the goal of civil society, engagement is a tool to transform policies or relations with the state as well as external parties (donors, business). In my view this is critical. It is impossible to avoid the pot (state) if a society wants to change. This requires active citizen participation and assistance. Particularly in the case of HIV/AIDS, activists in all four countries discussed in this paper have understood that power is not only about challenging state power and policy - it is also about transforming the daily lives of poor people by assisting and engaging with the state on the delivery of social services. This is also in line with Madlala-Routledge's explanation of engagement.

Domestically and internationally civil society is increasingly using the power of alliances to bring about policy reform and transform power relations. But this is not something new to health rights activism. In Keck and Sikkink's *Activists Beyond Borders*, the historical reliance on state power by non state actors to bring about policy shifts as far back as the 18<sup>th</sup> and 19<sup>th</sup> centuries is documented and highlighted: The movements to abolish slavery in the USA (1833-1865); provide women with the vote (1888-1928); prohibit foot binding in Imperial China (1874-1911); stop female circumcision by the Kikuyu in the then British colony of Kenya (192-1931) all made strategic use of state power while

simultaneously challenging it. These movements depended on alliances with non-state actors and international governments to bring about policy change. Mainly, it depended on alliances with local politicians, political parties and state authorities.

Ironically, democratic and independent states are not always the first to recognize the need to act with speed to change policy. For example, of the four specific movements mentioned above, it was in Imperial China that policy reform was the speediest (within 16 years a total ban on foot binding was imposed)<sup>15</sup>. Compare this to the antislavery<sup>16</sup> and suffrage campaigns which were mounted in so called democratic and independent states. These campaigns took the longest (60 and 50 years respectively).<sup>17</sup>

These early campaigns illustrate two things that are relevant for understanding notions of alliances with the state today. First, even in situations where state power is undemocratic it can be used or transformed to bring about incremental policy changes. Secondly, ironically, democratic spaces do not necessarily translate into rational or speedy policy changes. Sometimes democratic states are the most difficult to challenge precisely because they see every policy challenge as a direct questioning of state power and authority. Where states see their power or authority being challenged (as in SA) they will resist change and block challenges to state policy because it is perceived as an attack of state power and executive decision making.<sup>18</sup>

### **Integrity politics**

What is critical is how and to what extent alliances with the state can be formulated and/or carried out with integrity. In countries with authoritarian regimes integrity is easier to identify and invoke. In other countries, where state power is not regarded as illegitimate, integrity is equally important to uphold but perhaps less clear or distinctive to an outsider looking in. For example, in a dictatorship, does a health activist turn down an opportunity to

meet with senior health officials to devise a treatment programme to treat a major disease or not? And if it does not, does the organization for which s/he works lose its integrity? Answering these questions require a consideration of the political context of the country in question as well as the severity of the prevalence of the health or other crisis at issue. There is no simple or unambiguous answer to these questions. In SA, where state power is not challenged or in dispute, cooperation and engagement is perhaps on the face if it less complex. But, ironically the SA government's misguided policy on AIDS in the last 13 years has resulted in repeated challenges to its policy approach. Because of its chaotic and unscientific attitude, alliances with the state are difficult to maintain, infrequent and fragile mainly because it often sees itself as beyond reproach and 'uncriticisable'. 'Integrity politics' in SA therefore requires civil society to be supportive of some state policies but critical of it. So while it is supportive of the state at times, it also documents and exposes abuses of state power including litigating against it.<sup>19</sup>

In Brazil, cooperation and engagement with the state is less complex because both state power and state policies on AIDS and health are generally not perceived as undermining democratic traditions or public health. Despite strong alliances between the state and civil society, co-operation and engagement have not meant absolute support for the state nor has it led to engagement that is uncritical. Activists in Brazil continue to question the growing unequal divide between rich and poor and the gap in the quality of social services including health. Yet, at the same time, it is part of every major alliance that formulates and implements policies to provide prevention, care and treatment services to people living with and affected by HIV/AIDS. On issues of medicine access, it has been foe and ally of government.

Civil society in SA and Brazil represent unique ways of engaging the state and other non-state actors. In Uganda I believe that the state has used such

alliances and cooperation in a sinister manner to hide its own abuse of power. I deal with this in detail later.

### **In country traditions of activism and engagement**

Madlala-Routledge cites two important aspects of activism in SA that are evident in Brazil and to a lesser extent in Thailand. First, a tradition of robust activism and struggle politics which materialized in the anti apartheid struggle in the case of SA (ended 1994) and similarly the military junta in Brazil (ended in 1984). Such traditions influence the approach to critical engagement with the state.

In other words, alliances with democratic states are not uncritical of government abuses or irrational policies simply because the state is democratic.<sup>20</sup> In SA, the questioning of the link between HIV and AIDS as well as the delay in the provision of effective life saving interventions has led to the HIV/AIDS policy terrain becoming adversarial and confusing.<sup>21</sup> This in turn raises concerns about the appropriateness of engagement. In Brazil, direct engagement with the state is less contentious and less adversarial precisely because such engagement is not tainted by state supported denialism. However, in the case of Uganda and Thailand, such engagement is being undermined by broader human rights abuses by state authorities that have nothing to do with denialism.

Significantly, the SA, Brazilian and Thai experiences suggest that if given the space, civil society will participate and contribute to state power. While this is confusing and at times controversial its advantage lies in its unpredictability. The state and international agencies or donors cannot predict when activists will ally with it and when it will not. This is not to suggest that new activism lacks the integrity to challenge state power or speak out against or document abuses or inappropriate donor practices. In fact, if anything, new activism is

often critical of aspects of state policy and state power though not necessarily primarily concerned with regime change (SA, and Brazil).

### **Cooperating with the state and state power**

Cooperating with state power may therefore appear inexplicable to some. But it can lead to schizophrenic results when state power is used to defend irrational policies. However, social movement 'theorists' who argue that cooperation is 'reformist' or against the grain of traditional activism forget that often such campaigns do not fall in neat traditional or conventional categories of activism where such action is designed to challenge the illegitimacy of the state and to end its illegitimate power.

