

# **HIV/AIDS** and Human Rights: **Public budgets** for the **epidemic** in

Argentina, Chile, Ecuador, Mexico and Nicaragua

*Summary*



# HIV/AIDS

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## ○ HIV/AIDS and Human Rights: Public budgets for the epidemic in Argentina, Chile, Ecuador, Mexico and Nicaragua *Summary*

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## ○ Introduction

Since the HIV/AIDS pandemic began, efforts to stop its spread have concentrated on the prevention-oriented model of public health in Latin America. Dealing with HIV/AIDS as a matter of public health and human rights implies providing information and education to prevent the disease, supplying services (detection tests, needle exchange, condoms, antiretroviral medication and safe blood) and combating discrimination against persons living with HIV/AIDS.

Prevention efforts have consequently taken two main forms. One is a model of individual risk reduction targeted towards high-risk sectors (such as men who have sex with men, intravenous drug users and sex workers), but actually aimed at wider sectors of society (for example, housewives and heterosexual teenagers). The other is the development of strategies around the contextual (sociocultural, economic and political) factors in which certain groups, like women, become vulnerable to the epidemic.

The HIV/AIDS epidemic demonstrates the indivisibility of human rights, since an effective response requires civil, economic, social and political rights to be exercised in concert. For instance, no public health policy or practice affecting people living with HIV/AIDS may violate the right to health, the right to nondiscrimination or women's rights.

An approach to HIV/AIDS that upholds human rights must therefore rest on the state's obligation to protect those rights, an obligation codified in both domestic law and international instruments. The essential principles of human rights are set out in such instruments as the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, the International Convention on the Elimination of All Forms of Racial Discrimination, the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the United Nations International Guidelines on HIV/AIDS and Human Rights. The guidelines are the closest to being an international pact on the issue, though it is important to mention that they do not impose obligations on states. Neither does the Declaration of Commitment on HIV/AIDS adopted by the United Nations General Assembly during its special sessions on HIV/AIDS.

In addition, a series of much more specific elements of fundamental importance for the subject have been developed. The United Nations Human Rights Commission's Resolution No. 2001/33 on "Access to medication in the context of pandemics such as HIV/AIDS" recognizes that, in a context

of epidemics, access to medication is fundamental to realizing fully the universal right to the highest attainable standard of physical and mental health. The resolution calls on states to launch policies that promote the availability of HIV/AIDS medication in sufficient quantities and in ways that are accessible to all people.

What follows is a study on public spending and policies relating to HIV/AIDS in five Latin American countries – Argentina, Chile, Ecuador, Mexico and Nicaragua – that seeks to put government efforts in a context of human rights. Since the available information and, consequently, the possibilities for analysis vary from one country to another, each study deals with relevant aspects in their own context. Such aspects include the universality and accessibility of services, the absence of discrimination in policies as implemented, and the impact of that implementation on the enjoyment of basic human rights.

This study is significantly different from previous studies on national AIDS accounts (NAA), carried out by the Regional AIDS Initiative for Latin American and the Caribbean (SIDALAC), because it focuses primarily on the public resource *allocations to the epidemic, as opposed to the entire health estimated expenditure* (as calculated by SIDALAC).

However, in the process of data collection for the country reports, the Nicaraguan authors used the SIDALAC National AIDS Accounts (NAA) expenditure estimates because of the lack of specific HIV/AIDS line-items in their national health budgets. The Chile government adopts the SIDALAC figures as their official expenditure figures and therefore the Chilean report presented here uses these same figures. In Mexico, the country report uses a combination of sources of data for this analysis. The Federal Ministry of Health does not capture the state level health ministries' expenditure on HIV/AIDS, and therefore the authors make use of the SIDALAC estimates of states' HIV/AIDS expenditure. They also present the Federal government's record of HIV/AIDS budget allocations.

This report aims to establish a link between two fundamental aspects: on one hand, the obligations of states with regard to human rights and the steps necessary to ensure that all residents enjoy these rights; and, on the other, the public nature of the resources that states devote to this end. In addition, a key objective of this research project was to empower civil society to undertake such budget analysis.

Presented in this book is a compilation of the most important findings on the epidemiological profile, the policies and the allocation of public resources in the five countries, based on the information contained in studies done of each. It also includes an evaluation of policies and budgets from a human rights perspective. The following persons were responsible for the country studies<sup>1</sup>:

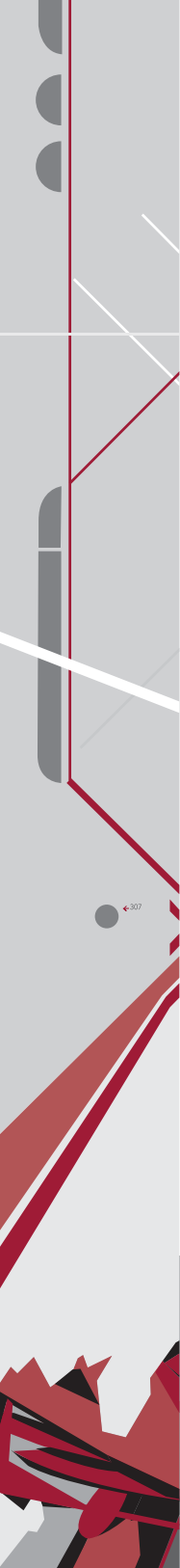
<sup>1</sup> The full country reports are available, in Spanish, at [www.fundar.org.mx](http://www.fundar.org.mx).

- Argentina: Carolina Fairstein, Silvina Zimmerman and Pabla Asa, from Centro de Estudios Legales y Sociales (CELS)
- Chile: Alejandra Valdés and Elizabeth Guerrero, from Hexagrama Consultoras
- Ecuador: Juana Sotomayor, Susana Chu Yep and Argentina Santacruz, from the Centro de Derechos Económicos y Sociales (CDES)
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The present compilation was integrated by Gabriel Lara and Helena Hofbauer.

This study of HIV/AIDS, human rights and budgets in five Latin American countries is part of an international initiative, coordinated by the AIDS Budget Unit of Idasa in South Africa and generously supported by SIDA (Swedish International Development Cooperation Agency). The regional coordination for Latin America was undertaken by Fundar. We appreciate the work done on the translation of this summary by Tania Sánchez, Gabriela Pérez and Claire Naval.





## 1. Characteristics and epidemiological profile of the HIV/AIDS epidemic in Argentina, Chile, Ecuador, Mexico and Nicaragua

Despite their differences in size, development and poverty levels, the five countries included in this study present similar epidemiological profiles and characteristics. Incidence rates follow an incremental pattern, while some specific characteristics change.

**Table 1: HIV/AIDS cases and prevalence rate: Argentina, Chile, Ecuador, Mexico and Nicaragua**

	Argentina /1	Chile /2	Ecuador /3	Mexico /4	Nicaragua /5
Total HIV/AIDS accumulated cases	21,865	14,013	4,491	71,526	1,099
Estimated total of people living with HIV/AIDS	130-150 thousand	23,920	45,000	150,000	No data
Average of new infections per year	No data	533	No data	4,100	No data
Deaths due to AIDS	No data	3,988	1,175	44,000	248
Prevalence rate 15-49 years old, at end 2003. (UNAIDS, 2004)	0.7%	0.3%	0.3%	0.3%	0.2%

/1 ONUSIDA, *HIV/AIDS Global Epidemic Report 2002 and Nation Ministry of Health*. The "total HIV/AIDS accumulated cases" refer to people living with AIDS.

/2 CONASIDA, Semester Epidemiologic Bulletin, number 14, December 2001. This is the latest update of official statistics.

/3 Fundación Ecuatoriana de Acción y Educación para la Promoción de la Salud; Ministry of Public Health, Statistical data for HIV/AIDS in Ecuador for 1984-2001, March 2002 and National AIDS Programme, 2003.

/4 C. Magis, E Bravo, P. Rivera, *AIDS in Mexico in 2000, and CENSIDA, 2003 HIV/AIDS epidemiology in Mexico*.

<http://www.ssa.gob.mx/conasida>.

/5 Ministry of Health and National Strategy Plan.

In **Argentina**, half of the cases younger than 13 (1 551 persons) reported up to May 2002 are female. For those older than 13, the distribution changes; for the age group 25 to 29, 79% of registered persons are men.

At first predominantly masculine, the disease has slowly feminized. Currently, yearly reported cases are distributed in the ratio of 2.6 men to one woman.<sup>2</sup> These figures, together with the important number of pediatric AIDS cases registered in the country, show that the epidemic is spreading increasingly among women of sexually active age.

<sup>2</sup> Nation Ministry of Health, *AIDS Bulletin*, 2003.

In Chile, 89.1% of AIDS cases are men. However, the epidemic average has been increasing yearly among women; over the last five years, cases of HIV among women have grown by 14.3%, compared with 8.3% for men. In asymptomatic infection reports, the increase among women almost doubles that observed among men (29% versus 15%).

The observed trend and the closing of the gap between men and women, which in 1999 reached a ratio of 5.8:1, suggests a feminization of the epidemic. HIV is increasingly affecting housewives with low educational levels who perform less qualified jobs and are in stable relationships. The main cause of infection is sexual, apparently via their partners.<sup>3</sup>

In terms of age, 84.6% of cases are concentrated in the age group between 20 and 49. From 1990 to 1998, the incidence of HIV/AIDS infection decreased progressively among youngsters between the ages of 15 and 24, but increased among adults.

**Table 2: Men-women ratio in AIDS cases:<sup>4</sup>  
Argentina, Chile, Ecuador, Mexico and Nicaragua**

	Argentina /1	Chile /2	Ecuador /3	Mexico /4	Nicaragua /5
Registered AIDS cases					
Men	76%	89.1%	76.3%	84.8%	74%
Women	23%	10.9%	23.7%	15.2%	26%
Men-women ratio	3.3 : 1 (2003)	5.8 : 1 (1999)	2.7 : 1 (2002)	6 : 1 (2003)	2.9 : 1 (2003)

/1 National Ministry of Health, *AIDS Bulletin*, 2002 and 2003.

/2 CONASIDA, Semester Epidemiologic Bulletin, number 14, December 2001. This is the latest update of official statistics.

/3 Ministry of Public Health, Statistical data for HIV/AIDS in Ecuador for 1984-2001, March 2002 and National AIDS Programme, 2003.

/4 CENSIDA, *2003 HIV/AIDS epidemiology in Mexico*. <http://www.ssa.gob.mx/conasida>.

/5 Ministry of Health and National Strategy Plan.

In the case of Ecuador, the same trend is observed: more men are infected with the virus. Between 1999 and 2002, the average annual HIV/AIDS incidence rate among men was 7.7 cases per 100 000 persons, while for women it was 2.88 cases per 100 000: a proportion of roughly 2.7 men per woman.

<sup>3</sup> Donoso, Virseda and Pascal. "Socioeconomic diagnosis for women living with AIDS in the metropolitan region", *Vivo Positivo*. Chile. 2002.

<sup>4</sup> It is assumed that "AIDS cases" used in the country epidemiological reports refers to those persons at Stage 4 of the illness.

The epidemic is concentrated in people between the ages of 15 and 54, with the highest percentage among those between 30 and 34 (19.2%), closely followed by the age group 25 to 29 (18.2%) and then by the 20 to 24 segment, with an alarming 16.2%. Two hundred persons under 15 were affected by this pandemic from 1984 to 2002.<sup>5</sup>

In **Mexico**<sup>6</sup>, most people with AIDS are men, at 84.8%. Thus HIV/AIDS in Mexico has been considered a predominantly masculine illness until now, though there are trends that indicate that this situation will change. The ratio of men to women is 6:1 – though when the epidemic began it was 11:1 – increasing to 8:1 when only the accumulated cases of sexual transmission are analyzed.

