

# Brazil: A Model Response to AIDS

By Pascual Ortells | April 2003

AIDS is the first epidemic of the age of globalization, and responding to the AIDS crisis constitutes a major challenge for all societies. In Latin America, Brazil stands as both a model and an inspiration. What are the pillars of the Brazilian AIDS model? How did the model evolve and what are the challenges it faces? Can it be replicated in other poor countries facing growing AIDS crises?

## The Right to Treatment

The 14th International AIDS Conference, held in Barcelona in July 2002, confirmed two basic concepts. First, the cure for AIDS is still far off. Second, the illness can be effectively treated.

The first antiretroviral drug, zidovudine (AZT) produced in 1985 by Wellcome under the commercial name of Retrovir, was for years the only drug used to control the HIV infection. Current research and practice has shown that one AIDS drug is not enough to control the reproduction of HIV. A combination of two, three, or even four antiretroviral drugs is required—the famous “cocktails.” In medical terms, the therapy is called Highly Active Antiretroviral Therapy (HAART). It was introduced in 1998 as the most effective way to reduce the virus’s presence to undetectable levels, thus allowing people who live with the infection to enjoy a very acceptable quality of life.

Some 15,000 scientists, government officials, industry executives, and activists at the Barcelona conference agreed that access to the antiretroviral treatment has become the major policy issue in combating AIDS. In 2001, the 57th session of the United Nations Commission on Human Rights issued Resolution 33/2001 declaring that access to drugs to treat AIDS is a human right. Currently, only 4% of the 36 million people living with the HIV infection around the world receive antiretroviral drugs.

Nearly half the people in poor countries who receive this therapy are Brazilian. This is the main reason—although not the only one—that Brazil stands out as a country with efficient, compassionate public health policies in response to AIDS. Other countries of the South with exemplary policies include Thailand in Asia and Uganda in Africa. These three countries are among the

few that have managed to halt the spread of HIV infection among their populations and have implemented treatment and care programs for people living with the infection.

## Brazil’s Bold Policy: A Model for the South

The United Nations’ Global AIDS, Tuberculosis, and Malaria Fund (UNAIDS) has calculated that 600,000 people, including men and women of all ages, live with HIV in Brazil. Of these, 116,000 need antiretroviral therapy and receive it free of charge through the public health system. The cost of antiretroviral therapy in Brazil is roughly \$1,000 per person per year, a tenth of the therapy’s cost in developed countries.

The Brazilian model demonstrates that universal treatment of people affected by HIV is possible. The Brazilian government produces eight of the 15 drugs used in antiretroviral therapy as generics, and buys the other seven from outside labs at below-market prices, thanks to agreements with the manufacturers. The governmental laboratory, FAR-Manguinhos, has produced low-cost generic drugs for many years, including those most frequently used in treating malaria, tuberculosis, leprosy, leishmaniasis or mountain leprosy, and high blood pressure. When the need arose, Brazil began to produce generic antiretroviral drugs against AIDS within the framework of government policy. Production began before 1997, when the country approved a patent protection law.

Although the government program of universal access to AIDS treatment does not cover 100% of the demand, the results of Brazil’s bold policy are readily apparent. Since 1996, the mortality rate due to AIDS has dropped 50%, while AIDS-related hospitalizations in the public



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health system are down by 80%. With each passing year, the government is spending less money on AIDS-related treatments, despite the fact that 15,000 new patients are incorporated into the public health system every year.

Through participatory public education programs, the country has also had significant success in prevention. Brazil's HIV infection rate during the epidemic's early years in the 1980s was similar to that of South Africa. Currently, the rate among adults in Brazil is 0.6%, while in South Africa it has now reached 25%.