So where cooperation is taking place, it does not mean that AIDS and health activists do not or will not challenge state power or macro-economic policies that adversely affect health and other social services. In SA, assumptions about AIDS campaigns being based on 'single issues' ignore civil society's efforts to alter the macroeconomic approach of health delivery in SA. Central to the campaign for better health services in SA is realizing the constitutional obligation of the state to provide health services to all people irrespective of their ability to pay. Health activists have been at the forefront of highlighting and challenging the inequitable allocation of health resources in the public and private sector. It has called for greater state regulation of the existing private health sector and resisted efforts to increasingly privatize health services for low income people. These are all aspects relating to the macroeconomic health and fiscal framework of government. It has shaped socio-economic jurisprudence which has had an impact on the progressive realization of other rights including housing, education and social security. It has used health rights as the basis to challenge state power, abuses of human rights and ensured that government is held accountable and acts transparently in line with its Constitutional obligations. While the right to health and HIV/AIDS treatment

underpins all of these campaigns, it also sets general standards for democratic governance.

### **Other actors**

Again, while donors and the business sector are not traditionally considered allies of civil society, in SA, Brazil, Thailand and Uganda they have played a significant role in sustaining pressure on the state and drug suppliers to introduce and scale up prevention, care and treatment programmes. In SA they are also part of several alliances to counter denialism. SA<sup>22</sup>, Thailand and Uganda have included the business sector into civil society alliances where necessary and prudent.<sup>23</sup> In Uganda however, with the US administration's role being questioned and challenged alliances with donors are under scrutiny.

Where it is politically prudent and appropriate, alliances do make sense. Where it harms or undermines policy efforts then of course such alliances have to be critically assessed.

The 'pot' is not just the state but influential donors and international agencies as well. With AIDS activism in all four countries, this second layer of rice cooking is particularly relevant given the role and financial muscle of donors and external agencies. For example, while civil society may oppose the US and UK supported occupation of Iraq and Afghanistan, it makes its opposition public but continues to critically engage with the funding arms of these governments. This is to ensure that treatment is scaled up and that foreign governments do not restrict treatment through funding practices.

In SA, if civil society fully opposed PEPFAR and its funding and/or aspects of PEPFAR funding, one third of the patients in the public sector treatment programme (about 100 000 patients) would be placed at immediate risk. In addition, about 50 000 patients in the not for profit sector would also be placed at risk because PEPFAR funds a significant number of community

treatment programmes. So while the US administration has been criticized for undermining the Global Fund to Treat AIDS, TB and Malaria (GFATM) by running what is in effect a parallel and bi-lateral donor programme (PEPFAR), activists have to engage with it in the interests of the thousands of patients that are directly and indirectly supported by PEPFAR on a daily basis.

### **Diverse political spaces: democracy and military dictatorships**

In SA and Brazil, democracy and rule of law defines the space in which civil society or non-state actors exist or operate. This is different in several other countries in Southern Africa, Latin America, Eastern Europe and Asia where one party, life long presidents or unelected monarchies rule. In countries such as Zimbabwe<sup>24</sup>, and some Eastern European countries, very little political or other space exists for pro democracy civil society or single issue based organizations (assuming there is some civil society activity) to exist. Uganda and Thailand appear to be exceptions in that despite having governments with military backgrounds they have arguably succeeded to respond to the AIDS epidemic in more sustainable ways than countries with functioning democracies such as SA.

### **State power and perceptions of power**

The Brazilian, Ugandan and Thai governments have too their credit not questioned the legitimacy of civil society in their countries. They have not attacked their personal reputation, funding sources or credibility. They also do not see them as anti-state. Several Eastern European and African governments see civil society as being driven by anti-state influences, funded by external governments or bodies with political agendas and generally illegitimate. Despite this, "civil society continues to set up roots in many parts of the world where its presence just two decades ago would have been unthinkable".<sup>25</sup> In Poland for example, policy gains by civil society have taken place on controversial issues such as tobacco control, needle exchange programmes and drug substitution treatment<sup>26</sup>. However, in that region, there is a risk that authoritarian political traditions could block further progress.<sup>27</sup>

In SA and Brazil, politics has played a large part in how civil society has organized itself, responded to and mobilized on socio-economic rights issues in the last decade. In SA there are national campaigns to resist the privatization of water and electricity services and there is a small land rights movement. But HIV/AIDS activism has been at the forefront of sustained civil society struggle in the last 10 years. This is mainly because we have the highest number of people living with HIV and in need of ARVs in the world and because we have a highly organized and mobilized civil society network working on HIV/AIDS issues at both national and local levels.

Despite the SA government's subtle efforts to undermine civil society, activists have been successful in changing policy on AIDS over the last few years precisely because it has understood that power doesn't operate only in pre-defined centers such as parliament or the courtrooms but is just as present in the so called "peripheries" such as the street and local organizations and councils. To effectively use this power for political change then requires an ability to be an effective player in these various micro-sites while at the same time making effective linkages between these sites. Changing public policy is therefore not merely a result of petitioning by smart lawyers or enlightened decisions handed down by a benevolent judiciary but on the contrary a strategic play between the various sites of power. The idea that democracy however is a requirement for rational policy and state action is put to the test when we look at what is really happening in Thailand, Uganda and South Africa.

#### **Thailand: What has democracy got to do with health?**

In 1991 a military government took power in Thailand. Ironically, this change in government coupled with the early identification of an HIV epidemic among commercial sex workers (CSW) led to public health specialists implementing speedy prevention programmes. A national HIV prevention programme was

launched in 1991/2, with high level political commitment. Each government ministry developed its own AIDS plan with significant budget allocations. In 1991 Thailand had documented 143 000 new cases of HIV infection, but by 2003 this figure dropped to 19 000. Today, Thailand provides “universal access to medicines through publicly funded government organizations” including ARVs.<sup>28</sup> In Asia, Thailand is treating the largest percentage of people with ARVs.<sup>29</sup>

However the initial speed that the Thais employed meant that consensus building processes for prevention planning programmes were ignored. This has come back to haunt the Thai government (see discussion below). But the early speedy response did allow the introduction of risk reduction measures as far back as 1995 especially condoms and compulsory public education through schools, religious institutions, television and radio in all communities including in areas where CSWs and their clients were based. In the 1990s this led to a massive reduction of HIV incidence. However these initial prevention interventions did not include injecting drug users (IDUs), men who have sex with men (MSM) and immigrant communities.