In **Nicaragua**, 74% of those diagnosed with HIV/AIDS as at June 2003 are men. Here too a downward trend in this proportion has been observed. In 1990 there were 6.1 infected men to each woman, in 1994 there were 4.1, and in June 2003 the proportion had fallen to 2.9. This tendency is revealed in the disaggregation by sex of the registered new infections, 28.3% of whom were women from March 2001 to June 2003.

From a different perspective, 58.2% of the people with HIV are youngsters or young adults in the age range between 20 and 34, and here the ratio of men to women is practically 1:1. The transmission potential in this age group is significant, as it is estimated that 50% of women start their sexual activity before they are 18 years old and 14.4% start even before they are 15 years old.<sup>7</sup>

### 1.1 Transmission modes

In **Argentina**, the number of reported new infections among men due to drug abuse began to decrease in 1996, while sexual transmission started to increase.<sup>8</sup> With respect to women, the main means of transmission has consistently been heterosexual, followed at some distance by intravenous drug use. The same pattern has been observed since the epidemic began.

According to the National Programme, transmission through drug injection has been decreasing steadily since 1996.<sup>9</sup> Nonetheless the percentage of cases related to drug abuse is the highest in Latin America.<sup>10</sup>

<sup>5</sup> AIDS National Programme, Ecuador, 2002.

<sup>6</sup> CENSIDA, *2003 HIV/AIDS epidemiology in Mexico*, in [www.ssa.gob.mx/conasida](http://www.ssa.gob.mx/conasida).

<sup>7</sup> Nicaraguan Demographic and Health Survey, 1998.

<sup>8</sup> Ministry of Health, *AIDS Bulletin*, Year IX, Number 21, August 2002, p 14.

<sup>9</sup> *Ibid.*, p. 15.

<sup>10</sup> In Argentina, drug use accounts for over 35% of cases, in Uruguay 23%, in Brazil 20%, in Paraguay 11% and in Chile only 5%. (Cf. *Sida: La Argentina lidera un ranking preocupante*, *Diario Clarin*, 13 de setiembre de 2003).

Since the epidemic began in **Chile**, the main exposure category has been sexual, accounting for 93.9% of cases. Within this category, 69% of cases result from homosexual or bisexual exposure.

In **Chile**, 4.6% of cases are transmitted by blood, most of these related to intravenous drug use. Blood donations have been screened for anti-HIV antibodies ever since the second half of 1987, curbing the risk of infection through blood transfusion or the use of blood products. Vertical transmission, which is from mother to child, represents 1.5% of all cases, or a total of 182 cases from 1984 to 2001.

**Table 3: Percentage of the main transmission modes: Argentina, Chile, Ecuador, Mexico and Nicaragua**

	Argentina /1	Chile /2	Ecuador /3	Mexico /4	Nicaragua /5
<b>Sexual</b>	50.9	93.9	90.1	89.7	89
Heterosexual	27.1	24.9	54.9	37.9	60.5
Homosexual/Bisexual	23.8	69	35.2	51.8 (MSM*)	28.5
<b>Blood</b>	1.1	4.6	0.5	7.3	0.4
Injected drug use	36.3	No data	0.3	1.1	5
Vertical	6.7	1.5	1.6	1.8	3

/1 National Ministry of Health, *AIDS Bulletin*, October 2003.

/2 CONASIDA, Semester Epidemiologic Bulletin, number 14, December 2001. This is the latest update of official statistics.

/3 Ministry of Public Health, Statistical data for HIV/AIDS in Ecuador for 1984-2001, March 2002 and National AIDS Programme, 2003.

/4 CENSIDA, *2003 HIV/AIDS epidemiology in Mexico*. <http://www.ssa.gob.mx/conasida>.

/5 Ministry of Health and National Strategy Plan.

\* MSM = Men who have sex with men.

The predominant means of HIV transmission in **Ecuador**, as in Chile, is sexual. According to official information from the Ministry of Health, this form of transmission accounts for 90.1% of HIV/AIDS cases reported up to 2002, most of them (54.9%) apparently affecting heterosexual persons. The second largest group comprises homosexual persons (20.5%) and the third, bisexual persons (14.7%). Other modes of transmission of HIV/AIDS are drug use (0.3%), accidents (0.6%), sexual work (3.7%), perinatal infection (1.6%) and blood transfusions (0.5%).<sup>11</sup>

Moreover, it must be noted that one population group that has registered an increasing number of cases is that of heterosexual women with one partner. The use of condoms in this sector is not frequent, and the group does not identify itself as susceptible to HIV/AIDS. There is a similar trend in Chile.

<sup>11</sup> Public Health Ministry, 2002.

In **Mexico**<sup>12</sup>, sexual transmission accounts for 89.7% of cases recorded between 1983 and 2003. From this figure, 57.7% occurred by homosexual and bisexual contact (mainly between men) and the remaining 42.3% by heterosexual contact.

The second most important mode of AIDS transmission is blood, accounting for 7.3% of cases, most of them caused by blood transfusion. Finally, though only 1.8% of cases resulted from vertical transmission, it was the main mode of infection among those younger than 15.

In **Nicaragua**, as in the rest of the region, sexual intercourse continues to be the predominant mode of AIDS transmission, accounting for 89% of cases in June 2003.<sup>13</sup> Within this percentage, most cases result from heterosexual activity, with homosexual contact being the cause in 32%.

The risk of infection by blood transfusion continues to fall as biosecurity measures improve. The transmission pattern for intravenous drug use is also decreasing steadily, having fallen from 9% in 2001 to 5% in June 2003. In contrast, vertical transmission is becoming more significant, having risen from 1% in 1998 to 3% in June 2003.

## 2. Argentina

The Republic of Argentina is a federal state with a territory of 3,761,274 km<sup>2</sup>. The country is organized in 23 provincial states and one autonomous city, with more than 1 100 municipalities. The last census carried out by the National Institute of Statistics and Censuses (INDEC) recorded a total population of 36 million persons, 90% of whom live in urban and suburban areas. Moreover, according to this census, about one fourth of the population is concentrated around the city of Buenos Aires, the so-called Greater Buenos Aires (GBA) area.

### 2.1 Economy and poverty

For at least the past five years, the Argentinean economy has been undergoing a recession, which has had a devastating impact on the quality of life of the population. Indicators of the economic crisis are the constantly declining GDP, stagnant or rising unemployment rates, increasing rates of poverty and indigence, and a drop in the purchasing power of salaries. The number of people falling into the categories of poverty and extreme poverty has slowly but steadily increased in recent years.

<sup>12</sup> CONASIDA, 2003 *HIV/AIDS epidemiology in Mexico*. <http://www.ssa.gob.mx/conasida>.

<sup>13</sup> Ministry of Health, Nicaragua, June 2003.

According to the Permanent Household Survey (Encuesta Permanente de Hogares, or EPH) by INDEC, as of October 2002 (the latest date for which official information is available), 57.5% of the population was below the poverty line. Even more disturbing, 27.5% of the population was below the extreme poverty line, an increase of more than 100% in just one year. The situation varies by region: as of October 2002, more than 40% of the population in several urban agglomerations was living in extreme poverty.

Furthermore, as the majority of Argentineans become impoverished, a small minority steadily gets richer, and wealth becomes increasingly concentrated. This process is transforming the country's social structure, which is characterized by wide middle-income sectors and the diminishing potential of the lower-income population to realize their social rights. The richest 10% of the population earn 26.7 times more than the poorest. This means that while the poorest 10% receive 1.4% of the income, the richest 10% amass 37.4%. This gap, one of the largest in the history of Argentina, helps explain the state of social disintegration in the country.

## 2.2 Government's response to HIV/AIDS

In the period 1983–89, with the restoration of democracy, the Ministry of Health started to take action on HIV/AIDS. The existing Office for Sexually Transmitted Diseases (STDs) incorporated HIV/AIDS into its agenda and created the National Register of HIV/AIDS (Registro Nacional de Enfermos).<sup>14</sup>

Public recognition of the epidemic as a matter that needed to be dealt with by the state came in 1990, with the adoption of the National AIDS Law (Law 23 798), making Argentina a pioneer in Latin America and the Caribbean. Notwithstanding the decentralized nature of Argentina's health sector, Law 23 798 declares the fight against AIDS to be matter of national interest and names the Ministry of Health and Social Action as the responsible authority.

This law was promulgated in 1991 by Decree 1244/91, which established the prerequisite of informed consent for the disease's detection and reaffirmed the rule of confidentiality relating to HIV testing and test results. Moreover, it introduced AIDS prevention as a topic into teaching programmes at primary, secondary and tertiary level.

The state attempted to ensure that persons who were under any system of health coverage would be guaranteed access to HIV/AIDS treatment and assistance. To this end, Law 24 455 was passed in

<sup>14</sup> Cf. Bianco, M; Pagani, L; Re, M.I; Correa, C: *Cultural approach on prevention and care for HIV/AIDS*. Programa de investigación UNESCO ONUSIDA. Estudios e Informes Serie Especial, No. 18. División de Políticas Culturales y de Diálogo Intercultural. UNESCO 2003, p. 45.

1995. It included the obligation to provide medical, psychological and pharmaceutical treatment for people living with HIV/AIDS, as well as programmes for the prevention of HIV/AIDS and drug abuse. In 1996, Law 24 754 was passed, providing for HIV/AIDS treatment among subscribers to private health insurance.

In accordance with the Aids Law, the National Programme against the Human Retrovirus HIV/AIDS and STDs, was created in 1992 within the Ministry of Health and Social Action. Part of the programme is a free and anonymous telephone line, "Dial Health / Ask AIDS", aimed at meeting the public demand for information on issues such as prevention and discrimination. The programme offers assistance regarding medication, determination of the viral load, reagents for blood banks, epidemiological surveillance and AIDS research, the control and prevention of sexually transmitted diseases and the dissemination of information.

Since 1996, when antiretroviral treatments were improved, there has been a new element in the government's response to the disease: a managing area, in the ministry, for the provision of antiretroviral medications. In the early years of the programme, the budget for HIV/AIDS treatment was insufficient to meet the programme's obligations. When evidence of the positive results of combined therapies increased expectations about treatment of the disease, six NGOs<sup>15</sup> dedicated to HIV/AIDS matters started a collective protection action on behalf of all the people living with the virus. The state attempted to absolve itself of responsibility, but, after a long judicial process, the Supreme Court ruled that the duty to provide free medical treatment against the HIV/AIDS virus lay with all of the country's hospitals, and determined that it was an obligation of the state, as the Ministry of Health was the authority responsible for enforcing Law 23 798.<sup>16</sup>

In 1997, the AIDS and STD Control Project (LUSIDA) was created, with the objective of reducing the spread of the epidemic through the promotion of prevention activities and the improvement of epidemiological surveillance. This programme was jointly funded by the Ministry of Health and the World Bank, with a US\$30 million budget for implementation over four years.<sup>17</sup>

LUSIDA's main objective is to reduce the transmission of HIV/AIDS through a permanent programme aimed at the prevention of AIDS and STDs, giving priority to those geographical areas with the greatest number of registered cases: the city of Buenos Aires, the province of Buenos Aires, Santa Fe and Cordoba. LUSIDA was designed to function collaboratively with the existing National Programme against the Human Retrovirus HIV/AIDS and STDs, and integrates five elements:

<sup>15</sup> Asociación Benghalensis, Fundación Descida, Fundación Estudio e Investigación de la Mujer, Asociación Intilla, Fundación Red y Fundación Pro Ayuda al Niño con SIDA.