## **A Shattered Myth and a Community Proposal**

Another indicator of the success of the model is people's adherence to treatment. Following the prescribed treatment is both vitally important and easily forgotten; people are always prone to stop treatment for medical problems as soon as they see the first sign of improvement. But in the case of antiretroviral therapies, a failure to follow the regime can be fatal, causing the virus level in the blood to increase drastically. Since these therapies require people to take several pills a day for life, adherence is often the Achilles' heel for models seeking successful treatment.

In Brazil the adherence rate is around 60-70% and over the years has been roughly equal to rates in the United States and France. Brazil has thus dispelled the myth that poor countries are unable to establish, much less maintain, good public health policies. Brazilian AIDS activist Veriano Terto notes that the alliance between the Brazilian government and associations of people living with HIV accounts for the high rate of adherence. "We are increasingly involving HIV-positive people as part of the solution to the AIDS crisis as a social phenomenon. This represents a way of viewing adherence not merely as an individual question, but as a political commitment. People know that taking their medication correctly is not only going to benefit them individually, it will also benefit the whole collective of people around them."

## **The Formula: A Tradition of Public Health Plus Grassroots Action**

Brazil has a longstanding tradition of commitment to public health. Despite IMF structural adjustment plans to downsize that commitment, since the 1980s Brazilians have struggled actively to defend their health system and have largely succeeded.

Brazil's Constitution establishes the right to life and health as a collective right and a state responsibility. Terto notes: "The fact that a public health model existed even before our struggle began was very important in our getting access to treatment. Our health system is based on universality, equity, and a holistic approach. AIDS cannot be addressed through prevention alone. You need a comprehensive approach, including both prevention and treatment." The country's solid public health history strengthened the Brazilian government's decision to produce generic antiretroviral drugs, despite opposition from multinational pharmaceutical companies. Roberto Paulo Teixeira, coordinator of Brazil's AIDS program, views the Brazilian model as "the enactment of the universal principles of the right to health and to life."

Terto currently coordinates one of the organizations responsible for bringing about the country's AIDS policy—the Brazilian Interdisciplinary AIDS Association (ABIA). This group pioneered new responses to AIDS that focus on mobilizing people by informing the public, developing public policies, and educating people living with HIV about their rights. ABIA was also the first non-governmental organization (NGO) whose president was openly HIV-positive: Herbert de Souza or "Betinho." Through his writings and actions, Betinho transformed the vision of AIDS. In 1992 he wrote, "AIDS is not mortal. We are all mortal."

Activists point out that the key to the success of Brazil's national AIDS program is its partnership with social movements. While the model would have been impossible without the government's unconditional commitment, the government acted in response to the mobilization of broad sectors of Brazilian society. From the late 1980s through the 1990s, scores of citizens' organizations waged a tough battle with the state over access to antiretroviral therapy through the public health system, arguing that it should be provided on a par with drugs for other serious illnesses. For two consecutive years, organized anti-AIDS groups took to the streets demanding that the Health Ministry devote more resources to drugs and other medical supplies including, but not restricted to, AIDS treatment.

Before that, the battle had been waged in the courts to defend the right to treatment. In most cases, the courts found in favor of people with HIV who were suing for their rights.

In 1996, in response to the pressure exerted by social movements, the Brazilian government decided to make generic versions of anti-AIDS drugs available in the coun-

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try. The decision aroused the ire of the United States government, which denounced Brazil to the World Trade Organization (WTO) for violating the Trade-Related Intellectual Property Rights agreement. Finally, the pressure of international public opinion and the powerful determination of Brazilian NGOs forced Washington to drop its case.

Since then, social movements have exercised constant vigilance to assure continued accessible and quality health care. On two occasions, Brazil's Health Ministry warned that a budget shortfall would prevent it from providing anti-AIDS drugs and other medicines. On both occasions, NGO pressure forced the Treasury to come up with the money. The joint effort of NGOs and grassroots organizations forms the basis of the public policy. Working in the field, the NGOs provide prevention and assistance programs to the most vulnerable social sectors.

