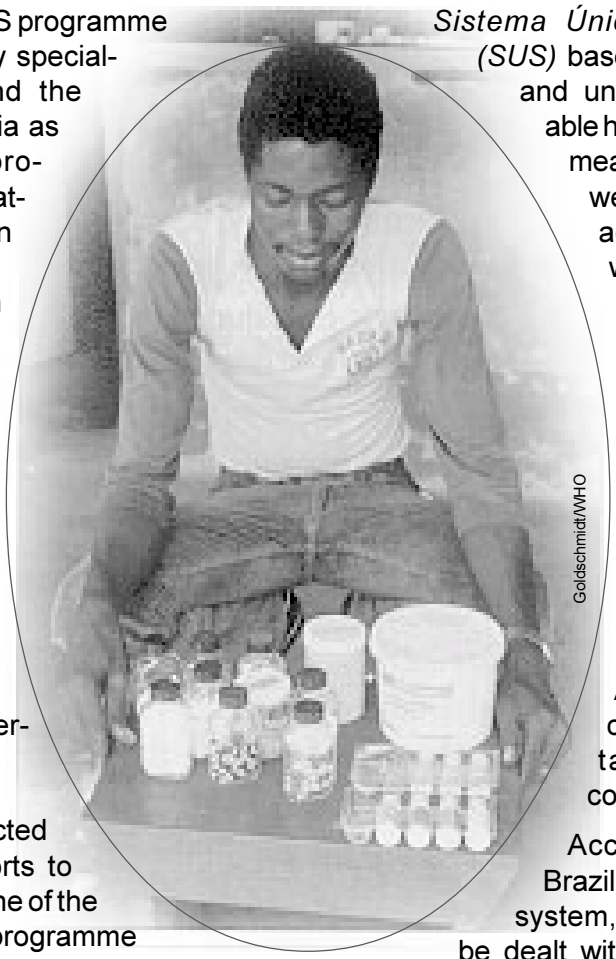
STAKING A CLAIM TO HEALTH

Access to medicines is one of the many issues that the 'Massive Effort' hopes to ensure. In Brazil the implementation of a distribution policy for ARVs was the result of a long struggle for social rights by activists, health professionals and government officials. ***Veriano Terto Jrt****.*

The Brazilian AIDS programme has been cited by specialists, activists and the international media as an exemplary programme for combating the epidemic in developing countries. The Brazilian public health system, which is routinely criticized for not finding solutions to endemic problems such as tuberculosis, malaria, schistosomiasis and other tropical diseases characteristic of developing countries, has received unexpected praise for its efforts to deal with AIDS. One of the outcomes of the programme that has attracted most attention has been the 50% reduction in the mortality rate for AIDS in the last five years. This certainly results from the national anti-retrovirals (ARVs) distribution policy, which ensures universal access to medicines for all HIV-positive individuals registered with the public health system who have been prescribed these medicines.



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The Brazilian public health system

The drafting and approval of the 1988 Brazilian Constitution was accompanied by a strong campaign by the public. The result was progress on various social issues, including the establishment of a *Sistema Único de Saúde (SUS)* based on free, full and universally available health care. This meant all Brazilians were to be given access to SUS, whether or not they were employed and or covered by other social security systems. This is unique to Brazil and the distribution policy for medicines for AIDS in this country is to be taken in this context.