<sup>16</sup> Asociación Benghalensis y otros c/ Ministerio de Salud y Acción Social – Estado Nacional s/ amparo ley 16.986", CSJN sentencia del 1/06/00. Fallos 323:1339.

<sup>17</sup> Qué es LUSIDA. <http://www.msal.gov.ar/hm/site/Lusida/QueEsLusida%5CQueEsLusida.htm>.



- a fund to give economic support to the prevention programmes of civil society organizations (CSOs), which participate in the design, implementation, and monitoring of each initiative
- social communication
- education on AIDS and STDs
- strengthening the governmental health sector areas dedicated to AIDS
- evaluation and monitoring

Among the activities developed by the project, its support of HIV/AIDS prevention programmes targeted at vulnerable groups by CSOs stands out. Others have been the training of primary and secondary level teachers in HIV/AIDS prevention and an AIDS prevention campaign in the mass media. The LUSIDA project, in which most activities regarding HIV/AIDS prevention have been concentrated, is now in its last year of operation. The strategy that will be followed to ensure the continuity of these activities is still not clear.

In 1998, the National Programme perceived the need for a strategic plan<sup>18</sup> which would support the actions to be developed in the following years, nationally as well as provincially and locally. To this end, efforts were made to set up a national decentralized planning network, aimed at devising a national response to the epidemic through a process that would develop and progressively increase the programme's management capacity and sustainability.

In the context of strategic planning, the top priorities for the years 2000 to 2003 were defined and an operational plan elaborated. This plan considers objectives, strategies, goals and actions, and identifies the types of resources that need to be allocated to such actions. It also determines which officials, institutions and/or jurisdictions should be responsible for implementation. The strategic objectives that inspire the work plan are prevention, integrated attention to people living with HIV/AIDS and the strengthening of management capacity.

At the national level, the programme's execution falls under the Coordination and Execution Unit. It is not quite clear who has this responsibility at the provincial and municipal levels, although coordination with provincial authorities is mentioned repeatedly in the plan.

The Ministry of Health purchases the medication centrally, and it is then distributed to the various jurisdictions, to the programme's hospitals or directly to patients. Similarly, the Ministry of Health authorizes and supplies the virus load tests for all the people being cared for by the public health system.

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<sup>18</sup> <http://www.msal.gov.ar/htm/site/Lusida/Programas/PlanEstrategico.htm>.

### 2.3 Budget allocated to HIV/AIDS

Value of 1 USD in Argentinean Pesos from 1999 to 2003	1999	2000	2001	2002	2003
	1	1	1	3.1384	2.9452

The budget allocated to health, in relation to the total national budget, maintained a ratio of around 6.5% to 6% in the years covered by this study, albeit with a downward trend that was accentuated in 2003. Simultaneously, the amount of revenue allocated to paying off public debt increased year by year in relation to the total budget, climbing from 17% in 1999 to 22.7% in 2003. The HIV/AIDS budget stayed at around 2% or 2.5% of the health budget, rising to 5.7% in 2003.

**Table 2.1:** Priority of HIV/AIDS and health in the actual budgets of 1999–2003 (nominal pesos)

	1999	2000	2001	2002	2003
Total national administration budget	51,040,000,000	51,602,000,000	52,609,700,000	49,598,100,000	61,514,400,000
Total health budget	3,180,000,000	3,147,200,000	2,802,000,000	3,146,900,000	3,671,100,000
HIV budget*	88,164,756	69,800,000	64,900,000	109,700,000	186,300,000
Health/total budget(%)	6.23	6.09	5.32	6.34	5.96
HIV/health budget (%)	2.77	2.21	2.31	3.48	5.7
HIV/total budget (%)	0.17	0.13	0.12	0.22	0.3
GDP at current prices	283,523,000,000	284,204,000,000	268,697,000,000	312,580,000,000	400,473,000,000
Health budget/GDP(%)	1.12	1.1	1.04	1	0.91
HIV budget/GDP(%)	0.03	0.02	0.02	0.03	0.04
Public debt servicing	8,680,900,000	10,298,500,000	12,978,700,000	7,209,000,000	13,946,500,000
Public debt/GDP(%)	3.06	3.62	4.83	2.3	3.48
Public debt/total budget(%)	17	19.95	24.66	14.53	22.67

Source: Elaborated by the author. Figures in this table represent current credit at the end term of the budget according to the information recorded in public accounts or financial execution reports. The GDP used is the one published by INDEC, National Accounts; the year 2003 GDP corresponds to the second trimester; from 2002 on data are provisional.

Aside from an increase in the proportion of the national budget allocated to HIV/AIDS, the data indicate a downward trend for the resources allocated to health in relation to the national administration total and the GDP, whereas public debt servicing shows an upward trend. It has to be taken into account that this prioritization of resources has happened in the context of an economic crisis – a crisis that has accentuated the population's vulnerability to disease and demand for public health services, due to their diminishing ability to access private health care or social security.

The increase in resources allocated to HIV/AIDS is attributable to the fact that, as a result of the socioeconomic crisis, the Ministry of Health adopted a policy on health emergency.<sup>19</sup> This policy included the reorientation of international loans and credits already allocated to the Ministry of Health to specific health priorities, including HIV/AIDS.<sup>20</sup>

In a sense, the government's concern regarding the negative impact of the economic situation on access to treatment for persons living with HIV/AIDS is a positive sign. However, it has to be pointed out that instead of increasing the overall budget for health, this measure only constitutes a reallocation of resources to very specific programmes within the ministry itself.

During the years covered by this study, the actual budget for the AIDS programme showed a 15% annual increase in real terms. It must be remembered that in January 2002 the Argentinean peso ceased to have parity with the US dollar. In 2000 and 2002, the budget allocated to AIDS decreased significantly, for which no clear justification can be found in budget documents. Neither was this budget reduction reflected in the goals of medication, investment in hospitals and serological determination, which were not only accomplished, but exceeded expectations.

**Table 2.2: HIV/AIDS budget**  
(pesos)

	1999	2000	2001	2002	2003
Nominal allocated value	71,831,372	63,404,071	82,011,705	63,435,781	186,259,653
Real value allocated	71,781,175	62,709,307	82,011,705	48,589,308	132,597,745
Nominal adjusted allocations at the end of financial year	88,164,756	69,754,572	64,912,220	109,677,000	186,107,000
Real adjusted allocations at the end of the financial year	88,103,145	68,990,221	64,912,220	84,008,260	132,489,072
Nominal Executed budget	77,145,573	56,641,160	53,227,097	76,933,000	56,168,000
Real executed budget	77,091,662	56,020,502	53,227,097	58,927,646	39,985,848

Source: Elaborated by the author with information from administrative allocation decisions and from executed budget reports, published by the National Budget Office. Real figures in 2001 pesos.

The decrease that took place in 2000 could be due to the reduction in medication prices per person. The cost of treatment went from an annual \$8 949 in 1999 to \$2 505 in 2000, according to the National Programme.<sup>21</sup> Moreover, it can be deduced, though it is not expressly stated, that from 2002

<sup>19</sup> The National Sanitary Emergency was declared by Decree 486/02 in March 2002.

<sup>20</sup> Other programmes that were similarly motivated were those on Maternal and Child Health and on the Prevention and Control of Diseases and Specific Risks.

<sup>21</sup> Cuenta de Inversión año 2000, Evaluación de Resultados de la Gestión Gubernamental. Resultados por Programas y Proyectos en Orden Institucional, Programa: Lucha contra el SIDA y Enfermedades de Transmisión Sexual. [http://www.mecon.gov.ar/hacienda/cgn/cuenta/2000/tomo\\_ii/16-80\\_ac.htm](http://www.mecon.gov.ar/hacienda/cgn/cuenta/2000/tomo_ii/16-80_ac.htm).

costs decreased again, because the Ministry of Health replaced original medication with cheaper generic medication.

**Table 2.3: Spending on each programme component<sup>22</sup>**  
(pesos – nominal and real)

	value	1999	2000	2001	2002	2003
Epidemiological surveillance and research	Nominal	446,472	387,668	77,202,199	60,384,340	61,924,492
	Real	446,160	383,420	77,202,199	46,252,025	44,083,879
Prevention and control of sexually transmitted diseases	Nominal	217,292	152,566	594,506	293,441	217,543
	Real	217,140	150,894	594,506	224,764	154,868
LUSIDA	Nominal	4,998,000	5,814,896	4,215,000	2,758,000	299,700
	Real	4,994,507	5,751,178	4,215,000	2,112,519	213,356
Medication assistance	Nominal	66,169,608	57,048,941	* No data	* No data	123,817,918
	Real	66,123,367	56,423,815	* No data	* No data	88,145,642

Source: Elaborated by the author with information from the administrative allocation decisions. Real figures in 2001 pesos.  
\* In 2001 and 2002 the line-item “Medication assistance” was discontinued and these funds absorbed into “Epidemiological surveillance and research”.

It is clear from the table that, with the exception of 2001, there has been a constant drop in the resources allocated to the prevention and control of STDs. The same applies to the LUSIDA project, the exception here being the year 2000. It should be noted that all HIV/AIDS prevention activities carried out by the state are concentrated in these two components.

Until 2003 it was not quite clear which programme component dealt with treatment and care, which with prevention and which with research, since these activities appeared to cut across all of the different components. Nevertheless, in order to facilitate comparison, activity 1 “AIDS epidemiological surveillance and research” will be deemed to concentrate on research tasks; activity 2 “STD prevention and control” (and its variables), along with the LUSIDA project, will be considered prevention-focused; and activity 3 “medication assistance” will be regarded as treatment and care. As a result, the analysis becomes complicated for 2001 and 2002, in which activity 3 “medication assistance” was combined with activity 1 “epidemiological surveillance”. Consequently surveillance, research and treatment can only be compared on an aggregate level and as a proportion of prevention and dissemination activities.

<sup>22</sup> The lack of information regarding the actual budget allocated to each component prevents replication here of the scheme of the previous table, in which approved and actual budget can be distinguished.

Table 2.4: Percentage of each programme component

	1999	2000	2001	2002	2003
Epidemiological surveillance and Research	0.63%	0.60%	94.10%	95.20%	33.20%
Prevention and control of sexually transmitted diseases	0.37%	0.20%	0.70%	0.40%	0.20%
LUSIDA	7%	9.20%	5.20%	4.40%	0.10%
Medication assistance	92%	90%	*	*	66.50%

Source: Elaborated on the basis of the data in table 2.3.

\* In 2001 and 2002 the line-item "Medication assistance" was discontinued and these funds absorbed into "Epidemiological surveillance and research".

As the table shows, treatment and care activity represents 90% or more of the budget allocated to the programme in all years, with the exception of 2003. In the 1999–2001 period, the next priority, in budgetary terms, was prevention activities, which, including the LUSIDA project, received 4.5% to 10% of allocated resources. This changed in 2002 and 2003, when surveillance and research tasks assumed more prominence than prevention, receiving 33% of the total HIV/AIDS budget in 2003.