Brazil's civil society also supports and legitimates the government's proposals in the international arena, where the pharmaceutical industries, the U.S. government, and the European Union call the shots.

## Patents Against Patients: A Fight for Life

In early 2001, Brazil launched a campaign in the United States to argue that "local production of many of the drugs used in the fight against AIDS does not represent a declaration of war against the pharmaceutical industry. It is simply a way to fight for life." Although the Brazilian AIDS program respects national law and international patent agreements, the global pharmaceutical industry opposes the Brazilian initiative. After several years of activism in many international forums, however, Brazil has won victories that legitimate its production of generic antiretroviral drugs.

In an email letter sent out in May 2002, Cristina Pimenta and Veriano Terto wrote: "The excessive profits of pharmaceutical companies, the neoliberal policies that privatize public health, the unjust intellectual property

laws imposed over and above public and community interests, and the failure of many of our rulers to address social inequalities mark the history of developing countries. All of these factors are killing people who live with HIV in Latin America and the world."

Pimenta and Terto propose examining how developed countries have dealt with the question of intellectual

property rights in times of crisis. For example, in response to the shortage of the antibiotic *cipro* in the United States during the disproportionate demand created by the post-9/11 anthrax letters, the U.S. government decided to produce a generic version of the drug without paying the patent rights. The situation was clear: without treatment, 100% of patients affected by inhalation of anthrax die; with early treatment, some survive. Penicillin was not effective against the strain of anthrax encountered, leaving *cipro* as the only effective drug. Faced with this scenario, the government acted.

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## Pharmaceutical Companies Stage a Tactical Retreat

When the South African government indicated the desperate need to import or produce generic drugs for antiretroviral therapy, pharmaceutical interests exercised tremendous pressure to prevent it from doing so. In the end, the transnational pharmaceutical companies dropped their suit against South Africa. Alejandro Teitelbaun, the American Association of Jurists' permanent representative to the United Nations organizations in Geneva, described it as a "tactical retreat," since Africa represents only 1.3% of sales in the global drug market.

During the AIDS conference in Barcelona, some pharmaceutical industry executives again accused the Brazilian government of "piracy" for its policy of producing antiretrovirals, but they did so in private. No one dared publicly criticize the plan announced by the director of the Brazilian AIDS program to help developing countries use and eventually produce generic antiretroviral drugs. According to this plan, Brazil will provide antiretroviral drugs to ten different projects presented by

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poor countries at a cost of \$1 million a year. It will also provide assistance and medical training in the use of these drugs, as well as training and technology for their future production. The Brazilian Fund approved by the country's Health Ministry will provide antiretroviral treatment to some 1,000 people.

Jeff Sturchio, an executive with the transnational pharmaceutical company Merck, said that "expansion of access to anti-AIDS drugs is a complex problem, and various approaches will be necessary. Generics will have to play an important role." Other pharmaceutical giants, however, do not share Merck's flexible policy. GlaxoSmithKline, Bristol-Myers Squibb, Roche Holding, and Abbott Labs all have enormous investments in AIDS research.

## **Lessons from the Brazilian AIDS Model**

One of the most important lessons from Brazil is its defense of human rights as a paradigm of health. Veriano Terto maintains, "We have to develop—or defend, in the case of countries that already have it—health systems based on equity, universality, and a holistic approach." Under the principle of equity, Brazilian citizens with HIV have the right to treatment, just like those with tuberculosis. The principle of universality means that all Brazilian citizens receive health services for free, including people with HIV, people who have an HIV-related opportunistic disease, and people already in the AIDS stage. A holistic approach means that health care must address all aspects of the human being.

Terto adds: "AIDS is the result of a crisis, an economic and social crisis, that has produced the conditions that allowed this epidemic to appear. So dealing with it also means dealing to some extent with the crisis that produced it. One of the important lessons we can draw from Brazil's experience is that if civil society participates, we can make good progress against the epidemic. If we want a health policy, we have to establish it with citizen participation."