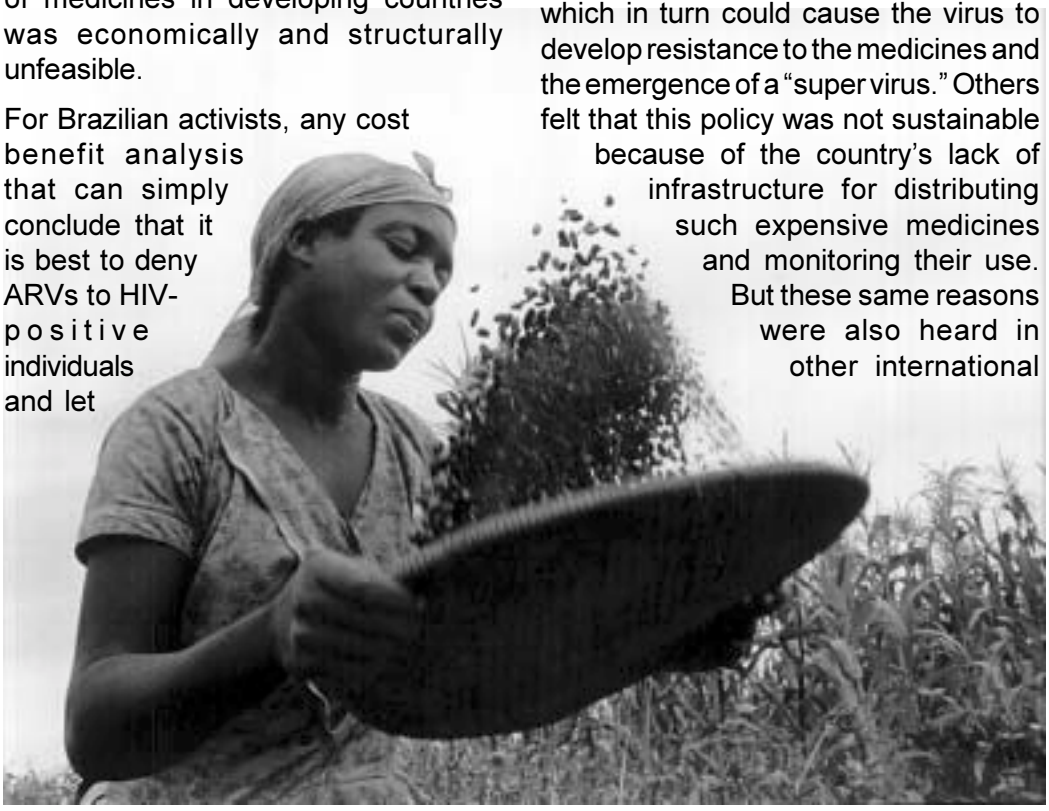
According to the Brazilian health care system, AIDS should be dealt with in the same way as any other disease. For example, if tuberculosis patients are given universal access to the medicines necessary to treat their disease, then AIDS patients must also be given such access. AIDS must not be treated as an exception, and must be dealt with in the same way as other diseases treated under SUS.

The fight for a public health system based on the principles of free, full and universally available health care and the right to health has not been easy nor is that struggle over. It has to overcome obstacles both inside and outside the country. The World Bank, for example,

AIDS should be dealt with in the same way as any other disease when it comes to accessing medicines.

claimed it was economic suicide for Brazil to provide universal health care. The Bank stated that a health system based on this principle could be a disaster for the country's public finances. They added that it would be cheaper to invest in prevention and that the free distribution of medicines in developing countries was economically and structurally unfeasible.

For Brazilian activists, any cost benefit analysis that can simply conclude that it is best to deny ARVs to HIV-positive individuals and let them die from their illness is completely unacceptable.



Awareness training places importance on the individual rather than the virus.

Between 1999 and 2000, AIDS NGOs and HIV-positive individuals took to the streets to protest against the government's economic policy, which involved cuts in social services, including health, and threatened the government's medicines distribution policy.

Finally the law was renewed to include universal and free access to AIDS medicines for all those who were prescribed medicines in accordance with the criteria established by the Ministry of Health. Until then, only some states and municipalities were distributing ARVs and the antibiotics necessary to treat opportunist infections and even these were not consistent.

However, it was only after the XI AIDS Conference in Vancouver – when ARV combinations were accepted as an effective treatment – that inhibitions to ARVs were overcome and the medicines were accessible throughout the country.

It was an important victory. But not everybody was forthcoming with support. Some argued that patients may not complete the treatment regimen, which in turn could cause the virus to develop resistance to the medicines and the emergence of a "super virus." Others felt that this policy was not sustainable because of the country's lack of infrastructure for distributing such expensive medicines and monitoring their use. But these same reasons were also heard in other international forums when access to medicines in developing countries is being discussed.

The reassuring fact is that despite all these difficulties, the policy of universal distribution of ARVs has become a reality and the last five years have proved doomsday forecasters wrong. Decreased mortality rates, savings in hospital expenditure, an improved quality of life for AIDS patients and a trend towards the stabilization of the number of AIDS cases are facts that no one can dispute.