Another issue deserving attention is the relationship between the component for epidemiological surveillance and research and that for medication. It is evident that surveillance enjoyed minimal priority during 1999 and 2000, getting less than 1% of the programme's budget, while medication drew more than 90%. Because both activities fell under the surveillance component in 2001 and 2002, this component received 95% of the budget. It can be assumed that only a tiny part of this amount was spent on surveillance and that the rest went to medication. However, in 2003 the relationship between surveillance and medication changed dramatically: the former increased and the latter decreased by 30% in relation to 1999 and 2000. These variations warrant attention when one notes that no tasks additional to those included in the programme in previous years seemed to have been planned; neither were there changes in costs to explain the different allocation of resources.

Finally, with respect to LUSIDA, it is useful to remember that until 2000 this project served as the channel for an important part of the programme's prevention activities by granting subsidies to CSOs to carry out prevention projects targeting vulnerable groups. When this LUSIDA component came to an end in 2000, the AIDS programme did not make allowances to continue funding such activities or similar ones. This might explain the reduced weighting for prevention activities since 2001.

These data, besides pointing to the lack of importance that the government accords to prevention and epidemiological surveillance, testify to the lack of clarity regarding criteria for dividing resources among the different activities of the programme. This complicates the task of evaluating and monitoring the HIV/AIDS budget according to human rights standards, and specifically the right to health.

## **2.4 Human rights considerations**

The policy developed by the Argentinean state regarding HIV/AIDS appears to be guided by the principles of universality and integrality of prevention, treatment and care. Nevertheless, in both design and implementation, the compliance with human rights standards is less consistent. These inconsistencies relate not only to the right to health, but also to essential obligations in terms of transparency and information, without which it is very difficult to evaluate, control and demand policies with adequate human rights standards.

There are various factors that create a gulf between the national HIV/AIDS policy and budget and basic human rights standards. These factors may be grouped in five large problem areas: a) the lack of an integral AIDS policy that encompasses treatment as well as prevention, education and surveillance; b) different types of obstacles that hinder access to medication in due time and form; c) the fragmentation and regional inequalities that characterize the health sector in Argentina, added to the lack of leveling or compensatory actions by the state; d) the insufficiency or failure of information provided by the National Programme, on the basis of which the public policy is designed; e) reduced resource allocations for health in the context of higher sanitary risk and service demand.

*The lack of a vision and an integral policy to fight AIDS, encompassing treatment, prevention, education and surveillance.*

In the fight against AIDS, the state's responsibilities are not limited to providing assistance to those living with HIV/AIDS. It must also ensure that prevention, information and education reach all the population, particularly the most vulnerable groups and those at greater risk of infection.

Article 12.2(c) of the International Covenant on Economic, Social and Cultural Rights (ICESCR) (1976) establishes the obligation to take steps to prevent, treat and control epidemic, endemic, occupational and other diseases. This calls for "the establishment of prevention and education programmes for behavior-related health concerns such as sexually transmitted diseases, in particular

HIV/AIDS, and those adversely affecting sexual and reproductive health, and the promotion of social determinants of good health, such as environmental safety, education, economic development and gender equity.”

However, the Argentinean state focuses its actions almost exclusively on medical treatment, without paying proper attention to those tasks involving education, information, prevention and epidemiological surveillance.

- (i) The state has not overseen the implementation of sustained and systematic prevention activities, nor is it involved in the improvement and expansion of sentinel sites and registers. It neither promotes educational activities nor undertakes research into social behavior and habits with a view to having an impact on the spread of the epidemic or on the way in which people living with HIV/AIDS are treated.
- (ii) It has not been possible to identify any specific measures taken by the National Programme to educate people who are at a greater risk from HIV/AIDS.<sup>23</sup> The prevention campaigns seem to have been reduced to a single yearly campaign around World AIDS Day (1 December). Consequently, sustained education and prevention activities have been reduced to the distribution of condoms and the availability of a toll-free number offering information about the epidemic and its treatment.<sup>24</sup>
- (iii) When the financial requirements for the AIDS programme are defined, prevention, education and surveillance activities are not considered. There are no output indicators that allow for a useful control of resources, while such indicators do exist for assistance with medication and serological testing.<sup>25</sup>
- (iv) Despite knowing that “opportunistic infections continue to be the reason for consultation that leads to the diagnosis of the infection”<sup>26</sup> and that the possibility of developing AIDS is reduced when the virus is detected in an early stage, the state has no policy oriented towards the promotion of early testing.
- (v) The few prevention and surveillance measures that the state has undertaken have been funded mainly with external financing, which puts their sustainability in doubt.

<sup>23</sup> It is obligatory, however, to offer HIV tests to every pregnant woman as part of normal pregnancy care (Ley Nacional 25 543, artículo 1).

<sup>24</sup> The call for proposals that are part of the Global Fund are not mentioned, since the national program neither mentions nor funds them.

<sup>25</sup> In the budget for year 2003 the 0-8000 phone line attention was included as a programmed goal for the first time.

<sup>26</sup> This information was supplied by the Director of the National AIDS Programme, Dr. Hamilton on October 30, 2003, due to a legal process initiated by the Network of People Living with HIV/AIDS (Red de Personas Viviendo con VIH/SIDA, expediente administrativo N° 2002-9016-03-3. Ref: Situación asistencial tratamientos. Afectados de VIH).

- (vi) A reduction in treatment costs, such as occurred in 2000, or a failure to spend some of the resources available, as in 2002, has not translated into more resources for better prevention, surveillance or educating activities. Instead, such patterns have led to a decrease of resources or their reorientation to other programmes.
- (vii) In the period covered by this study, the resources allocated to the two activities that focus on the prevention and surveillance actions, STD prevention and LUSIDA, consistently decreased.
- (viii) The state relegates the prevention and epidemiological tasks to the provinces, but without any incentives for or monitoring of their implementation.

*Different types of obstacles that hinder people's access to medication in due time and form*

The right to health presumes that the state undertakes the essential obligation of ensuring access to health facilities and services for everyone. The state must also eliminate any physical, economic or judicial barriers obstructing such access. In the context of the right to health, the state has basic obligations that cannot be ignored, and failure to comply with them is not justifiable under any conditions; they are the minimum essence of the right itself.<sup>27</sup> Among these basic obligations are the following: "to make essential medications, as defined in the programme of action of the World Health Organization, available."<sup>28</sup> In the case of HIV/AIDS, this includes triple therapy.

In Argentina, even though the law guarantees the cost-free provision of treatment and medication for people living with HIV/AIDS who do not have resources, this access encounters various obstacles in practice, resulting in interruptions and, in some cases, the abandonment of treatment.

- (i) Delays in purchasing processes and failure to spend the budget have resulted in the unavailability of medication, interruptions in treatment or incomplete deliveries of medicines.<sup>29</sup> This situation forces affected people to travel repeatedly to health facilities in different areas.<sup>30</sup>

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<sup>27</sup> ESCR Committee, General comment N° 14, paragraph 47.

<sup>28</sup> *Ibid.*, par. 43.

<sup>29</sup> The Director of the National AIDS Programme herself acknowledges that medication supplies are interrupted by problems of procurement (Respuesta brindada por la Directora Ejecutiva del Programa Nacional de SIDA, el 30 de octubre de 2003 en el Expdte administrativo N° 2002-9016-03-3 referenciado "Situación Asistencial Tratamiento afectados de VIH", a la RED de PVVIH).

<sup>30</sup> People living in different regions have frequently had to go to the capital city's Health Ministry because of the shortage of medication in their own distribution centers.



- (ii) In many cases, the treatment centers are found in major urban areas, and a “travel voucher”, that would allow lower-income people to access them easily, does not exist.<sup>31</sup>

*The fragmentation and regional inequalities that characterize the health sector in Argentina, added to the lack of leveling or compensatory actions by the state*

Among the core obligations of states in ensuring that they provide, at the very least, the minimum essential levels of the right to health are “to ensure the right of access to health facilities, goods and services on a nondiscriminatory basis, especially for vulnerable or marginalized groups” and “to ensure equitable distribution of all health facilities, goods and services”.<sup>32</sup>

The obligation to ensure the universal coverage of health care and treatment services and effective access to them requires public policy to promote the inclusion of the most vulnerable or marginalized sectors. This implies that in the designing of the HIV/AIDS policy, both groups – those most vulnerable to infection and those who face greater obstacles in accessing treatment – have to be considered.

In this matter, the fragmentation and regional inequalities that characterize the health sector are especially worrying. The result is that people living with HIV/AIDS only have access to care and treatment in conditions of inequality, depending on where they live. Some of the troubling factors are:

- (i) Provinces generally do not base their health budget on indicators derived from the population’s health requirements.<sup>33</sup> The level of prioritization of the health budget among provinces ranges from 8% to 16%.
- (ii) Equity and redistributive principles are not among the criteria for the allocation of resources among the provinces. Similarly, there are no positive steps towards the reduction of existing regional disparities in the field of health services.
- (iii) Some key tasks in the fight against HIV/AIDS are left to municipal authorities, which then perform them in a very irregular way<sup>34</sup>, without any effort on the part of the state to improve the situation.

<sup>31</sup> There are a number of proposals before Congress regarding travel vouchers tickets. Generally speaking, their aim is to subsidize the use of public transport for those people without resources who need to travel for treatment in the public health system. <http://www.cicop.org.ar>.

<sup>32</sup> ESCR Committee, *Op. cit.*, par. 43 a. and e.

<sup>33</sup> Maceira Daniel, *Equity and financing the Argentinean Health System*, Centro de Estudios de Estado y Sociedad, Serie de Seminarios Salud y Política Pública, Seminario VII-Octubre 2002.

<sup>34</sup> Other deficiencies have been mentioned: a) insufficient sentinel sites, b) insufficient or lack of resources for the transportation of medicines, c) unavailability of milk substitute for nursing mothers with HIV.

- (iv) Despite the existence of covenants and its obligation to guarantee health for all, the state does not control the provinces' performance of the required actions.

*The insufficiency or failure of information provided by the National Programme, on the basis of which the public policy is designed, and the lack of strategic policies in the fight against AIDS*

An essential first step that a state must take to promote the effectiveness of human rights in the context of HIV/AIDS is to carry out a comprehensive diagnosis of the existing situation.<sup>35</sup> In complying with the obligation to draw up and implement a detailed action plan to tackle the epidemic, it is of the utmost importance to have precise knowledge of the epidemic's situation, characteristics and geographical distribution, the social sectors with the most urgent needs or in the most vulnerable position, and the factors that influence the spread of the epidemic or impede access to services.<sup>36</sup>

Producing the information required to compile this diagnosis and to control the implementation of policies is a step that the state must take immediately. A scarcity of resources cannot be accepted as an excuse for not complying with this requirement.<sup>37</sup> "The state is obliged to adopt and apply, on the basis of epidemiological information, a national public health strategy and action plan, in order to confront the health issues of the population; the strategy and the action plan are to be devised and periodically revised through a transparent and participative process; the strategy and the plan must provide methods, such as the right to indicators and health reference bases, that allow the close monitoring of realized progress; the process for conceiving the plan and the strategy, as well as their content, has to consider vulnerable groups and marginalized population."<sup>38</sup>

The present report shows that these necessary measures are not being implemented.

- (i) Although the strategic planning process was an important step forward, the operative plans derived from it were not implemented, nor was continuity ensured in the process of diagnosis and planning.
- (ii) The state does not have mechanisms to evaluate the situation of the persons living with HIV/AIDS in the different localities throughout the country; nor does it have a mechanism to monitor the equitable implementation of the National AIDS Programme in each jurisdiction.