Another lesson relates to the need for solidarity. In ABIA's case, the belief in solidarity took root with the organization's founders, Betinho and Herbert Daniel, who viewed solidarity as a political strategy with concrete results. "Solidarity is the capacity to put yourself in the place of another person and feel that the other person's problem is also your problem and your responsibility. It humanizes us," asserted Herbert Daniel.

Daniel participated in the armed resistance against the military dictatorship in Brazil from 1960 to 1970. After seven years of political exile, he returned to his country after the 1979 amnesty and, as a writer and political activist, fought for the liberation and rights of sexual minorities. He was president of the Grupo pela VIDDA (Pela Valorização, Integração e Dignidade de Doente de AIDS)—the Group for Life, for the Appreciation, Integration, and Dignity of People with AIDS—and vice-president of ABIA. He died as a result of AIDS in March 1992 at the age of 45. Betinho was known throughout Brazil for leading a massive grassroots Campaign Against Hunger every year. He died in 1997, after nearly two decades of living with and fighting AIDS, with an extraordinary energy that belied his 100 pounds.

The relationship between Brazil's Catholic Church, the government, and grassroots movements also provides an interesting lesson for the rest of Latin America. The Brazilian Bishops Conference has a national commission responsible for pastoral work in the area of AIDS and sexually transmitted diseases. Conflicts exist between activists and the Catholic Church: the church has problems with promoting condoms in prevention work and would limit the role of the media. And many activists severely criticize the Catholic Church's official position on homosexuality and sexual and reproductive rights.

Despite these differences, there is an atmosphere of mutual respect in Brazil, as groups do their work without attacking the positions of others. Many in the Brazilian Catholic Church are involved in humanitarian aid as well as efforts to prevent stigmatization and discrimination because of AIDS. The country has 40 Catholic NGOs providing various AIDS-related services. The Brazilian Cardinal Paulo Evaristo Arns is an important figure in this work, not only in Brazil's Catholic Church but also nationally and internationally.

Neither the Brazilian model nor its social partnership is perfect, and the country still has a long way to go. ABIA's coordinators lament the fact that shortages in Brazil's public health system make it hard to provide correct follow-up to people undergoing antiretroviral treatment. Brazil does not have enough lab kits for either the HIV antibody test used to diagnose infection or the exams used to monitor HIV. There are problems with exams that monitor the virus level and the lymphocyte or CD4 cell count. Opportunistic infections are often not adequately treated, and there are serious obstacles to providing adequate care for other diseases and improving prevention work.

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Moreover, although antiretroviral therapy is the best that science has done thus far against HIV infections, it is not a cure. The virus remains in the organism. Its level in the blood increases when the therapy is interrupted or when, for little-studied and less-understood reasons, one of the cocktails fails, and two or three of the drugs have to be replaced by another, completely different combination.

Antiretroviral drugs are a global experiment, and little has been said about their secondary effects, some identified and others still less known. In spite of these drawbacks, Terto defends the treatment model in Brazil: “The numbers show the mortality rate has fallen 50%, and people have achieved a better quality of life. The drop in the mortality rate in a poor country, with inadequate basic care and so many problems in the health care system, is surprising. This means that the drugs are so effective that they may even outweigh problems like inadequate services, poor doctor care, problems with antibiotics, and several other structural problems.”

## **Antiretroviral Drugs in Central America**

Brazil’s success in providing accessible treatment contrasts sharply with Central America, where only a small percentage of those who need antiretroviral treatments receive them. Access to treatment was the principal demand at the two Central American AIDS conferences, the first held in San Pedro Sula, Honduras, in 1999 and the other in Guatemala City in 2001. Costa Rica is the only Central American country where all people who need antiretroviral therapy, including foreign residents, receive it. The Costa Rican Supreme Court issued a decision in 1997 obliging the Social Security Institute to provide antiretroviral drugs, based on the argument that economic interests cannot stand above the right to life and health.