Lee Nah (UNESCO) describes some of the early Thai interventions and notes that it “adopted a multi-level and multi-pronged strategy on HIV prevention. Not only was the government involved, but also more than 150 NGOs, private sector businesses and networks of PLWHAs. Together they collaborated to promote the use of condoms and HIV preventive education in ways easily acceptable to the general public and young people”.<sup>30</sup> In the first phase of prevention education, owners and managers of sex establishments, sex workers and their clients were also included. However two events in the last 15 years have affected the initial success of the Thai response. The first is the Asian economic crisis in the late 1990s which resulted in a massive reduction in overall health spending and a massive cut in the AIDS budget. In 1996 the latter amount stood at \$ 86 million but by 1999 dropped by about 43%. Early

aggressive and compulsory public education, prevention and condom distribution programmes were consequently replaced with poorly funded interventions or no interventions at all, leading to an overall increase in HIV incidence as “people naturally thought that without condoms, without messages, AIDS must be gone”.<sup>31</sup>

### **The war on drugs (and drug users)**

Why do you have to kill people? ....It's better to help drug users find ways to change their behavior instead of killing them. There are not enough graves to bury us all. *Odd Thanunchai*<sup>32</sup>

The second event is the ‘violent state sponsored’ “war on drugs” which officially commenced in February 2003 by the then by Prime Minister Thaksin Shinawatra. This played a significant part in driving the epidemic underground among IDUs. They were forced into rehabilitation treatment programmes; given substandard treatment; and excluded from government funded HIV services. Many were penalized for being in possession of sterile syringes. Instead of curtailing drug use, the climate of fear made it more dangerous for IDUs to use drugs safely and /or access health services because of the fear of blacklisting and arrest.<sup>33</sup> Health and human rights abuses during the ‘war on drugs’ led to a massive increase in the number of IDUs living with HIV. Violations of human rights including the right to access health services have been documented by Human Rights Watch (HRW). In a 2004 report on the human rights abuses perpetrated by the Thai administration it noted six serious violations at the time. It also called on international governments and donor agencies to pressure the Thai government into ensuring that such abuses were investigated and prevented.

These abuses included:

1. Extrajudicial killings of criminal suspects in the war on drugs (about 2000 documented cases);

2. Inaccurate and wrongful blacklisting of thousands of 'drug suspects';
3. Arbitrary arrests and the violation of due process including endorsement of extreme violence and discrimination against drug users and traffickers;
4. A climate of fear that prevented affected groups from seeking health services leading to an increase in poor health indicators and HIV prevalence (through sharing needles);
5. Absence of harm reduction measures in communities affected by drug addiction; and
6. Lack of HIV prevention and treatment services in detention facilities.<sup>34</sup>

The combined effect of the Asian economic crisis and the 'war on drugs' resulted in an increase in HIV prevalence especially among vulnerable and marginalized groups. In addition, an attack on state power due to state sponsored violations of human rights. For example, the UN and international donors were lobbied by HRW to denounce human rights violations in Thailand as well as implement public health measures to undo the impact of the war on drugs. By 2003, this coupled with local activism led to the GFATM allowing direct funding to the Thai Drug Users Network (TDN) to implement harm reduction measures in IDU communities, the first direct grant to an NGO by the GFATM. At the 2004 15<sup>th</sup> International AIDS Conference held in Bangkok, activists and international agencies managed to highlight the increase in HIV prevalence among youth, pregnant women and IDUs. Given the Thai governments initial speedy prevention work with sex workers and their clients in the 1990s and introduction of harm reduction measures (condoms), it is remarkable that it took two decades for the Thai government to recognize men who have sex with men (MSM) as a vulnerable group which now permits MSM access to state funded education programmes and health services.<sup>35</sup> The latter however only occurred because of civil society activism against such exclusionary practices.

Frequent changes in Thai state power has contributed to changing state priorities. About a year ago, a military coup took place and another new administration took power. Will this political change herald a new and better direction on health and other issues? It may just.

### **The costs of universal medicine access in Thailand**

Today, about 10% of Thailand's overall budget is spent on medicines. Therefore, in an attempt to ensure that its universal medicine access programme is sustainable and affordable in the long term, in the last few months Thailand negotiated with drug companies to reduce the prices of several essential medicines. These negotiations did not end positively. During November 2006 to February 2007 the Thai government responded by issuing three compulsory licenses for two ARV medicines, Kaletra (patent holder is Abbott Laboratories) and Efavirenz (patent holder is Merck) and a third medicine that is used to treat coronary disease, Plavix (patent holder is Sanofi-Aventis). These licenses permit generic imports from India for use in the public sector in the short term.<sup>36</sup>

Of course such action was greeted with opposition by the relevant drug companies as well as certain sections of the US government (the headquarters of the drug companies are in the USA). Abbott immediately threatened to withdraw its applications for regulatory approval of certain other drugs in Thailand<sup>37</sup>; the US Trade Representative (USTR) placed Thailand under Special 301 "Priority Watch List" surveillance<sup>38</sup> (as it did with SA in 1997 as part of the PMA case- see below); Merck condemned the decision<sup>39</sup>; and the Director General of the WHO Dr Margaret Chan initially challenged the decision but subsequently rescinded her reservations after alliances of local and international activists pressured the WHO into respecting the right of the Thai government to take such action. Ironically, in 2006 the World Bank recommended that Thailand should issue compulsory licenses in order to ensure the sustainability of its universal medicine access programme. The Thai

government action against Merck and Abbot are significant. Prior to this, no other developing country had issued formal compulsory licenses, though it may have threatened to.

### Uganda- AIDS and dictatorship

“Speaking to foreign audiences, the Ugandan president is ready to credit his country’s success in reducing HIV to whatever a particular donor is most interested in promoting. To evangelical Christians, he emphasizes abstinence and fidelity; to AIDS activists he jokes about the number of condoms his country needs; and to European ministers of development cooperation, he stresses the integrated national AIDS programme established by his administration. In return, the world has paid little attention to his government’s single-party rule, military adventurism and corruption”.<sup>40</sup>

In the early 1990s Uganda was one of the first countries in Africa to freely distribute condoms and provide anonymous HIV testing. Public education and awareness programmes led to a reduction in infection rates and a stable prevalence rate for many years. For these reasons, Uganda is hailed as the blueprint for responding to AIDS in Africa. Some also refer to Museveni’s leadership as ‘mould breaking’.<sup>41</sup> Many commentators have tried to grapple with the nuances of Uganda’s response. International institutions have praised the government for its bold and early public response to AIDS and credited it with reducing and stabilizing new infections.