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<sup>35</sup> ESCR Committee, General comment N° 1 and 3.

<sup>36</sup> *Ibid.*

<sup>37</sup> *Ibid.*

<sup>38</sup> ESCR Committee, General comment N° 12, paragraph 43 f.

- (iii) No strategic policy exists to ensure the right to health of all the population, considering regional differences.
- (iv) As a consequence of delays, underreporting, interruptions and a lack of complementary studies of the mechanisms of epidemiological surveillance (such as sentinel sites), the state works with inaccurate information on the number of people living with HIV/AIDS, as well as faulty data on gender, age, socioeconomic situation and address.
- (v) Research into the social practices and habits of different groups of the population, which is necessary in order to understand and identify situations of vulnerability and discriminatory behavior, is not carried out.

*Reduced resource allocation for health in the context of higher sanitary emergency and service demand*

Article 2.1 of the ICESCR provides that states must take economic and technical steps, and use the maximum of their available resources, in order to achieve progressively the full realization of the rights recognized in the covenant, by all appropriate means, including, in particular, the adoption of legislative measures.

This requirement gives substance to two obligations that must guide the state's action in each concrete case. On one hand, the state is obliged to take steps that progressively protect human rights; on the other, the maximum of the state's available resources must be used in order to do so. The commitment to progressive realization means that the state is prohibited from taking measures that worsen a previously achieved level of protection of the right.

While the available information does not allow for a consistent evaluation of these principles, certain troubling facts suggest that measures needed to stop the deterioration of the population's health are not being taken.

- (i) While the demand for public-sector health services is increasing, both the approved and the effectively spent budgets present a downward trend, in relation to the total budget and as a proportion of the GDP.
- (ii) An under expenditure of funds from external sources resulted in an increase in spending per

capita on HIV/AIDS in the years 2002 and 2003, in comparison with 2001, of only 10.9% and 13% respectively, while the cost of treatment per patient increased by 44% and the number of patients treated monthly by 14% and 16.4%.

- (iii) There has been a decrease in funds for prevention activities and projects forming part of the policy to fight AIDS; the remodeling of hospitals and strategic planning are being either under-achieved or abandoned.

### 3. Chile

Chile comprises 13 regions, which in turn are divided into provinces and municipalities. The political regime is centralist; public policy and budgetary decisions are taken by central government and the ministries. Policies are executed at the regional level, where there are reduced margins for making decisions regarding resources. Efforts have been made to advance towards a more decentralized state, by devolving competencies, functions and resources to regions. Moreover, there have also been processes of decentralization to the 338 municipalities that comprise the local level. In the field of health, this meant that, during the 1980s, municipalities took charge of primary care, using transfers they received from the central level based on subsidies for the types of benefits offered at municipal health centers (FAPEM).

When the democratic transition began in 1990, the decentralization process gained new strength. In 1994, the Law of Municipal Rents was modified, bringing about changes in the budget allocation to health and education. In the case of health, that year the FAPEM system was replaced by a per capita allocation system. This means that the costs of municipal health care are financed by a subsidy given by the Health Ministry for each person enrolled in the system. Under this scheme, primary health care generates deficits, especially for the poorest municipalities, because 1) the formula used to establish the per capita allocation does not take into account the effective costs generated by the different types of population served; 2) not all of the potential users are enrolled in the system; and 3) when demand exceeds estimates, the budget does not provide for the surplus of people needing health care.

#### 3.1 Economic situation and poverty levels

The neoliberal economic model established by the military dictatorship has not changed; neither has macroeconomic stability nor the high rates of economic growth, with an average of close to 7%

virtually throughout the 1990s. Inflation is low, registering rates of 2.3% in 1999, 4.5% in 2000, 2.6% in 2001, 2.8% in 2002 and 1.1% in 2003.<sup>39</sup> At the same time, the unemployment rate has been rising, reaching levels that range from 8% to 10% in recent years.

Per capita GDP is approximately US\$4 500. The legal minimum wage is \$155 per month. In terms of working conditions, a significant number of people perform precarious and unstable jobs, temporary work, fixed-term employment and half-time jobs, and the lack of work contracts is becoming more and more common. All of this is conducive to situations that lack health protection.

According to the 2000 Socioeconomic Characterization Survey (CASEN), a little over 20% of the country's population is in a situation of poverty and 5% in a situation of extreme poverty, which means that they do not have enough income to cover basic needs. Moreover, there is an acute inequality in the distribution of resources and important gaps that divide the rich from the poor. According to the same survey, the income of the richest 10% of the population is 38.5 times larger than that of the poorest 10%.

### **3.2 Government's response to HIV/AIDS**

From 1984, when the first AIDS case was reported in Chile, to 1990, AIDS fell under the Sexually Transmitted Diseases (STD) Programme of the Ministry of Health. In 1990 the National Commission on AIDS (CONASIDA) was created to act as the technical body responsible for the design, executive coordination and global evaluation of the HIV/AIDS Control and Prevention Programme in Chile. Currently, this programme is run by the Division of Sanitary Guiding and Regulation in the Ministry of Health.<sup>40</sup>

At the level of policy definition, the National Commission on AIDS is a permanent and intergovernmental body, formed by the Undersecretaries of the Interior, of the Secretariat-General of Government, of Education, of Justice, of Planning and Cooperation, of Work and Social Provision, and of Police and Investigation, and it is directed by the Undersecretary of Health.

The AIDS Control and Prevention Programme has three general functions:

- to promote the prevention of HIV/AIDS transmission and nondiscrimination against persons living with the virus
- to improve the quality of life of those who are affected by HIV/AIDS

<sup>39</sup> National Statistics Institute, IPC Figure sheets. Prices Statistics Department. <http://www.ine.cl>, 2003.

<sup>40</sup> CONASIDA, *HIV/AIDS Prevention and Control Policy*, Ministry of Health, Chile, 2001.

- to maintain a system of epidemiological surveillance that is adequate to the situation of the epidemic in the country.

Since 1991, the prevention policy has been formulated on the basis of different proposals through media campaigns, working with social communicators and the public health system (social level); through educational proposals targeting specific social groups (group level); and through pre-test and post-test counseling (individual level). Additionally, since 1995, FONOSIDA, a national telephone information service, has been operating. The prevention strategy therefore works at three work levels:

*Mass level:* The objective here is to maintain alertness and risk awareness in the population through the mass media, public events and direct interaction with communicators in the regions. The central action at this level is the social communication campaign.

*Community group level:* At this level, the aim is to socialize preventive learning among peers and to promote social environments that value prevention. To this end, work is done with vulnerable sectors of the population and in intergovernmental projects.

*Individual level:* Risk management is supported through personalized information and orientation offered via telephone and face-to-face counseling, detection, treatment and prevention of STDs.

CONASIDA's lines of action comprise the regional HIV/AIDS prevention plans, which cut transversally across the individual, group and community levels. The objectives of these plans are: to construct a national, intergovernmental, decentralized and participative response regarding HIV/AIDS prevention that responds to the needs of the epidemic, taking into account the local context, and to develop capacity within the public health system to generate intergovernmental work and construct joint HIV/AIDS prevention actions.

One of the most important areas of the AIDS Control and Prevention Programme is the provision of integrated attention to persons living with HIV/AIDS and of the related therapies. In 1993, a programme of monotherapies (AZT) was implemented, covering 100% of public-sector beneficiaries holding therapeutic prescriptions. In 1996, the delivery of bitherapy was launched, with such positive effects that CONASIDA requested the necessary budget to expand the delivery of therapies. In 1999, the programme started to deliver triple therapies. In June 2001, CONASIDA's negotiation with the pharmaceutical companies resulted in a considerable fall in the price of medication, which in turn helped the coverage of antiretroviral therapies for adult beneficiaries of the public health system under active control to rise to 80%.<sup>41</sup>

<sup>41</sup> CONASIDA, *HIV/AIDS Prevention and Control Policy*, Ministry of Health, Chile, 2001.

It is worth underlining the importance of the actions of civil society organizations, which, from 1998, presented three protection appeals before the Santiago Appeals Court based on the defense of the right to life established in the Chilean constitution.<sup>42</sup> These appeals were denied.<sup>43</sup> However, the presentation of cautionary measures relating to these three cases before the Inter-American Human Rights Court resulted in a resolution that forced the Ministry of Health to supply medication to the plaintiffs. In 1999, 21 protection appeals were lodged, which were granted by the Supreme Court, constituting a legal precedent and testifying to governmental weakness with respect to the delivery of medication up to that date.

Moreover, 100% coverage has been attained in the preventive treatment of HIV/AIDS vertical transmission through pregnancy. Such treatment is administered to every woman during pregnancy, delivery and breast-feeding. Therapies for boys and girls living with HIV are freely available to beneficiaries of the health system.

### 3.3 Budget allocated to HIV/AIDS

Value of 1 USD in Chilean Pesos from 1999 to 2003

1999	2000	2001	2002	2003
508.78	539.49	634.94	688.34	691.4

The central government's total budget represents approximately 25% of GDP. The budget of the Ministry of Health ranged from 4.4% to 4.7% of GDP in the 1999–2002 period. With health considered to be one of the current government's priorities, the ministry's budget is equivalent to 18% of the national budget.<sup>44</sup>

**Table 3.1: Ratio of health budget to national budget**  
(real figures in millions of pesos)

	1999	%	2000	%	2001	%	2002	%
Total budget	9,972,105		10,471,099		11,245,219		12,092,239	
Health Ministry budget	1,819,211	18.2	1,888,817	18	2,041,582	18.2	2,144,111	17,7

Source: Elaborated with information from the Budget Bill 1999, 2000, 2001, 2002, DIPRES.

In real terms, the national budget rose by 21.3% from 1999 to 2002, while the amount allocated to the Ministry of Health rose by 17.9%. In annual terms, the national budget rose by 6.6% each

<sup>42</sup> This strategy was coordinated by the National Coordination of People Living with HIV/AIDS VIVOPOSITIVO, in collaboration with the Juridical Clinic of Public Interest Actions from the Universidad Diego Portales and the Centre for Justice and International Rights (CEJIL).

<sup>43</sup> Actualidad Jurídica. Official Journal Database. Santiago, August 28, 2001.

<sup>44</sup> Data from the Budget Office from the Finance Ministry. Budget Bill for each year.

year, while the amount allocated to health grew by 5.6%. In part, this increase is directly due to the resources allocated to the National HIV/AIDS Control and Prevention Programme.

Until 2000, CONASIDA's resources, including the budget for antiretroviral treatments, were included in the budget of the Ministry of Health's Programme of Sanitizing Campaigns. Since 2001, resources for antiretrovirals, high-cost medication for opportunistic infections and monitoring tests have been managed and administered by the National Health Fund, FONASA.

Consequently, CONASIDA's budget – which finances HIV/AIDS prevention, HIV/AIDS studies, communication, STD prevention and integrated HIV/AIDS care programmes, as well as the functions of executive coordination, international cooperation and administration – is complemented by FONASA's resources for medication. FONASA plays an important role in the flow of resources for the treatment of HIV/AIDS, in that it is the public institution responsible for providing care for everyone who is part of the public system. Resources to ensure access to high-cost benefits in the public health system, including those for HIV/AIDS, are transferred through FONASA's Complex Benefits Scheme, or Catastrophic Insurance. Additionally, a budget for social communication campaigns was allocated in 2000.