National production of medicines

Another factor that has helped in the battle against AIDS is the country's protocol for the production of medicines. In Brazil, seven of the twelve medicines used in ARV combinations are produced by the national pharmaceutical industry. Further, drug production is not hindered by the 1996 Patents Law, because

Keys to success

- Simple diagnosis and treatment
- DOTS strategy: Free and constant drug supply
- NGO - Government collaboration
- Unified reporting
- Simple issue-based operations research
- Health sector reforms: TB a part of essential service package

production was authorized before that date. Moreover, the Brazilian Patents Law states that a medicine patented by the international pharmaceutical industry can be ignored if it is in the national interest to do so because of a national emergency, or if prices are excessively high. It also permits the government to license local production of patented medicines if the patent holder has not begun local production within three years from the date on which the patent was registered in the country.

National production of generics made it possible for the Brazilian government to avoid becoming a hostage of multinationals. It facilitated fairer negotiations on medicine prices and although there has not been a sharp fall in the price of medicines, at least there is a trend towards stable prices.

Lessons from the Brazilian experience

- Perhaps one of the biggest lessons to be learned from the Brazilian experience is that good access to AIDS medicines cannot be achieved by specific and isolated initiatives, such as donations and clinical research protocols. It can only be achieved by an integrated health policy in which health care prevention and respect for human rights is included.
- Organized civil society has a decisive role. Without the mobilization of various sectors of society, including political action by HIV-positive individuals, it would be much more difficult to implement and sustain the national medicines distribution policy.
- The AIDS epidemic in Brazil has not been halted. In the health care field, there is a lack of laboratory tests for, for example, CD4, CD8 and viral load tests. Also inadequate attention is paid to some poverty-stricken areas on the outskirts of the big cities. With regard to prevention, the epidemic continues to spread in socially vulnerable and unprotected groups such as women, injectable drug users, young homosexuals, Afro-Brazilians and prisoners.
- The free market principles of the international pharmaceutical industry are not applicable to the public health situation of developing countries. Economic interests must not prevail over the right to life and health. The Brazilian experience shows that effective strategies to deal with the HIV/AIDS pandemic cannot be achieved where industrial monopolies exist, where there is profit without social control and where there are no ethical guidelines to regulate intellectual property rights over scientific discoveries.

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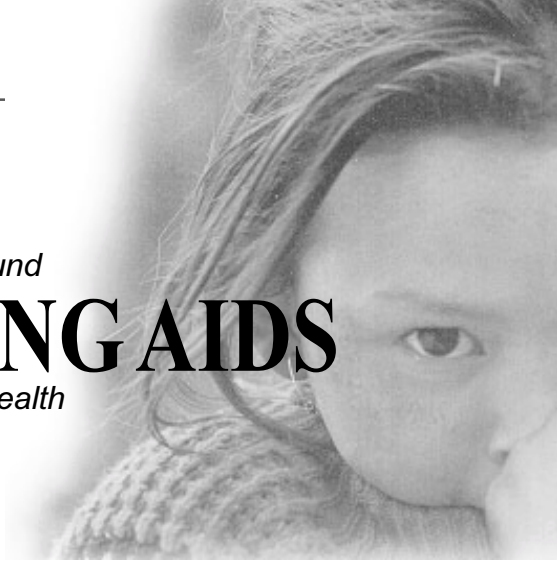

LOOKING AIDS

Senegal has developed an innovative mode to face the HIV/AIDS challenge and is a good example of how practical alliances and partnerships have compensated for the shortcomings normally found in resource-poor environments.
***Ibrahima Bob** narrates how communities receive outreach activities beyond the usual services offered by health facilities, and how this extensive networking has resulted in collaboration rather than competition.*

Senegal, a West African country with a population of 10 million, currently has about 79,000 people living with HIV/AIDS: 76,000 adults aged 15-49 years, of whom 40,000 are women, 36,000 are men and 3300 children. Since the beginning of the epidemic, nearly 42,000 children below 14 years of age have lost their mother or both parents due to HIV/AIDS. A grim picture but it has not stopped them from trying.