Today, several commentators are less optimistic. They ascribe political shrewdness as the basis for Museveni’s past and present responses and interventions on AIDS.<sup>42</sup> To some, Museveni’s government (liberation movement with a military background) permitted civil society the space to “play an active role in addressing the epidemic” precisely to “extend the state’s authority”. By being the poster child, the AIDS and international donor community conveniently lost sight of the Ugandan governments’ involvement in the war in the Democratic Republic of Congo (DRC).<sup>43</sup> Given that Uganda fought two guerilla movements on its borders, banned political parties, harasses political

and pro democracy activists and uses violence against its civilians, it is worrying that its governments response to AIDS is seen in isolation from gross human rights violations. A critical assessment of the Ugandan example reveals that civil society activists<sup>44</sup> and networks played a significant role in risk reduction and behaviour change but that Museveni (a professor turned guerilla turned president)<sup>45</sup> took the credit for exclusively bringing about such change to secure donor funding and endorsement from foreign governments to rule without a fixed term.<sup>46</sup> De Waal strongly argues that the Ugandan HIV programme has everything to do with Museveni's desire to hang on to power than with sound public health policy.

So will Uganda be able to continue to justify the reputation and praise it has generated? Crucially, after 15 years of low infection rates, a slight increase has led to a critical interrogation of Uganda's public health and political response to AIDS. The last two years has shown that "the incidence of the disease is sharply rising" with infection rates approximately 6% of all adults. Furthermore, the first lady of Uganda is reportedly publicly flirting with evangelical notions of sexuality which are not evidence based. Because of this, Uganda's free national condom programme has been placed at risk. The sudden increased promotion of abstinence and faithfulness messages to the exclusion of safe sex messages is seen by many activists as a result of political opportunism. That is, to satisfy the US administration and its conditions for PEPFAR funding. It is hard to predict if we will witness the 'boomerang effect' in Uganda where local activists will link with international activists to bypass Museveni and his repressive tactics.

### **Brazil and South Africa**

Brazil and SA have historically struggled for democracy against illegitimate governments. Both also registered their first four AIDS cases at about the same time in the late 1980s.<sup>47</sup> However the responses and policy approaches to

health and AIDS by the Brazilian and SA government have been very different. Below I set out these divergent paths.

## **Brazil**

In 1984 the military junta gave way to a democratic government in Brazil. This democratic space permitted the state in alliance with civil society who is mainly made up of former liberation struggle, gay rights and women's rights activists to respond to the epidemic early on.

By 1986 Brazil had already established a National AIDS Control Programme (NACP) made up of scientists, civil society representatives, and state officials funded by the Brazilian government and World Bank. At the same time GAPA, a prominent Brazilian HIV and AIDS NGO was started.

*"The important thing was solidarity, full participation by everyone based on respect for differences, fighting for full citizenship, not just for HIV positive people, but for everyone facing a situation of vulnerability" V Terto ABIA [www.avert.org/aids-brazil.htm]*

By 1998, a new rights based Constitution was adopted in Brazil, recognizing the right to health as a human right. Thus, constitutional protections coupled with political leadership, scientific developments elsewhere in the world led to Brazil's free ARV programme being implemented from 1996.<sup>48</sup> Over time this has led to significant reductions in AIDS related hospitalization and mortality. In addition, because sex work is not illegal though brothels are<sup>49</sup> significant prevention and education work has always been undertaken with CSW communities leading to reduced infection rates among CSWs. However, this has costed the Brazilian government large sums of US funding because of its refusal to condemn prostitution as is required by the US administration. Alliances by civil society with the state have given the Brazilian government the room to retain its sovereignty and integrity against funding requirements and policy interference. This is because civil society in Brazil has supported its government on issues such as this and campaigned internationally to highlight these issues.

### **Medicine access and political will**

No developing country has done more for third world medicine access than Brazil. Despite this, it has been criticized by Brazilian activists for its initial legislative framework that favored the “multinational” industry over its own “domestic industry”; implementing TRIPs sooner than was legally necessary (1996) and granting additional patent protection to MNCs.<sup>50</sup> The ramifications of the Brazilian medicine access activism (through state and civil society) are three fold:

First, Brazil showed that third world countries despite their insufficient public health infrastructure can manage to treat thousands of people with ARVs. Doing this reduced new infections, limited illnesses, hospitalization and mortality. Second, it was the first developing country to successfully challenge multinational drug companies despite enormous trade and political pressure. Third, it showed that in new democracies, democratic governance allows civil society to be ally of and not a threat to state power. It showed that civil society and state alliances can be beneficial both for state power and service delivery for poor people.

The results of these efforts are encouraging: national adult HIV prevalence in Brazil is less than 1% - in the 1990s it was about 20% of adults. What is distinguishing about the Brazilian experience is the high level of alliance and cooperation between the state and non-state actors. The results of such an alliance have international implications for how to engage with the state to bring about meaningful change in people’s daily lives.<sup>51</sup>

### **Understanding why real action is taking place now**

Given that Brazils ARV treatment programme has now been in place for about a decade, significant number of patients require what are called ‘second line drugs’. These drugs are patented by MNCs. In Brazil in order to ensure cost savings and an affordable and sustainable treatment programme, it has had no

option but to issue licenses against the manufacturers of key ARVs. Up until April 2007 it had never actually issued a license as prior threats resulted in drastic voluntary price reductions. In April 2007 however, like Thailand, it issued formal compulsory licenses against Merck for EFV.<sup>52</sup> Like the Thai government, it has been condemned by Merck. However, through alliances with civil society both locally and internationally it proceeded with issuing the license and withstood the pressure. In turn, civil society is targeting and pressurizing Merck to lower its price on EFV and issue licenses elsewhere in the world.

