HIV/AIDS and Treatment Access in Africa

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THE BURDEN OF HIV/AIDS

UNAIDS estimates that as of the end of 1999, more than 22.5 million people in the region carried HIV. Of the 11 people infected every minute with HIV worldwide, 10 of them live in sub-Saharan Africa. Two per cent of all babies born there are infected with HIV.

Five countries bundled together in southern Africa now form the global epicentre of the epidemic. South Africa counts 1600 new infections a day, the highest rate in the world, while in Namibia, Botswana, Zimbabwe, and Swaziland, one in four adults carries HIV. It is estimated that 90% of those infected do not know it, and therefore aren’t aware that they might transmit the virus to their partners.

Southern and eastern Africa is where 60% of all AIDS deaths have happened so far. And it is where a whole generation of children are now losing their parents to AIDS. The global epidemic is now estimated to have left 11 million orphans – and 90% are African children.

Many businesses are now over-hiring to keep pace with AIDS deaths in the labour force. And this pressure is no less within African health systems.

HEALTH CARE ARRANGEMENTS

Due to many factors, in many developing countries, generally speaking, health facilities are often poorly equipped, drugs are not always available and in particular, STD/HIV prevention and care is poor. A recent WHO paper commented on the use of resources within poor countries: ‘National health systems tend to spend money on poor quality and low-impact interventions.’

And of course, in some developing countries, the increased mortality of health sector staff due to HIV has started to affect the delivery of health services directly. Financing of health care may be predominantly government funded, predominantly privately funded or a mixture. Governments also determine the priorities for available funds: in Zambia, for instance, only 0.8% of GNP (Gross National Product) is spent on health care, compared with about 7–10% in most industrialised countries.

It should be noted that financial resources for health are overwhelmingly provided within countries. This situation does not change even in those countries which are the recipients of significant international development assistance from sources such as development banks, bilateral development agencies, international non-governmental organisations, foundations and UN agencies. For example, in 1994 health spending in low and middle income countries totalled about US$250 billion, of which only US$2 or 3 billion was from development assistance.

Substantial reforms in the health systems of many countries in the past few decades have led in many cases to substantial privatisation or significant increases in co-payments by patients. Dr Gro Harlem Brundtland, Director-General of the World Health Organization, states in her introduction to the World Health Report for 1999 that ‘Active government involvement in providing universal health care has contributed to the great gains of recent years – but many governments have overextended themselves. Efforts to provide all services to all

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1. Paper includes material drawn from a recent policy paper on Migrants' Rights to Health Care prepared by the author for UNAIDS and the International Organisation on Migration.

people have led to arbitrary rationing, inequities, non-
responsiveness and inadequate finance for essential
services.' She notes that governments cannot ‘provide
and finance everything for everybody’ but also rejects
the approach of rationing health services to those with
the ability to pay: ‘Not only do market-oriented
approaches lead to intolerable inequity with respect to
a fundamental human right, but growing bodies of
theory and evidence indicate markets in health to be
inefficient as well. But the very countries that have
relied heavily on market mechanisms to achieve the high
incomes they enjoy today are the same countries that rely
most heavily on governments to finance health systems.’

She calls for changes in all countries to ensure partic-
ipatory, fair and efficient regulation of the health sector.

Most industrialised countries provide universal or
widespread health insurance for all nationals and legal
permanent residents: thus, the burden of health care is
rarely substantial for any individual, and in particular
drug costs are relatively cheap - in marked contrast to
the situation in most developing countries.

Even between neighbouring developing countries, there
may be disparate health care provision: Burkina Faso, Ghana
and Togo have large numbers of cross-border workers:
migrant patients mainly attend clinics in Ghana (sometimes
crossing over specifically for this purpose), because
health services cost the least among the three countries.

In many African countries, AIDS patients occupy more
than half the hospital beds. The cost of HIV/AIDS
prevention and care, 2.5% of gross domestic product
in some countries today could rise to 6% by 2010. Many
are angry that effective drug treatments for HIV and AIDS
exist, but are too expensive for poor countries to afford.

‘Those countries that have come up with solutions
to prolong life should be willing to share them,’ says Linah
Mohohlo, governor of Botswana’s central bank, ‘whether
by giving access to the drugs, or helping to meet the costs.’

RIGHTS TO HEALTH CARE

The International Covenant on Economic, Social and
Cultural Rights entered into force in 1976. A majority of
the world’s countries are a party to this Convention,
thereby opening the door to international monitoring of
their human rights practices. Among other items, the
International Covenant on Economic, Social and Cultural
Rights explicitly recognises the right of everyone to the enjoy-
ment of the highest attainable standard of physical and mental
health. In addition, Article 2 (1) provides that each State
Party to the Covenant undertake to take steps, individu-
ally and through international assistance and co-operation,
to achieve progressively the rights in the Covenant.

A forthcoming statement by the UN Committee on
Economic, Social and Cultural Rights is expected to state
their interpretation that health is both a fundamental human
right in itself and an indispensable precondition for the
exercise of other human rights.