In Panama, the government has ostensibly offered full coverage to people who need antiretroviral therapy, but so far only those covered by social security receive the drugs, and then only as the result of an intense campaign in 1999 led by Orlando Quintero, director of PRO-BIDSIDA. The policy of ensuring universal access to antiretroviral drugs is making very slow progress due to the country’s bureaucracy and infrastructure problems, according to Norma García de Paredes, of the International Human Rights and Health Institute.

Since 1999, people living with HIV/AIDS in El Salvador have demanded an AIDS law based on a bill they submitted. In 2000, the Salvadoran Social Security Institute

began to provide antiretroviral therapy to some people with HIV who are covered by social security. People who are not covered have repeatedly demanded that the government provide the treatments free of charge. In a major step backward, the Salvadoran Congress approved a law last year allowing employers to demand an HIV test from prospective employees.

In Guatemala, a group of people infected with HIV sued the government in May 2002 demanding dignified treatment in hospitals and access to therapy, and reached an agreement with the President. With support from the UNAIDS program to facilitate drug access, the Honduran government convinced several pharmaceutical companies to reduce the cost of antiretroviral therapies by as much as 85%, cutting them to \$1,300 per person per year. Last year, the Honduran Congress approved \$190 million in emergency spending to buy antiretroviral drugs, but bureaucratic snags have stalled the purchase.

In May 2002, responding to the tide of public opinion supporting the Honduran organization of people living with HIV, Honduran Health Minister Elías Lizardo announced that 260 people would be given antiretroviral therapy beginning in June and that the government had requested \$27 million for AIDS alone, including \$8 million to buy antiretroviral drugs. This represented two-thirds of the \$41 million that the Honduran government requested from the Global AIDS, Tuberculosis, and Malaria Fund. Lizardo made these announcements in the city of Tela, speaking to over a hundred people living with HIV at their third national conference. The previous day, hundreds of activists and people affected by the epidemic had demonstrated in the streets of Tela to demand medical attention, nondiscriminatory treatment, drugs for opportunistic infections, and access to antiretroviral therapy.

The Nicaraguan health minister made a commitment in June 2001 to put into practice the agreements reached at the United Nations Special Session on HIV/AIDS. The declaration proposes to “make every effort to progressively and sustainably provide the highest attainable standard of treatment for HIV/AIDS, including prevention and treatment of opportunistic infections and effective, careful and monitored use of quality-controlled antiretroviral therapy to improve adherence and effectiveness and reduce the risk of developing resistance.” This commitment reaffirmed Article 46 of the Constitution and Articles 1, 3 and 19-30 of Law 238, the Law to Promote, Protect and Defend Human Rights against AIDS, which specifically establishes the right of all Nicaraguans to decent treatment and care, with no discrimination based

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on gender, ethnic group, social condition, or HIV status. The Nicaraguan government has requested \$34 million from UNAIDS to meet the objectives of its National Strategic Plan to Prevent and Control STDs and HIV/AIDS over a five-year period.

But so far, Nicaragua's commitment exists only on paper. Very few people in Nicaragua receive antiretroviral treatment, and then only thanks to the support of their families or other people acting in solidarity. Social security does not cover treatment for HIV infections or AIDS. Even worse, some insurance companies have done HIV tests without permission and, on finding a positive result, have turned people away, refusing to serve them and thus violating their human rights and Article 5 of Law 238.

Another sign of the critical situation in Nicaragua's public health system is the lack of drugs, which tends to increase their price. For example, one tablet of fluconazole by Pfizer costs nearly \$14.40, while in Guatemala, Doctors Without Borders obtain it at \$0.28. This drug is not an antiretroviral but is indispensable in treating meningitis caused by *criptococcus*, a fairly common opportunistic infection. The price differences between generic and brand name products are considerable for all of the antiretroviral drugs. For example, Costa Rica buys generic AZT at \$0.17 a tablet, while Panama buys a patented AZT for over \$2 a tablet. Costa Rica buys D4T at \$0.38 a tablet, while the same product sold under a brand name can run from \$3 to \$7 a tablet in other countries.