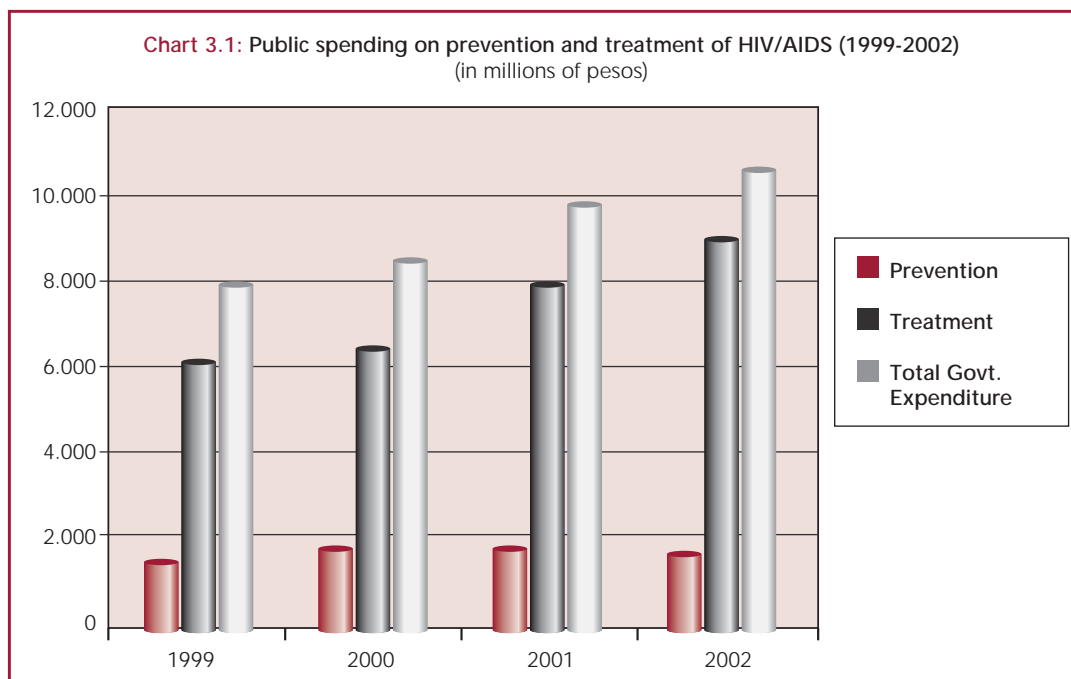
**Table 3.2: HIV/AIDS Control and Prevention Programme budget**  
(nominal figures in millions of pesos)

	1999	2000(1)	2001	2002(2)
Sanitizing Campaign	3,213,767	2,957,000	522,575	418,935
Social Communication Campaign	No data	No data	No data	23,469
Remuneration and operating costs	No data	No data	127,643	134,000
Medication Continuity Project – FONASA	No data	No data	4,596,100	6,078,279
<b>Total</b>	<b>3,213,767</b>	<b>2,957,000</b>	<b>5,246,318</b>	<b>6,654,683</b>

Elaborated with information from (1) DIPRES. Final Evaluation Report. HIV/AIDS and STD Prevention and Control Programme 2000. For the years 1999 and 2000 (2) Preliminary information taken from the study Information Systems on National Responses on AIDS: Financial Indicators for the years 2001–2002, provided by CONASIDA.

As can be seen from this table, there was a significant increase in the HIV/AIDS Control and Prevention Programme budget over this period, largely attributable to the increase allocated to purchasing medication, as budgeting for other components of the programme decreased. On average, caring for people living with HIV received 80.4% of the budget, while 16.6% was allocated to prevention.





Elaborated with preliminary information taken from the study Information Systems on National Responses on AIDS: Financial Indicators for the years 2001-2002, submitted by CONASIDA.

An analysis of the pattern of public resource allocation to the epidemic by source of financing shows that the role of central government is predominant.

**Table 3.3: Sources of financing for HIV/AIDS expenditure in 1999-- 2002**  
(real figures in millions of pesos)

SOURCE OF FINANCING	1999	%	2000	%	2001	%	2002	%
Central government (Health Ministry)	3,005	37.6	4,922	56.9	5,075	51.6	7,465	70.3
Subnational government	0	0	0	0	350	3.6	189	1.8
Social security	4,990	62.4	3,727	43.1	4,409	44.8	2,967	27.9
Total government expenditure on HIV/AIDS	7,994	100	8,650	100	9,834	100	10,621	100

Elaborated with preliminary information taken from the study Information Systems on National Responses on AIDS: Financial Indicators for the years 2001-2002, submitted by CONASIDA.

Of total expenditure on HIV/AIDS, approximately half is public spending and the other half private. Total national expenditure on HIV/AIDS, public and private, has gone from 14 774 million pesos for 1999 to 21 150 million for 2002. These figures represent approximately 0.04% of the GDP, 0.2% of government expenditure and 0.8% of public expenditure on health.

**Table 3.4:** National expenditure on HIV/AIDS as a share of GDP and government expenditure

	1999	2000	2001	2002
Total HIV expenditure (1) / GDP (2)	0.04%	0.04%	0.04%	0.05%
Total HIV expenditure / Government expenditure	0.18%	0.16%	0.18%	0.20%
Total HIV expenditure / Government expenditure on health + FONASA*	0.81%	0.73%	0.815	0.87%

Elaborated with information from: (1) Information Systems on National Responses against AIDS: Financial Indicators (1999–2000), preliminary information from the same study for the years 2001–2002, submitted by CONASIDA. (2) DIPRES. Functional Classification of Spending.

\* FONASA – National Health Fund.

### 3.4 Spending on HIV/AIDS and human rights

#### Universality

The strategy of providing medical attention for persons living with HIV embraces vertical transmission, treatment in public health facilities, periodic evaluation of the virus and immunological situation of every person living with HIV, antiretroviral treatments, the prevention and treatment of opportunistic infections, support for adherence to treatments and clinical controls, as well as psychosocial support.

Within this strategy, the only dimension that is ensured universally is the prevention of vertical transmission, because every pregnant woman undergoes this, regardless of her social security status in the health system. The rest of the dimensions linked to integrated attention for people living with HIV are covered by governmental resources, but only for those who are beneficiaries of the public health care system. In this respect, CONASIDA and other institutions encourage the transfer of patients from the private to the public system, so that they can gain access to free antiretroviral treatment. Currently, 85% of people living with HIV are FONASA beneficiaries, while the rest belong to the private system.

Access to antiretroviral treatments has been a priority for governmental policy, as may be inferred from the high percentage of the HIV/AIDS budget allocated to such treatments; antiretroviral treatments have gone from 22% to 67% of the public resources allocated to the epidemic. The government set the goal of providing medication to 100% of people covered by the public system that might need it. Yet a number of people do not have access to antiretroviral treatment: those who belong to the army and those who are imprisoned. Also in this situation are those who have not yet completed the procedure for the delivery of medication and those who have had to change it.

Nongovernmental organizations<sup>45</sup> have stepped in to provide antiretroviral therapies for almost 300 persons who either subscribe to the private system but cannot afford to buy antiretrovirals or are included in the public system but have suffered delays in starting or changing treatment. On the other hand, the Global Fund to Fight AIDS, Tuberculosis and Malaria has brought new resources to finance 100% coverage of antiretroviral therapy for beneficiaries of the public sector. However, it is not yet clear what will happen to the people who belong to the private sector but cannot afford the treatment and, until now, have relied largely on the NGOs.

#### Economic accessibility

As indicated above, the state's support for people living with HIV is essentially directed at users of the public health care system. Those who pay contributions to the private medical system or are treated privately do not access to this benefit. Nonetheless, these people may seek incorporation into the public system (FONASA) by changing the destination of their contributions through a fairly simple procedure. Medical attention, as well as the delivery of antiretrovirals, is free in FONASA.

The free provision of medication and advances in the government's goal of reaching 100% of the population that might need medication clearly indicate progress from a human rights perspective. The upward trend in the budget allocated to HIV is also a positive indicator – most of all because this increase is directly related to the provision of antiretroviral medication.

However, at the same time that spending on treatment, especially antiretrovirals, has increased, spending on other aspects of the control of the epidemic, such as preventive actions, has decreased. An example is the decrease in public spending on free condoms: per capita spending on condoms was \$9 606 for 2001 and \$3 984 for 2002, an investment which is low if we consider the importance of the use of prophylactics in controlling the epidemic and their high cost to ordinary people.<sup>46</sup>

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<sup>45</sup> Fundación Savia and Fundación Laura Rodríguez.

<sup>46</sup> Condom prices vary from \$0.57 to \$1 per unit.

Related to this is the fact that the use of the condom has not been an explicit element of Chile's sexual and reproductive health policies or programmes. The government has not carried out the social marketing strategies for the condom which would lead to the lowering of its cost and make its use more accessible. Only in April 2004 the "Strategy of Social Marketing of the Condom in Chile" was launched, with the aim of increasing the use of this means of preventing infection. The initiative will be financed with resources from the Global Fund.

### Physical accessibility

The strategy of treatment for people living with HIV is implemented at local level by professional teams in the health care system. In order to access therapies for opportunistic infections, persons living with HIV must go to their nearest health centre. The public health system has hospital treatment for people living with HIV (adults and children) at 26 of its 28 health care facilities. At each centre, there is an interdisciplinary team responsible for reception, evaluation and treatment.

These facilities are located in the regional or provincial capitals. For people who do not live close to these areas, accessing such centers entails high costs in time and money, owing to the long distances, especially in regions other than the metropolitan area. This is the first shortcoming relating to physical access. Also, persons who have to be treated for emergencies go to emergency units, which generally have no trained personnel with the necessary information required to attend to patients adequately and without prejudice. Another difficulty is the bureaucracy and the waiting times involved in accessing specialist medical attention.

In addition, health care teams attending to patients with HIV have to work under a lot of pressure and excessive work loads, since their budget allocation has not effectively been increased in recent years. In various ways, this overload affects the quality of attention. Despite the pressure experienced by the health care teams, patients and organizations of people living and working with HIV/AIDS acknowledge the commitment and professionalism with which they perform their work.

Another weakness that has been identified is the lack of psychological attention provided for people living with HIV, attention that is very important given the characteristics, dangers and difficulties that the illness presents. In general, there is a shortage of psychologists and psychiatrists in hospitals, but in the case of HIV/AIDS these professionals need special training to respond adequately to the realities experienced by patients. This violates the principle of the integrality of the right to health, which involves not only physical health but also mental health, two dimensions that should be

inseparable. In current policies and programmes, priority is given to caring for physical health, while mental health is neglected.

### Nondiscrimination

Regarding the persistence of discriminatory situations for people living with HIV, the research carried out by Vivo Positivo has produced important findings. These show that the main situations of discrimination for persons who live with HIV occur when they are hospitalized, undergo treatment by medical specialists in other disciplines or use emergency services. In the case of hospitalization, the incidence of neglect, lack of hygiene and even segregation – being sent to other wards that might not even be adequately equipped, or to segregated restrooms – has been denounced.

The discrimination experienced by people living with HIV when visiting specialists takes the form of long waiting times, of being attended to last even when having arrived first and of specialists refusing to examine them due to their serological condition. Another situation, which is ascribed to the deficient training of health care personnel, is the lack of confidentiality regarding positive HIV tests. This occurs when health care staff ask patients in public whether they are HIV positive.

### Access to information

Access to information involves people living with HIV/AIDS as well as the general population, who could eventually become infected with the virus.