However, as noted by Barlinguer, ‘the notion of health
as a cornerstone of economic growth, as a multiplier
of human resources, and most importantly as a primary
objective of such growth, has been replaced far and wide
by an opposing notion. Public health services and
health care for all are now perceived as an obstacle, often
as the hardest obstacle, threatening public finance and
the wealth of nations; reduction in health expenditure
(not so much to any nations, which is the imperative every-
where) has become one of the top priorities for all
governments.

The model of primary health care as fundamental for
the prevention and treatment of diseases has been almost
abandoned. The trend is now towards dismantling the whole
machinery of public health. Even in countries with
minimal resources, priority is given to costly technologies.’

Some of the past change in the understanding of the
importance to economic growth of health has been perceived
to arise out of the policies and approach of the
World Bank and the International Monetary Fund.
The World Bank is now committed to highlighting that
health sector reform is a means rather than an end in
itself, and to ensure that there is a focus again on the deter-
minants of health (education, poverty, environment, gender)
and on tangible health outcomes.

Ngwena recently noted that, in Africa, ‘the state health
care sectors are overburdened, ill equipped and badly
managed. Declining health budgets as a result of reduced
public sector expenditure on public services have seen many
public health services collapsing in several African
countries. Drugs for common diseases are either unavail-
able or of poor quality and so is the medical equipment.
The structural adjustment programmes that have been
implemented by the Bretton Woods institutions to assist
Africa in economic reform, are at the same time leaving
little by way of adequate resources for health care.’

The World Bank announced in July 1999 that it planned
in future to take more aggressive action against AIDS. A
Bank official noted that AIDS is no longer solely a health
problem, but a development crisis that is particularly
affecting Africa. Working with governments and other groups,
the World Bank has stated it will review its existing efforts
in Africa and plans to redirect funding, if needed.

Discussing the World Bank’s new emphasis on the
African AIDS epidemic, Mr Callisto Madavo, Vice
President, Africa Region, said: ‘With ferocious speed,
AIDS has wiped out many of the development gains Africa
has achieved over the last decades. It has reduced life
expectancy in the most-affected areas and now threatens
businesses and economies’, he said. ‘Africa is in urgent
need of resources and support to turn around this
catastrophe. For this reason we are putting the epidemic
at the centre of our development agenda, mainstreaming
AIDS into all aspects of our work in Africa.’

The bank’s latest research suggests that when the adult
infection rate reaches 8% – it is already at that level in 21
African countries - it reduces per capita growth rates by 0.4%
year. With annual growth rates in Africa averaging just 1.2%
over the past few years, that is a significant loss of income.
INCREASING TREATMENT ACCESS

Thanks to new drug therapies, many people living with HIV/AIDS in most developed countries are now able to live relatively healthy lives. Combination anti-retroviral therapies allow HIV-positive people to reduce their viral load significantly, in some cases to undetectable levels, thus enabling many individuals to return to the workplace. In developing countries and countries in transition, however, these and many other therapies used to treat HIV infection and related illnesses are unavailable for a simple reason: they are not affordable. Even for those few who may be able to afford them, sometimes pharmaceutical companies conclude that the potential market is too small to bother with licensing and distribution arrangements.

The issue of the cost of drug therapies is of immense importance in relation to HIV/AIDS. Over 89% of people currently living with HIV/AIDS reside in countries ranked in the lowest 10% in the world in terms of gross national product. Even in slightly wealthier countries in Southeast Asia, there are major cost constraints. At the Bamrarnaradura hospital in Bangkok, Thailand, for example, only 20 of the 2000 patients who seek treatment each month can afford the triple drug cocktails that have become the standard of care in developed countries.

Ways to lessen or remove the gap in access between developed countries and developing countries are increasingly being explored. Two strategies that are receiving substantial attention are parallel importing, which involves bringing drugs in from another country; and compulsory licensing, which involves using a legal intervention to restrict the monopoly rights of existing patent holders and make generic drugs more available.

In July 1999, the International Council on AIDS Service Organizations (ICASO) published a background paper on the potential role of compulsory licensing and parallel importing in improving access to essential drugs for people living with HIV/AIDS. The paper aimed to provide people with sufficient information to participate fully in the debate about the effect of international trade laws on access to essential drugs, especially HIV-related medications; and to help people better understand the potential for advocacy work on these matters in their own countries and with their own governments.

It should be noted that in the developing world the specific access to treatment needs of each country might be different. Only countries with more developed medical infrastructures have the widespread capacity to use combination anti-retroviral drugs. For other countries, it may be more important to obtain greater access to anti-microbial and other prophylactic (disease preventing) drugs.

CURRENT TREATMENT INITIATIVES

There are a few international initiatives in place aimed at improving access to treatment for people living with HIV/AIDS in Africa. Some that have received substantial publicity include:

UNAIDS HIV Drug Access Initiatives (pilots in Chile, Cote d’Ivoire, Uganda, and Vietnam)
Involves a controversial drug access model

Enhancing Care Initiative (pilots in Brazil, Senegal, Thailand and South Africa)
Using multidisciplinary AIDS care teams to improve HIV/AIDS care in resource poor settings
Secure the Future (five southern African countries)