### **South Africa and schizophrenia**

Since 1994, significant policy changes have occurred in SA<sup>53</sup>. Some changes have taken place because of voluntary state action and its own prioritization of certain social services. Most changes have however have been the direct result of sustained struggle and activism.

The techniques or tactics used by civil society to bring about such change are similar to that used by the African National Congress (ANC) and other anti-apartheid movements in the struggle against apartheid (save for the armed struggle and economic sanctions). Non-violent civil disobedience, information sharing through mass meetings, symbolic protests and sit-ins, broad based local alliances, t-shirts, songs, posters, vigils, research and expert evidence, personal testimonies, non-violent marches, petitions, international alliances, lobbying, appeals to international bodies and governments, appeals to donor agencies and funders, use of the legal machinery and courts, class actions, media and an appeal to citizen participation are tools that have always been used in social justice campaigns in SA. However, these tools were used against an illegitimate government. Today, targeting a post 1994 state requires an adaptation of these tools. Protests and legal action are therefore part of the process to get state buy-in, but they do not by and in themselves create political will. Policy shifts may occur because of moral or international pressure

and judicial pronouncements. However, political will is necessary to ensure that better policies are implemented with the requisite resources.

### **Policing activists**

Unlike Uganda and perhaps even Thailand, SA civil society is given the political space to mobilize. Aside from a handful of police and protestor skirmishes involving teargas, batons and rubber bullets -health activists are not detained without trial, not refused bail, not tortured, assassinated or physically attacked if they are critical of government policy or the President. The state does however carry out attacks through public statements designed to marginalize and undermine the personal reputation of civil society activists on the basis of race, sex, class or funding sources.<sup>54</sup> Defamatory perhaps, but hardly life threatening.

So while we have the tools of democracy at our disposal, especially free speech, most of it is taken up to challenge the overt and covert battle mounted by a few senior ranking and decision making officials in the SA government and health ministry against evidence based interventions and rational health policies. In many other Southern African countries, civil society battles are about democratic freedoms, not their governments' pseudo-scientific positions on HIV/AIDS.<sup>55</sup> It is impossible to weigh the cost of one against the other as each battle comes with its own needless human suffering.

### **Using multiple strategies - 'leverage politics'**

In SA, AIDS and health are<sup>56</sup> inherently political issues and any changes whether through lobbying or litigation is brought about by a nuanced understanding of this political terrain and the deployment of a variety of strategies to influence it. The strategies though seemingly disparate are designed to act cohesively to influence the politics of HIV/AIDS. The overall strategy of civil society groups can best be classified as a collection of a number of micro-strategies acting in tandem, with an understanding that power in the South African AIDS landscape

is not located in any one particular place but a number of different sites, ranging from the more obvious as courtrooms, media and parliament, to the more discrete but equally effective sites such as universities, townships and the streets. For this reason the state's vulnerability lies in its inability to resist the pressure being leveraged against it. This is why 'leverage politics' depends on alliances with a range of non state actors.

### **When the state acts as if it has no partners**

The "PMA case" of 2001 which has been extensively written about and documented, resulted in 39 multinational pharmaceutical companies withdrawing a three year legal case against the SA government. It is widely celebrated as a victory for civil society and transnational activism (Oleson) and ironically celebrated by the SA government as an indication of its own commitment to secure affordable medicines for sick and poor people.<sup>57</sup> But the SA government has consistently refused to acknowledge the role of the Treatment Action Campaign (TAC) and its local and international allies in bringing considerable attention to a lengthy 3 year court battle that was withdrawn 6 weeks after the admission of the TAC as amicus curiae. Government opposition and dislike of civil society is one thing, but its revisionism is startling.<sup>58</sup>

### **Aftermath of PMA - consequences for South Africans**

Even though the PMA case is credited with catalyzing international action in the form of the Doha declaration, it has not translated into any significant policy reform on affordable medicine access and it certainly did not result in the immediate provision of ARVs in the public sector in SA.<sup>59</sup>

Basically, since the 2001 withdrawal of the case,<sup>60</sup> the SA government has refused to take formal steps against the multinational pharmaceutical industry to lower the prices of ARV medicines and ensure generic competition. Crucially, unlike Brazil and Thailand, the SA government has not threatened to issue

compulsory licenses. It has not done so despite the fact that about 5.5 million people are living with HIV and of those 1 million need immediate access to treatment. The failure to exercise state power in this case has meant that there have been two main components of medicine access activism by civil society in the last 6 years in SA. First, challenging the SA government on its refusal to make ARVs available in the public sector. Second, unlike Brazil, challenging multinational companies on pricing and licenses for the generic manufacture and production of medicines without the state's support or even acknowledgment.

But one recent aspect of policy intervention brings the tension of cooperation and critical engagement in democratic but denialist states such as SA to the fore. The process leading to the adoption of the *National Strategic Plan on HIV/AIDS and STIs (2007 - 2011)* (NSP) has been affected by problems relating to inclusion and exclusion and puts the theoretical utility and my defense of alliances with the state to the test.

### **Uncertain alliances: The NSP and the way forward?**

Events at the 13<sup>th</sup> international AIDS conference in Toronto symbolize the conflict between civil society and the Minister of Health in SA. By the end of the conference, in a case of *de ja vu* (Durban 2000) international attention was again directed at the SA governments poor and ridiculous 13 year record on AIDS. On the penultimate day of the conference, a silent protest was held calling for the dismissal of the Minister. At the same time in SA, activists began a civil disobedience campaign as a result of the unexpected death of a prisoner living with HIV during a legal battle with the government to provide ARVs to all prisoners.<sup>61</sup> At the closing plenary session in Toronto, Stephen Lewis the former UN envoy on AIDS in Africa, reiterated the call for the Ministers dismissal and publicly lambasted the SA government's embrace of pseudo-science. Internationally, the public image of the SA government took another beating.