The average expenditure on HIV information, education and communication in the period of the study was 438 million pesos. This is equivalent to a per capita spending of 29 pesos, an amount that does not reflect the importance of these actions in preventing the spread of the epidemic and ensuring that the population has access to information. Along with low public expenditure in prevention campaigns, it is important to mention their lack of frequency, as well as the weakness of messages encouraging the use of the condom as the main means of prevention.<sup>47</sup>

The background regarding expenditure allocated to information and prevention is relevant in that the state is obliged not only to respect human rights, and therefore not violate them, but also to guarantee their fulfillment, which implies promotion, information dissemination and education on

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<sup>47</sup> In prevention campaigns, the use of the condom is mentioned along with other options, such as sexual abstinence or stable partners – options that ignore sexual practices in today's Chile but seek not to offend certain conservative sectors, such as right-wing political parties and the Catholic Church.

such rights. Thus, the lack of such activities regarding HIV/AIDS can be considered as noncompliance by the state with its obligations. By giving priority to the treatment of persons living with HIV, the state has sacrificed the right to information and neglected preventive measures targeting the general population.

#### *Progressive fulfillment*

Government expenditure on HIV/AIDS shows an upward trend in the period of this study, increasing by 33%, although it has remained constant as part of central government expenditure generally and government health expenditure in particular. In other words, although more resources have been allocated to HIV/AIDS, the problem does not enjoy greater priority within the budget as a whole.

The highest increase is observed in the area of the treatment of people living with HIV – 43% over the whole period and 13% annually. Within this item, the highest increase was registered in the expenditure on medication, which rose 324% between 1999 and 2002, with an average annual growth of 62%. Compared with the increase in treatment expenditure, the expansion in prevention is rather insignificant.

## 4. Ecuador

Situated on the northern Pacific coast of South America, Ecuador is one of the continent's smallest countries, with a total surface area of only 270 670 km<sup>2</sup>. According to the 2001 census, it has a population of 12 156 608 inhabitants, and it is estimated that about 10% of the population has emigrated to the United States, Spain and Italy. Since the beginning of the oil boom in the 1970s, people have gradually abandoned the rural areas and the population has become primarily urban.

Currently, 61% of the population lives below the poverty line, of which a third endure conditions of extreme poverty. If we add to this the fact that social spending for 2004 does not even reach 1996 levels, the systematic social deterioration of living conditions becomes obvious. The 1999 economic crisis worsened the existing loss of purchasing power among the population, especially in the lower income groups. In 2000 inflation rose to 91%, causing even greater inequality in income distribution. In that year, the income of the wealthiest 20% of the population was 29 times that of the 20% in the lowest income brackets. From 1998 to 2000, economic recession and low wages increased under-employment from 42% to 60%.<sup>48</sup>

<sup>48</sup> Ecuador Integrated System for Social Indicators.

The national economy is primarily based on oil revenue and debt, which jointly represent more than 45% of the country's income. More than half of public spending, not surprisingly, is allocated to paying the interest on public debt and state workers' salaries.<sup>49</sup> In 2003, spending on long-term defense assets increased 196%, while that on education and hospital equipment was reduced by 88% and 49%, respectively.<sup>50</sup> These are indeed alarming trends.

#### 4.1 Public policies for HIV/AIDS

Although Ecuador's first AIDS case was identified in Guayaquil in 1984, it was not until 1987 that the Programme for the Prevention and Control of HIV/AIDS and STDs was created. CONASIDA was established as a follow-up to this initiative, and in 2000 the HIV Comprehensive Prevention and Assistance Law was passed by the legislature.

According to the guidelines presented as part of the National AIDS Programme in June 2001 by the former Minister of Health, Patricio Jamriska, the Ministry for Public Health (MSP) is committed to promoting, supporting and developing the following areas of action:

*Prevention:* The MSP seeks to articulate all actions in the health and education sectors in order to develop prevention programmes for schools, while also designing other strategies for people without access to formal education. A gender perspective and respect for human rights are incorporated in all activities.

*Treatment:* Activities in this area are focused on guaranteeing the diagnosis, treatment and correct referral of HIV-infected people by health professionals. The ministry also seeks to provide the necessary treatment and testing at a low cost. The training of health personnel is emphasized, along with special attention to those groups with special needs, such as children, sex workers, the incarcerated population and sexual diversity groups.

*Laboratories and blood banks:* The MSP seeks to ensure biosecurity, efficiency in Elisa (enzyme-linked immunosorbent assay) testing, quality control programmes and top-quality laboratories.

*Human rights and HIV:* The MSP attempts to guarantee, at all levels, the individual, social, sexual, reproductive, economic, cultural and political rights of all Ecuadorians, and in particular of those living with HIV/AIDS.

<sup>49</sup> UNICEF. 2003.

<sup>50</sup> State General Budget, 2003.

## 4.2 The public budget for the prevention and control of HIV/AIDS

### Ecuadorian economy adopted USD as local currency since 1999

Today, the MSP is responsible for all activities relating to HIV/AIDS, and the National AIDS Programme (PNS) specifically targets HIV. It should be noted that in 2003, although the PNS requested \$2 million, it only received \$95 000.<sup>51</sup>

Despite what one might expect, there is no entry for HIV recorded in the budgets of other ministries, such as Human Development (formally known as Social Welfare) or Education, nor is it included in the budgets of agencies such as the National Women's Council (CONAMU) and the National Institute for the Child and Family (INNFA).

Resources allocated to the health budget have been reduced significantly over recent years as a result of the economic crisis. From 1999 to 2001, health spending amounted to less than 4% of the state's total budget. Since 2002, a small increase has been noted, and health now accounts for around 5% of the total budget.

The resources assigned to the prevention and control of HIV/AIDS are insignificant in the context of the national budget. Within the health budget, such areas are given less than 1% of available resources. It appears that AIDS spending has increased significantly as a proportion of the national budget, rising from 0.003% in 2001 to 0.208% in 2002. From 1999 to 2001, resources for the prevention and control of HIV/AIDS accounted for less than 1 cent in every \$1 000 of fiscal spending. This increased to 11 cents in 2002 and to 12.5 cents in 2003.

The budget for AIDS prevention and control was approximately \$27 000 in 1999 and dropped to around \$5 000 in 2001. In 2002, however, it rose to \$618 700, an increase of 11 700%, thanks to the efforts of PNS director Dr María Elena Acosta.

Taking public spending on AIDS prevention and control in relation to the total population, it can be observed that in 1999, \$0.03 was spent on each person, regardless of whether they were infected or not. The amount fell to \$0.01 in 2001 and rose again to \$0.05 in 2003. If one divides this budget by the number of people living with HIV/AIDS, then it appears that the state spent less than \$15 on each of them from 1999 to 2001. However, starting in 2002, annual spending on every HIV/AIDS patient rose to more than \$100, which can be ascribed to the increased distribution of medication.

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<sup>51</sup> This information was provided by Rita Mejía, Coordinator of the Budget Unit at the MSP, during a meeting held on Friday, 5 September, 2003.



**Table 4.1: Components of the HIV/AIDS programmes**  
(US dollars<sup>52</sup>)

DETAILS	1999	2000	2001	2002	2003
Personal services by contract	4,400	2,057	2,047	10,484	17,823
General services	207	111	133	37,671	41,062
Current consumer and user goods	900	484	3,056	no data	61,048
Medication and pharmaceutical products	7,890	4,981	no data	570,576	621,928
National programme for HIV/AIDS prevention	no data	no data	no data	no data	95,000
Total	13,396	7,633	5,236	618,731	836,861

Source: Public Health Ministry, Finance Ministry: budget documents and budget execution reports.  
<http://www.ec-gov.net>.

There is a tendency for HIV/AIDS spending to be concentrated on medication, indicating that the government gives higher priority to treatment than prevention. In 2003, medication and pharmaceutical products represented 74% of the HIV/AIDS budget, while only 11% was assigned to the national programme for prevention. For 2003, the MSP asked the Ministry of Economics and Finance for a \$2 million budget, of which only \$95 000 was authorized, representing a 95% reduction.

#### *Foreign resources: loans and donors*

In September 2002, the Coordination Mechanism for Ecuador (MCE) presented the "National project for the fight against malaria, tuberculosis and HIV/AIDS in Ecuador", which was approved in the second round of proposals to the Global Fund. One of the central parts of the project's HIV/AIDS component was to "decrease the rate of infection of the epidemic and its impact" (MCE). Additionally, it sought to increase the participation of civil society with regard to the HIV/AIDS epidemic.

This proposal envisages the participation of civil society, the state and the nonprofit private sector. Its budget amounts to approximately \$14 million. Considering the fact that a large part of the funding used for training, for prevention campaigns and for strengthening and organizing civil society participation comes from the Global Fund, the lack of sustainability and guarantees for mechanisms of this type, due to their not being part of a clear state policy, is unsettling.

<sup>52</sup> The Ecuador government uses US dollars in its budget documents.

**Table 4.2:** Spending percentage of HIV/AIDS from national public resources

YEAR	%
1999	60.9%
2000	0.6%
2001	0.3%
2002	13.7%
2003	16.1%

Source: Public Health Ministry, Finance Ministry: budget documents and budget execution reports. <http://www.ec.gov.net>. Central Bank monthly statistical report. <http://www.bce.fin.ec>. <http://www.globalfundatm.org/proposals/round2/files/ecuadorhivsp.doc>.

### 4.3 HIV/AIDS and human rights

#### *Principle of universality*

This principle raises at least three important questions: Should the Ecuadorian state focus its HIV/AIDS policies exclusively on people living with HIV/AIDS? Does it possess the information to act universally? Is this principle of universality taken into account in defining the scope of policies, objectives and the budget?

First, according to the principle of universality, the responsibilities of the state are not limited to people living with HIV/AIDS. It is obliged to include all the people living in its territory in prevention initiatives, although special emphasis should be given to the more vulnerable groups (those groups whose environment and sexual practices place them at higher risk of catching the disease). This obligation includes ensuring the protection and direct coverage for people officially registered as living with HIV/AIDS as well as those not so registered.

From the information available, there are reasonable grounds to believe that state programmes do not cover the whole population affected by HIV/AIDS; indeed, official figures indicate only 4 491 reported HIV/AIDS cases between 1984 and 2002. Such estimates do not take cognizance of the recommendation by the Pan-American Health Organization (PAHO) and organized civil society that reported cases should be multiplied by ten in order to arrive at a more realistic number.

Taking this into account, it is obvious how important the under-registration of HIV/AIDS cases is for human rights. Since the state is the entity responsible for handling epidemiological information appropriately, the following elements should be recognized as sources of state disinformation:

- i) the general limitations of the National Health System, for instance in its implementation of decentralized laboratory testing<sup>53</sup> and reliance on diagnosis by its agencies
- ii) the hiding of information because of prejudices, stigmas, and serious forms of discrimination relating to HIV/AIDS and sexuality issues in general
- iii) the information and statistical system's own deficiencies regarding the health centers
- iv) the absence of effective reporting and accountability mechanisms in relation to the number of detected HIV/AIDS cases in the private health institutions, which have a wide discretion regardless of official norms
- v) the limitations in training medical personnel in the country

Universality also includes the obligation to keep disaggregated statistics regarding the different groups affected by HIV/AIDS, future projections and data that could help the decision-making process. Even though it is true that there are some groups identified as high-risk in Ecuador who engage in diverse sexual practices – for example, men who engage in intercourse with other men, and sex workers – the infection rate of heterosexual women is on the rise. Other vulnerable groups are migrant workers, who move from rural to urban and from mountain to coastal areas, Ecuadorians who leave the country and Colombians or Peruvians working in the border provinces. Finally, the vulnerability that adolescents face should be stressed and discussed. The need to identify specific groups contrasts with the lack of reliable statistics on the topic.