The cost of antiretroviral treatment also varies significantly within each Central American country. The cheapest therapy in Guatemala is one using three generic antiretroviral drugs distributed by Doctors Without Borders at an annual cost of \$788 per person. The Guatemalan government spends around \$5,000 per person per year for a similar combination of brand-name antiretroviral drugs, benefiting only a small group of people selected by lottery. Another combination of three different brand-name antiretroviral drugs costs the Guatemalan government

even more: \$17,297 per person per year. It is important to note that the kind of treatment varies according to medical criteria, since each case is different. The price of antiretroviral therapies in Costa Rica ranges from \$2,469 to \$6,050 per person per year, according to a price chart provided by Richard Stern, who has been following access to treatment in Central America very closely over the past six years.

## Spreading the Model in Latin America

Obviously, the responsibility for providing antiretroviral treatments to all Latin Americans who need it cannot fall on the shoulders of a single country. Nor does it make

sense to assume that all countries in Latin America can follow Brazil's model of national drug production. The technical difficulties in producing this family of drugs makes national production impossible in countries with small populations and scarce resources, like those in Central America and the Caribbean, except for Cuba. National production is too expensive to be competitive in those countries, as has already been proven in the Dominican Republic and Costa Rica.

The Brazilian government's investment makes it possible to respond to growing national demand but does not yet allow for export. Experts calculate that Brazil could increase its production of antiretroviral drugs by some 50,000 addition-

al treatments. But this production volume would not substantially address the need for these drugs in Latin America. It would only serve to continue covering the country's own internal demand, as nearly 20,000 people begin antiretroviral treatment in Brazil each year.

One possible solution would be technology transfer to encourage the production of antiretroviral drugs in countries that already have sufficient technical and economic means, like Mexico, Colombia, and Venezuela. Another is the sale of antiretroviral drugs to countries that cannot produce them, at least until they begin their own produc-

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tion. These may be workable solutions, since most Latin American countries have no intellectual property rights impediments related to the most commonly used anti-retroviral drugs.

The Brazilian experience also shows that success breeds success. The country's successful response to the AIDS crisis has given Brazil special clout in international forums and the ability to do very effective lobbying on global policies. For example, the country played a leading role in creating the UN Global AIDS, Tuberculosis, and Malaria Fund. UNAIDS has recognized Brazil's influence in global and regional policies and its pioneering treatment with generic drugs as important factors in the increased global access to treatment that has occurred in recent years. The new paradigm adopted during the UN General Assembly's Special Session on HIV/AIDS, which includes an integrated prevention and treatment focus, was based on the Brazilian experience. Brazil's effective lobbying with the international community has played a pivotal role in the following series of declarations and actions:

- The approval of Resolution 33/2001 by the United Nations Commission on Human Rights during its 57th session, establishing access to AIDS drugs as a basic human right.
- The approval of Brazil's May 2001 proposal to the World Health Organization on the need to have drugs at accessible prices available to all people living with HIV.
- The commitment signed at the UN General Assembly Special Session on HIV/AIDS in June 2001, which reiterates the need for a holistic approach including prevention, care, treatment, and the protection of human rights.
- The establishment of the UN Global AIDS, Tuberculosis, and Malaria Fund, which guarantees equal participation in resource administration to rich and poor countries and thus constitutes a unique case among international funds. The Global AIDS Fund will also finance projects that include distribution of anti-retroviral drugs.
- The declaration of the WTO's Fourth Inter-Ministerial Conference, held in Doha, Qatar, in November 2001. This declaration, promoted by Brazil and other countries, defends the preeminence of public health above intellectual property rights.