### **From garlic and lemons to consensus**

Following Toronto and within three weeks, three cabinet briefings were held on the HIV/AIDS crisis (23 August, 6 September and 20 September). "After its second meeting, Cabinet publicly announced that there would be a new approach, which included resuscitating the Inter-Ministerial Committee (IMC) on AIDS, tasking the Deputy President to oversee the restructuring of the South African National AIDS Council (SANAC) and resolving the disputes that were dividing society".<sup>62</sup> This period also saw a decline in public utterances and statements by the Minister of Health on AIDS. Significantly, the Deputy President immediately met with civil society with a view to re-building the states relationship with it; restructuring the South African National AIDS Council (SANAC); drafting a new national strategic plan (NSP) on HIV/AIDS for the period 2007 - 2011.

### **Schizophrenic inclusion and exclusion**

There are 3 parts of the NSP process that best illustrate the schizophrenic battle to partner with the state. The first is what I call the 'exclusion period'. The second is the 'inclusion period'<sup>63</sup> and the third is the 'uncertainty' or 'watch this space' period.

#### **Exclusion**

The first draft of the NSP was publicly presented in November 2006 by the health ministry. It was written without any consultation and participation by civil society or other stakeholders. Civil society and the business sector therefore responded by challenging their exclusion from the process and the drafting team. Again, international and local media exposed the attempt by the SA state to bypass consensus building processes to put in place a plan devoid of any real substance or achievable targets.

**Inclusion** [This period coincided with the Minister being out of office for a lengthy period of time]

As a result of the criticism leveled against the state and following the post Toronto 'inclusive' approach, a multisectoral writing task team including civil society was agreed upon by the Deputy President to "evaluate [the NSP] and refine it on the basis of scientific knowledge and understanding". Other than government, the team also included leading scientists, health care workers, researchers, civil society leaders and business sector representatives who worked tirelessly to develop a significantly improved version of the NSP.<sup>64</sup> The final document released in May 2007<sup>65</sup> (months prior to the dismissal of the former deputy minister) represented a refreshing multi-sectoral approach. It makes significant undertakings to reduce new infections and set targets for prevention, care and treatment services. This part of the NSP process confirms that cooperation is vital in shaping key policy decisions. It reiterates that active citizen participation is still possible and necessary to achieve policy shifts as well as targets for interventions.<sup>66</sup> Without the participation of a range of civil society actors, the NSP would have ignored key targets and essential political and health interventions such as the decriminalization of sex work.

### **Watch this space**

The positive aspects of the second part of the NSP process have been somewhat short-lived. By August 2007, the Minister of health returned to office after a period of sick leave. By September 2007, President Mbeki fired the former deputy minister of health for not being a 'team player' and undertaking 'unauthorized travel'. The true reason for her dismissal was her forthright assessment of the infant mortality crisis at Frere Hospital in the Eastern Cape and her increasingly positive public image which directly challenged and embarrassed the Minister. Civil society has stated that her dismissal is an abuse of Presidential and state power. Yet, despite many senior ANC members unhappiness with the Ministers conduct and the Presidents approach to AIDS, not a single ANC member currently in office publicly supported Madlala-

Routledge or criticized her dismissal though they may have done so through internal ANC party structures.

At the same time SANAC appointed its first deputy chairperson from civil society under the chairpersonship of the deputy president of SA. On paper, the space for constructive and critical engagement with the state via SANAC exists. But to what extent the state will permit SANAC to be used for real engagement remains to be seen. More importantly, how and to what extent civil society uses this space to bring about social and policy change will be crucial in determining the perimeters of critical but meaningful engagement.

### **Conclusion**

The countries that I have reviewed represent examples of alliances as well as critical engagement with the state that have yielded certain policy shifts on health issues including medicine access. Each country's experience suggests numerous possibilities regarding state alliances and cooperation and each have developed this aspect in diverse ways. In Uganda and Thailand, current trends in the abuse of state power suggest a lack of democratic governance. Yet there are no signs that civil society in those countries is losing their ability to force policy changes on health issues, which ultimately is an inherently political act. What each country shows is that the notion of civil society as a tool to fight state power are not that unambiguous and is in fact quite outdated. In fact, often state power is unpredictably supported and then challenged in a cyclical manner through what I have called 'integrity politics'.

Today's 'new activism' (for want of a better phrase) relies on alliances with the state (Brazil, SA, Uganda and Thailand), the business sector (SA, Thailand) and the scientific and research community (Brazil, SA). The way in which civil society activism has played out in all four countries suggest that when it comes to health issues, it is not as concerned with structural opposition as it is with policy change to immediately save lives. This is not to suggest that activism in

these four countries is not at all concerned with structural imbalances. In fact, at the heart of all of these campaigns is a demand that structural relations and power imbalances are addressed to bring about a particular policy change. Often, cyclical support /challenge of the state gives civil society more political power than originally intended. It does so by making communities willing and able to directly engage with the state on issues that most affect it; and implementing policy changes on the ground where people tangibly benefit from such change. It also does so by keeping people healthy and alive so that they can engage the state and challenge the state through active citizen participation in the future. The perfect pot of rice remains elusive. But while we stir, the fire should not be extinguished

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<sup>1</sup> The author would like to thank the Fleishman Fellowship Programme at the Terry Sanford School for Public Policy, Duke University. In particular, the resource room for research assistance, faculty advisors and the programme director. All errors remain that of the author. Correspondence should be directed to hassanf@alp.org.za.

<sup>2</sup> I have used this metaphor from Madlala-Routledge who has in turn taken it from the writings of Comrade Mzala an anti-apartheid activist and intellectual. See 'A tradition of activism' Nozizwe Madlala-Routledge. Address delivered on 13 September 2007 at Centre for Civil Society, UKZN as part of the Harold Wolpe Lecture Series.

<sup>3</sup> Senior Attorney, AIDS Law Project South Africa. Convener of the Joint Civil Society Monitoring Forum. Board of Directors MSF South Africa. The author has been part of the legal team that has acted in several cases against the SA government, multinational drug companies and the business sector.

<sup>4</sup> Nozizwe Madlala-Routledge, note 2 above.