Early response

While some African countries were denying AIDS, the Senegalese accepted AIDS as an epidemic from the beginning and opted for an aggressive prevention campaign.

In 1987, when National AIDS Control Programmes (NACP) first started, the country had 45 known AIDS cases. Since then, a multi-sectoral response to HIV/AIDS has been a high priority of the government. An open dialogue and cooperation between the government team and civil society helped to determine adequate responses to the epidemic. The National AIDS Committee collaborated with a network of NGOs and CBOs besides religious and political community leaders. With support from donor agencies and technical assistance from outside, the government drew up a list of priority areas that included safe blood for transfusions, educating vulnerable groups and establishing a sero-surveillance system.

Key players

Representatives from hundreds of community development, cultural and sports associations along with youth and women's groups throughout the country received training to increase their awareness on HIV/AIDS. They, in turn, have communicated their knowledge to their respective groups.

In addition, these sessions place importance on the individual, rather than the virus and emphasize on positivity. Each group receives information about Information Education and Communication (IEC) methods and is given planning tools to adapt to their specific needs. Other key players in this campaign are trade unions, associations of sex workers, youth groups, women's cooperatives and networks of People Living with HIV/AIDS (PLWHAs).

Unique strategy

Senegal's public health policies involving vulnerable groups are unique. Instead of punitive action, it allows sex workers to keep the government card which permits them to continue with their work. Those who work must get tested at special public health clinics

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IN THE EYE

every month for sexually transmitted infections (STIs) and every six months for HIV. This process has made them aware of the dangers of unsafe sex. However, if they ever do test positive for AIDS, the card is not revoked.

Public health officials maintain that a harsher policy would only drive infected sex workers underground. Instead, women who test positive are counselled about why practising safer sex is in their own interest. As a result of this 'different' approach, STIs, HIV included, have fallen among Senegalese sex workers over the past three years.

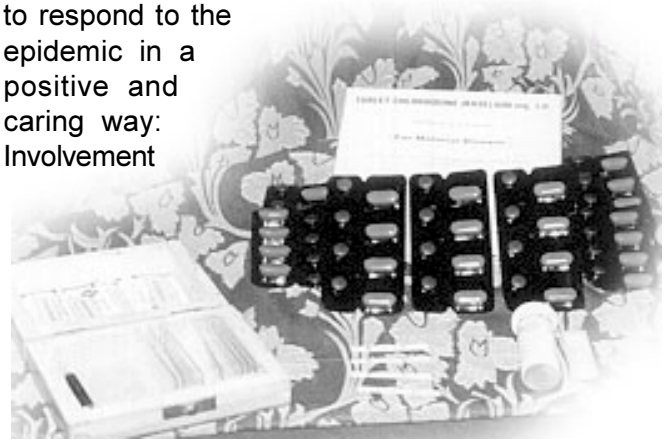
The role of religion

By involving religious leaders and community elders and by capitalizing on Islamic and Christian protective norms (abstinence before marriage, fidelity, care of those affected), Senegal has avoided the harsh resistance seen in some other countries. SIDA Service, a progressive Catholic organization, gives out condoms only to married couples in which one or both partners are infected. During awareness building sessions, community health workers advise the audience to use condoms as a "lesser evil" if they cannot be faithful, and glean from religious texts to get across their message. However, the religious response to the AIDS pandemic is not limited to sexuality.

One of the successes of the Senegalese campaign is that fewer and fewer people consider themselves immune to HIV infection, understanding that anyone can be at risk. *Kepka ba sida am garap* (keep your legs crossed until there is a remedy for AIDS) is a common expression used by youngsters, meaning that "in our age group" we are still at risk.

Lessons learned

Senegal's success has been in engaging communities to respond to the epidemic in a positive and caring way: Involvement



of community leaders, cultural and religious protective norms and a national programme catering for all, designed by the people rather than by experts.

Remaining challenges

Although Senegal's population is well educated about AIDS and has a low prevalence rate now,it does not necessarily imply behaviour change. In addition, the Senegalese population is highly mobile, a factor that contributes to the spread of AIDS, especially with high prevalence rates in its neighbouring countries. Policies are not yet in place to provide free ARVs. Nor has the issue of guaranteeing the human rights of HIV-positive people been resolved.

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