"After the Doha declaration on patents was announced in November, several opportunities were created for

developing countries to gain access to these treatments," Teixeira explained. "We're just trying to do what's possible to help." One of the first actions that Brazil took to help was the establishment of a lab in Guyana for the national production of antiretroviral drugs. Eloan Pinheiro, director of the principal drug production lab in Rio de Janeiro, says that many countries already have the infrastructure needed to begin production, and their main problem is quality control. Brazil is trying to address this problem through the transfer of technology aimed at ensuring bioequivalence and bioquality controls, to guarantee that generic drugs possess the same properties as the original, patented drugs.

## International Advances

Factors that can facilitate access to treatment for the 36 million people who live with HIV around the world include a reduction in prices, local production, and the mobilization of international funds to purchase drugs. Negotiations on prices, held under the auspices of UNAIDS, have led international pharmaceutical companies to offer treatments ranging in price from \$1,600 to \$2,000 per person per year. This is a significant reduction compared to current prices of between \$5,000 and \$9,000 per person per year, depending on the particular combination used. The reduction is even more dramatic when compared to the \$15,000-\$20,000 per person per year that the therapies cost only six years ago.

Nevertheless, these reduced prices have been offered to only a few countries in Africa, and are well above the prices offered by the private lab Cipla Ltd. of India or the government of Thailand. The latter announced at the start of 2002 that it would market the world's most economical antiretroviral therapy, offering a combination of three generic antiretroviral drugs for \$330 dollars a year, or less than a dollar a day. Currently 2,000 people with HIV/AIDS are receiving free antiretroviral therapy in Thailand.

In an action that could help lower the price of AIDS drugs in poor countries, the World Health Organization (WHO) included generic versions of drugs still under patent on its list of approved drugs for treatment of HIV/AIDS published early this year. The move has been described as a challenge to the transnational pharmaceutical companies. UNAIDS Director Peter Piot said that he trusts the list will help patients gain "greater access to affordable, good quality drugs." The list includes 11 anti-retroviral formulas and five drugs used to treat opportunistic infections, such as zoster infections, bacterial

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infections, and Kaposi's Sarcoma. The largest pharmaceutical companies appear on the list, along with Cipla Ltd. The Indian lab was the first generic drug producer to try to break the patent monopoly at an international level by offering antiretroviral therapy to charitable organizations and African governments in February 2001.

## **The Foreign Debt Kills in Many Ways, Including AIDS**

There are still no signs of any initiative by UNAIDS, WHO, or any other agency associated with the joint United Nations program to convince the IMF to let the governments of the most impoverished, heavily indebted countries increase their health budgets in response to the AIDS crisis. During a WHO meeting in October 2000, Harvard economist and professor Jeffrey Sachs observed that an annual health investment of 3% of GDP in represented only \$8 per capita in many of the poorest countries, while in rich countries the figure ranges between \$3,000 and \$5,000.

Heavily indebted poor countries, which in Latin America include Nicaragua, Honduras, Haiti, Guyana, and Bolivia, must choose between paying their foreign debt or paying their social debt by investing in health, education, and food security. Reducing the foreign debt depends on applying structural adjustment programs that require cutting the share of the national budget devoted to health, education, and food security, but unless these countries do so, they become ineligible for new loans. In this vicious circle, there is no question but that debt kills.

During the UN Special Session on HIV/AIDS held in New York, Archbishop Lozano, the Vatican's representative, recognized this dilemma: "Too often we have failed to raise our voices to denounce the structural injustices and social sins perpetuated by the structural adjustment programs of the International Monetary Fund and the global economic system, which directly affect the poor." Pope John Paul II's message on that occasion denounced inequalities and lamented that the high cost of the patented drugs required for antiretroviral therapy has made it impossible to treat HIV infections in poor countries. He recalled that there is a social debt outstanding

on all private goods, and called for applying the same criteria to intellectual property rights, since "the law of profits cannot be the only one applied in the struggle against hunger, disease, and poverty."