<sup>5</sup> 'Taking On Apartheid, Then a Nation's Stance on AIDS', Michael Wines: New York Times 8 September 2007. Also see Clare Kapp, Lancet 0099-5355 Nov 18 2006 v 368 i9549 p1 7592 (2). See also 'The President fired the wrong Minister' F Hassan and M Heywood, Mail and Guardian Counterpoint. 21 August 2007. Available at [http://www.mg.co.za/articlePage.aspx?articleid=317262&area=/insight/insight\\_\\_comment\\_and\\_analysis/](http://www.mg.co.za/articlePage.aspx?articleid=317262&area=/insight/insight__comment_and_analysis/)

<sup>6</sup> See [www.pbs.org/newshour/bb/health/july-dec03/brazil\\_7-16.html](http://www.pbs.org/newshour/bb/health/july-dec03/brazil_7-16.html)

<sup>7</sup> The Anglican Church in South Africa is just one example of clergy promoting safer sex practices.

<sup>8</sup> Cited in *Activism Against AIDS*. Brett C Stockdill. Lynne Rienner Publishers London 2003 at page 20.

<sup>9</sup> See also Hakan Seckinelgin. 'Who can help people with HIV/AIDS in Africa? Governance of HIV/AIDS and Civil Society'. Inter Journal of Voluntary and Nonprofit organizations Vol. 15 No.3 September 2004 at page 291.

<sup>10</sup> See B Rau, 'The Politics of Civil Society in Confronting HIV/AIDS'. Royal Institute of International Affairs 82, 2 (2006) 285 - 295. Rau's definition of civil society does not include trade unions, business and donors.

<sup>11</sup> See Seckinelgin note 9 above at page 360.

<sup>12</sup> See Seckinelgin note 9 above. He cites Caroline Sahley in arguing the impact of insecure funding in planning activities. In some countries such as Burkino Faso and Mali local NGOs were the first to import generic medicines for use by patients living with HIV/AIDS. Therefore any assumption that NGOs in these parts of Africa only focus on service delivery to the exclusion of policy issues is incorrect.

<sup>13</sup> Rau note 10 above, at page 228.

<sup>14</sup> See S Friedman and S Mottiar 'A Rewarding engagement? The Treatment Action Campaign and the Politics of HIV/AIDS'. Politics & Society, Vol. 33 No. 4, December 2005 511-565. See their reference to an interview with a 'social movement activist' in SA.

<sup>15</sup> *Activists beyond borders -Advocacy Networks in International Politics*. M E Keck and K Sikkink Eds, Cornell 1998. In Imperial China, politicians, locals and international missionaries worked together to start a moral and political campaign to ban foot binding despite the Chinese authorities use of state power to clamp down on these and other reformist campaigns. Within 16 years, they had won a decree banning foot-binding.

<sup>16</sup> Largely credited with shaping every civil rights campaign thereafter. Keck and Sikkink note 15 above at page 43.

<sup>17</sup> Keck and Sikkink note 5 above, at page 42.

<sup>18</sup> See for example Minister of Health v Treatment Action Campaign 2002 (5) SA 721 (CC) and M Heywood 'Debunking 'Conglomo-talk': A Case Study of the Amicus Curiae as an Instrument for Advocacy, Investigation and Mobilisation.

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<sup>19</sup> The most obvious health related case where state power was supported by civil society was the so called PMA case. The Pharmaceutical Manufacturers Association and Others v. The President of the Republic of South Africa and Others, case no: 4183/98, High Court of South Africa (Transvaal Provincial Division).

<sup>20</sup> Education, land, water, food and electricity rights activists do not have to contend with a denialism that education, land, water, food and electricity are harmful tools of western companies or that they are not necessary because alternatives are available.

<sup>21</sup> For detailed analysis of the Mbeki administration's flirtation with pseudo science see James Myburgh. 'Mbeki on AIDS'. Oxford Forum available at [http://homepage.mac.com/zoe.flood/oforum/issue\\_01\\_2005/of\\_01\\_2005\\_p2427.htm](http://homepage.mac.com/zoe.flood/oforum/issue_01_2005/of_01_2005_p2427.htm). See also Friedman et al note 14 above. Steven Robins, 'Long live Zackie, Long Live': AIDS Activism, Science and Citizenship after Apartheid. *Journal of Southern African studies* Vol 30 Number 3 September 2004. N Natrass *Mortal Combat* 2007. E Cameron *Witness to AIDS*. See also the resources available on the TAC website [www.tac.org.za](http://www.tac.org.za).

<sup>22</sup> . While this can be contentious and even complex, such alliances have been crucial in ensuring: -the introduction of free ARV treatment programmes in the workplace even before the provision of ARVs in the public sector  
-the adoption and finalization of the 2007-2011 National Strategic Plan  
-the restructuring and strengthening of the South African National AIDS Council (SANAC) which is also the country co-ordinating mechanism for the GFATM.

<sup>23</sup> Leclerc-Madlala Suzanne (2005) 'Popular responses to HIV/AIDS and Policy' *Journal of Southern African Studies*. 31:4, 845 - 856. See also an ANC document entitled : 'Caravans, Cats, Geese, Foot and Mouth and Statistics: HIV/AIDS and the Struggle for the Humanisation of the African'. Author unknown.

<sup>24</sup> See C Boon and J Batsell 'Politics and AIDS in Africa: research Agendas in Political Science and International Relations' *africaTODAY* pages 3-33. See their analysis of NGOs operating in Zimbabwe and the role that the ZCTU has played at page 17. Due to political and legislative measures to undermine civil society mobilization civil society in Zimbabwe has been unable or unwilling to "engage in overt political action even as advocates for better AIDS policy" at page 6.

<sup>25</sup> K Malinowska-Sempruch et al note 25 above at page 632.

<sup>26</sup> See the example of Polish tobacco control reform in K Malinowska-Sempruch et al 'Civil society - a leader in HIV prevention and tobacco control' *Drug and Alcohol Review* Nov 2006, 25, 625-632. By 1999 civil society had managed to ensure a total ban on tobacco related advertising in Poland.

<sup>27</sup> See K Malinowska-Sempruch et al note 25 above. Note the attempts by the Russian government to legislatively contain the activities of civil society.

<sup>28</sup> Access to Essential Medicines: Lessons learned since the Doha Declaration on the TRIPs Agreement and Public Health, and Policy Options for the EU. J H Reichman and F M Abbott. June 2007, European Parliament 2007. At page 25. available at [www.europarl.europa.eu/activities](http://www.europarl.europa.eu/activities)

<sup>29</sup> Reichman and Abbott, see note 28 above.

<sup>30</sup> Lee Nah Hsu 'Building dynamic democratic governance and HIV resilient societies' *UNESCO 2005 ISSJ* 186 at pp 699 - 713 at page 703.

<sup>31</sup> See [www.avert.org/aidsthai.htm](http://www.avert.org/aidsthai.htm). Mr Mechai is the Condom King or Mr Condom.

<sup>32</sup> Cited by Human Rights Watch : 'Not Enough Graves: The War on Drugs, HIV/AIDS and Violations of Human Rights in Thailand' 2004. Available at [www.hrw.org/reports/2004/thailand0704/5.htm](http://www.hrw.org/reports/2004/thailand0704/5.htm)

<sup>33</sup> HRW 2004 report note 32 above

<sup>34</sup> HRW 2004 report note 32 above

<sup>35</sup> Given that among MSM in Bangkok, HIV prevalence is about 28.3%, this is significant but attributed to activist pressure not state benevolence. See [www.ips.news](http://www.ips.news)

<sup>36</sup> See Reichman and Abbott, note 28 above at page 26 and footnote 85. After the announcement, Merck offered to reduce its price to 20% above the Indian generic price. The

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Thai government intends to reduce the price of Kaletra by about 20% and expects to reduce its costs for Plavix by a factor of 10.

<sup>37</sup> See Reichman and Abbott, note 28 above at page 26.

<sup>38</sup> See Reichman and Abbott, note 28 above at page 27.

<sup>39</sup> Merck Inc statement 4 May 2007 cited in Reichman and Abbott, note 28 above at page 27, footnote 87.

<sup>40</sup> Alex de Waal 'The Politics of a Health Crisis Why AIDS is not threatening African Governance' Harvard International Review Spring 2007 pp 20-24 at page 23.

<sup>41</sup> D Curtis 'Looking for Strengths in Response to AIDS: Individual Group and Public Authority Roles in Strategy' Public Admin. Dev 24, 51-59 [2004] at page 59. See also Lee Nah Hsu at page 705, note 30 above.

<sup>42</sup> See Alex de Waal note 40 above and Boone and Batsell at page 9, note 24 above.

<sup>43</sup> See Rau note 10 above at page 292.

<sup>44</sup> For example, Alex de Waal refers to efforts by civil society and singer Philly Lutaya that have been overlooked. He also argues that Uganda was the first success story of Africa because at the time Africa needed a success story. Note 40 above.

<sup>45</sup> Rau note 10 above at page 292.

<sup>46</sup> See Alex de Waal note 40 above.

<sup>47</sup> See news.bbc.co.uk/1/hi/world/Americas/3065397.stm

<sup>48</sup> Unlike other developing countries it also permits prevention work with MSM. In respect of IDUs, it runs clean needle exchange programmes and provides assistance to IDUs who need drug substitution therapy through state funded harm reduction programmes.

<sup>49</sup> See [www.pbs.org](http://www.pbs.org). In 2003 the figure of CSWs was estimated to be about 170 000.

<sup>50</sup> Reichman and Abbott, note 28 above at page 24.

<sup>51</sup> Lee Nah Hsu note 30 above at page 702.

<sup>52</sup> The cost savings through this measure is reportedly \$30 million per annum. See note 28 above.

<sup>53</sup> See Pieter Fourie 'The Political Management of HIV and AIDS in South Africa'. Basically, the apartheid government did nothing on HIV/AIDS during the first few years of the epidemic. See also Didier Fassin 'When Bodies Remember: Experiences and Politics of AIDS in South Africa'.

<sup>54</sup> In 1993 the Malaysian government attempted to undermine the credibility of NGOs claiming misuse of funds.

<sup>55</sup> For background see T Olesen 'In the court of public opinion: Transnational problem construction in the HIV/AIDS Medicine Access Campaign 1998 - 2001 International Sociology Jan 2006 vol 21 (10) 5-30. K Johnson

'AIDS and the Politics of rights in SA: A contested terrain' 115 - 129 Human rights review, Jan - March 2006. H L Matisonn 'Beyond party politics- Unexpected democracy deepening consequences of one party dominance in SA'. See also note 23 above, Leclerc-Madlala Suzanne.

<sup>56</sup> Boone and Batsell, note 24 above at page 16 refers to tensions between civil society and the Kenyan government.

<sup>57</sup> The most significant aspect relating to advocacy was the framing of the case as one about 'human lives'. Framing the case as one about transnational problem of 'patients versus profits' provided the moral high ground but also provided the space for domestic activists to link up with international activists (particularly Oxfam MSF and US based orgs). Unlike during the anti-apartheid struggle, new, innovative and speedier technology lent itself to effective 'framing' and communication across borders. See Heywood note 18 above.

<sup>58</sup> For example, at the time, the TAC in particular, was excluded from the victory rally. It was never shown the withdrawal agreement. It has never been acknowledged in any government document that discusses or mentions the case. Basically, government has attempted to write civil society out of history.

<sup>59</sup> It took more than 4 years to bring into effect the impugned provisions. It also took several years before a 'single exit price' system for medicines was implemented. A transparent pricing system for medicines is still not yet fully in place.

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<sup>60</sup> The terms of the withdrawal have not been made public.

<sup>61</sup> See generally [www.alp.org.za](http://www.alp.org.za) ALP 18 Month Review January 2006-June 2007.

<sup>62</sup> See [www.alp.org.za](http://www.alp.org.za) ALP 18 Month Review January 2006-June 2007.

<sup>63</sup> See Clare Kapp *Lancet* 0099-5355 Nov 18 2006 v 368 i9549 p1 7592 (2)

<sup>64</sup> The NSP is available at [www.doh.gov.za](http://www.doh.gov.za).

<sup>65</sup> 'In March 2007, a new draft was produced and placed before a genuinely national consultative meeting, where it was interrogated and debated, with proposals for amendments being put forward. This meeting of 500 people was a genuine exercise of democracy in health policy-making. Proposals made were incorporated into the final version of the NSP that was adopted by SANAC on 30 April and approved by Cabinet on 2 May 2007 as a strategic framework that will guide the national response to HIV and AIDS over the next five years' see ALP 18 Month Review available at [www.alp.org.za](http://www.alp.org.za)