## **Human Rights: The New Health Paradigm**

The social crisis posed by AIDS clearly involves a whole set of human rights: the right to information, to respect for one's private life, to choice, and above all, to equality without any kind of discrimination. Because of AIDS, human rights have become the new health paradigm, as is increasingly recognized by public opinion and included on the political agendas of many countries. Preventing discrimination in health care is the most appropriate and viable strategy for responding to the HIV/AIDS epidemic, not only for humanitarian reasons but also from the perspective of efficiency and effectiveness. This paradigm

demands the use of different approaches to understanding the HIV epidemic than those used in classical epidemiology. Measures like isolation, obligatory testing, quarantine, migratory restrictions, and subtle or open repression simply do not work in response to the AIDS crisis. Health must be seen from human rights, generational, gender, and sustainable development perspectives.

All over the world, AIDS has highlighted other ethical dilemmas. One of the most salient is

the unjust distribution of wealth. The vast majority of people with HIV live in poor countries ruined by the inequitable laws governing world trade, financial globalization, and one-size-fits-all structural adjustment plans.

Throughout the 1990s, 95% of the \$7 billion invested in AIDS prevention, education, treatment, and research was spent in rich countries. In 2000, it was estimated that African countries would need some \$3 billion a year to provide AIDS prevention, basic treatment, and orphan care. This is not an unreasonable amount if compared to the \$52 billion that the United States invests every year in dealing with the consequences of obesity. And it is more than reasonable when compared to massive U.S. military spending.

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**Preventing discrimination in health care is the most appropriate and viable strategy for responding to the HIV/AIDS epidemic.**

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One last fact worth emphasizing is that despite the solemn declarations, the human tragedies, and the growing national and international mobilizations, there is still a lack of political will, commitment, and leadership to address the global AIDS crisis. UNAIDS has received only \$2.8 billion of the \$10 billion required to launch the Global AIDS, Tuberculosis, and Malaria Fund promised by the G-8 countries. The AIDS pandemic is far from reaching its peak, and future prospects are so grim there is no room for complacency.

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## **LINKS:**

### **ORGANIZATIONS**

#### **UNAIDS**

Switzerland

Email: [unaids@unaids.org](mailto:unaids@unaids.org)

Website: <http://www.unaids.org/>

#### **United Nations**

Dag Hammarskjold Plaza

New York, New York 10017

Voice: (212) 963-1234

Website: <http://www.un.org/>

#### **World Health Organization**

Switzerland

Email: [info@who.int](mailto:info@who.int)

Website: <http://www.who.int/>

#### **Fundación Nimehuatzin**

Managua, Nicaragua

President: Rita Arauz

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#### **Latin American and Caribbean Council of AIDS**

**Services Organizations (LACCASO)**

Ontario, Canada

Website: <http://www.laccaso.org/>

#### **International Council of AIDS Services**

**Organizations (ICASO)**

Regional Secretariat: Caracas, Venezuela

Website: <http://www.icaso.org/>

#### **Brazilian Interdisciplinary AIDS Association (ABIA)**

Associação Brasileira Interdisciplinar de AIDS

Tel: (21) 2223-1040

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Email: [abia@abiids.org.br](mailto:abia@abiids.org.br)

Website: <http://www.abiids.org.br/>

#### **National Council of Sexually Transmitted Diseases and AIDS**

Brazilian government

Director: Paulo Roberto Teixeira

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## **PUBLICATIONS**

### **Notiese**

Mexican information source on AIDS.

Email: [notiese02@laneta.apc.org](mailto:notiese02@laneta.apc.org)

### **Agua Buena**

An electronic bulletin on access to treatment and human rights in Central America.

Email: [rastern@racsa.co.cr](mailto:rastern@racsa.co.cr)

### **Revista Envío**

Managua, Nicaragua

Editor: María López Vigil

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