Any policy seeking to compile reliable and up-to-date information on the prevention of HIV transmission and on the promotion of a healthy sex life requires decision-makers to have objective knowledge regarding the different sectors that make up the population.

An equally relevant aspect of universality is access to specific information about the disease, testing and the free availability thereof, and possible infection routes. All people within the country's territory, including foreigners, should be able to access this information easily. Since 1988, PAHO has made it clear that one of the principles these programmes and policies must observe is "the

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<sup>53</sup> There are very few large hospitals in the country, all situated in the big cities. Of these, not all have laboratories where Elisa testing can be done or qualified medical staff that can perform such tests. In many cases, people in rural or isolated areas end up traveling between 6 and 12 hours to get to one of these hospitals, without any guarantee that, once there, they will be offered the minimum health services or lab tests needed. The situation is even more complicated for those people living with HIV/AIDS who need periodic testing and constant evaluation of their treatment and health.

principle of access to information, because silence, as well as discrimination, worsens the impact and consequences of the epidemic".<sup>54</sup>

The population's ignorance regarding the means to detect HIV/AIDS complicates matters. According to the ENDEMAIN (Demographic Survey of Maternal and Child Health) of 1999, 44% of the population over the age of 10 does not know how to be tested for HIV. This lack of knowledge is considerably greater in the countryside (61%) than in the cities (37%). The percentage of the population which, if diagnosed with HIV, does not know where to find help is even larger: 79% in the countryside and 68% in the cities.

Unfortunately, one of the problems one frequently encounters when trying to analyze the principle of universality is the tendency to link it exclusively with state programmes for treatment and medication for people living with HIV/AIDS, specifically with that related to budget spending for fighting the disease. In very general terms, from 1999 to 2001 the state allocated less than \$10 per person officially registered as carrying HIV/AIDS. From 2002, spending increased to more than \$50. This substantial increase is the result of higher expenditure on medication in the 2003 budget.

Even considering the official number of people living with HIV/AIDS, the resources allocated for this purpose are insufficient. In the state's 2003 budget, the amount assigned to medication and pharmaceutical products for HIV/AIDS was \$621 928 dollars. Hypothetically, this amount should cover the treatment of 3 122 registered patients, which translates into \$199.84 per patient. This is much lower than the actual average cost of the treatment (\$1 810 per patient).<sup>55</sup>

In brief, from a universality point of view, we can observe that not all people in the territory of Ecuador are considered when prevention policies and campaigns are created. Furthermore, not even the most vulnerable groups are given special attention. The resources assigned are not sufficient to guarantee adequate treatment even for the people officially registered as living with HIV/AIDS, who account for only 15% of those actually living with the disease. Finally, resources spent on this disease are not utilized effectively because they are not allocated with a global view in mind, which would allow for policies to establish bridges between the prevention, treatment and education of the general public.

<sup>54</sup> WHO, WHA 41.24 13/95/88, Cf. Advocaci and UNFPA "Sexual and reproductive rights in the perspective of human rights", Rio de Janeiro, October 2003. p. 85.

<sup>55</sup> According to data published in FEDAEPS. Nonetheless, it is important to stress how difficult it is to establish the actual amount that the state spends, or should spend, on people living with HIV/AIDS. The data usually only takes into account estimates regarding antiretrovirals, leaving aside collateral illnesses, medical complications, controls and additional testing needed, especially in the advanced stages of the disease.

### Principle of equality of rights and nondiscrimination

This principle also raises some questions: Is it limited solely to equality of access to public health services, medication and specialized attention? Should the state enforce special measures to eliminate forms of discrimination that are the product of stigmas and prejudices about AIDS and being HIV-positive? What information regarding state action – or lack of action, for that matter – is needed to better understand the principle of nondiscrimination? Should HIV policies limit themselves to the right to health in order to promote and guarantee nondiscrimination?

In an effort to answer these questions, we should bear in mind that the principle of equality of rights includes some of the fundamental pillars of human rights: equality before the law, and equal opportunities in all spaces of life. This principle strengthens the idea that people living with HIV/AIDS should have the same opportunities as those not diagnosed with HIV/AIDS to access all state programmes for treatment, support and information about the disease, in a comprehensive manner, and not just medically. It also stresses that people living with HIV/AIDS should not encounter discrimination when trying to access other private or public services, or when trying to use any of their other rights, simply because they are HIV-positive.

For a better understanding of what we mean by discrimination, we should recall what is stated in article 1 of the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW)<sup>56</sup>, since it is such a central concept in the human rights arena:

For the purposes of the present Convention, the term "discrimination [...]" shall mean any distinction, exclusion or restriction made on the basis of [any particular aspect] which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise [...] of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.

The available budgetary information is not sufficiently disaggregated for us to determine whether society's different segments are receiving nondiscriminatory and specific treatment. Nor can we ascertain whether measures, in the form of both legislation and specific policies, have been adopted to protect vulnerable populations, reduce inequalities and eradicate recurring discriminatory practices, such as unjustified firings, forced evictions, denied enrolment in educational institutions, and physical and psychological abuse in penitentiaries. The right not to be discriminated against has special significance in the wake of the HIV/AIDS epidemic, and as a fundamental tool for

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<sup>56</sup> Convention on the Elimination of all Forms of Discrimination Against Women adopted by the General Assembly, Res. 34/180, 18 December 1979.

guaranteeing the dignity of people living with HIV/AIDS. It should also be stressed that “the principle of nondiscrimination means that the protection of public health cannot be used as a justification for measures that reject people with AIDS, by sending them into obscurity, complicating the prevention of new infections, and putting on the line support demanded by people who live with HIV/AIDS”.<sup>57</sup>

The principle of nondiscrimination is ignored every day for people living with HIV/AIDS; secrecy and clandestine lifestyles seem to be not only inevitable, but also a personal survival strategy. If we consider that those groups with higher infection rates (gay and bisexual men and sex workers) are, in reality, exposed to a variety of forms of social discrimination, then it cannot be denied that their struggle is not only against the disease but also against all ways in which discrimination can hurt them.

The disproportionate impact of HIV/AIDS on the most excluded and vulnerable populations should not be seen as a natural occurrence. On the contrary, it is a consequence of the social exclusion that contaminates the quality of life of these populations. The relationship between economic crisis, poverty and HIV/AIDS, for example, is clear from the professional occupations of people living with HIV/AIDS. In 2002, 45% of men living with HIV/AIDS worked in the informal sector (construction, commerce, private security), while 15% were unemployed. Among women living with HIV/AIDS, 60% stated that they worked in homes, while 11% described themselves as sex workers.<sup>58</sup>

Since it first appeared, HIV/AIDS has been strongly and persistently stigmatized around the world, and consequently people living with it have been discriminated against and are generally excluded from society. Thanks to bad information and the Catholic tradition, this is also true for Ecuador.

## 5. Mexico

Mexico is a federal republic comprising 31 states and one federal district where the three branches of government are seated. The federal administration is organized into federal ministries, which, in the case of health and education, are responsible for the design and normative coherence of federal programmes. State governments are in charge of the execution and service delivery of these programmes through their own state ministries. By the year 2000, according to the last population census, it was estimated that the country's population stood at around 97.4 million.

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<sup>57</sup> Advocaci & UNFPA, *op. cit.*, p. 36.

<sup>58</sup> AIDS National Programme, Ecuador, 2003.

### *5.1 Economic situation and levels of poverty*

During the 1980s, Mexico undertook a process of macroeconomic adjustments; this produced particularly negative repercussions for the quality of life of a large proportion of the population. Poverty increased in absolute terms, and the gap in income distribution widened significantly. In 2002, 53.1% of the country's current income was concentrated in the two highest income brackets, while the two lowest brackets accounted for 4.4%.<sup>59</sup> The social repercussions, which are obvious in recent calculations of levels of poverty in the country, are the result of the shifts in the economy over the past two decades: it is estimated that 50 million Mexicans live in poverty, of which 26 million endure conditions of extreme poverty.

At the beginning of President Zedillo's administration in 1994, Mexico experienced its last major economic crisis. The following years witnessed considerable improvement in the country's macroeconomic indicators, such as better growth rates. However, the following presidential term, that of Mr. Fox, was immediately marked by economic deceleration. Today, Mexico is in the midst of economic stagnation: GDP growth for 2003 was 1.5%<sup>60</sup>, which is not enough to satisfy employment demands.

#### *A brief description of the health system*

The Ministry of Health and Assistance (SSA) was created in 1943 when two institutions – the Ministry for Assistance and the Health Department – were merged into one.<sup>61</sup> The Mexican Institute for Social Security (IMSS), the Institute for Services and Social Security for State Workers (ISSSTE), the Mexican Armed Forces Institute for Social Security (ISSFAM) and the social security services for PEMEX, the state-owned oil company, were also established during this same period, each operating independently.

Consequently, the public health system, since its inception, has been divided into two separate sections: health services for the general public and social security. The social security system provides services to individuals who are legally employed and their families. Fluctuating levels of employment and unemployment cause the percentage of people with access to these services to vary, but it generally hovers around 45%. This population has access to a series of comprehensive health services, both preventive and for treatment, at all three levels of attention; and, in addition to this, medication is free of charge.

<sup>59</sup> National Statistics Institute, *Households income and expenditure national survey 2002*, México.

<sup>60</sup> Finance Ministry, *Economic policy general criteria for the revenue bill and budget proposal 2004*, SHCP, Mexico, 2003.

<sup>61</sup> A. Torres Ruiz, *Health decentralization: the Mexican case*, Centro de Investigación y Docencia Económicas, División de Administración Pública, paper number 69, Mexico, 1997, p. 10.

In striking contrast to this, the rest of the population – called the general or open population, because they lack formal employment and therefore are not eligible for social security arrangements – are catered for by the services provided by the Ministry of Health. Until the 1990s these health services were managed by the federation. After a decentralization process, the execution of budget resources and supply of health services were turned over to each state. This means that the system responsible for taking care of the general population's health needs is now made up of 32 different state health services. The SSA has been transformed into the regulating body of the health sector as a whole, including the 32 health services and social security institutions.

## 5.2 The Mexican government's response to HIV/AIDS

In 1986, the National Committee for AIDS Prevention was created in order to deal with the HIV/AIDS epidemic. Two years later, this committee was transformed into the National Council for AIDS Prevention and Control (CONASIDA). Most of CONASIDA's activities were financed using international funds, mainly those of the World Health Organization's Global AIDS Programme. As part of the Ministry of Health, CONASIDA began to receive federal funds in 1991.<sup>62</sup>

The National Programme for HIV/AIDS Prevention and Control was put into operation during the 1994–2000 administration. With this programme, CONASIDA consolidated its role as the normative, advisory and coordinating body for HIV/AIDS programmes, which called for institutional changes to suit its new obligations. This resulted in a decentralization process that created new strategies in order to strengthen state programmes and actions concerning the HIV/AIDS epidemic. Each federal state now has its own HIV/AIDS programme and budget, which are managed by the state's health services.<sup>63</sup>

Through the work of its three committees – Comprehensive Care, Monitoring and Evaluation, and Prevention – CONASIDA has been able to strengthen itself. Its committees are integrated in a multisectoral way and include civil society representation.

In 2001, Mexico became a part of the UNAIDS "International Initiative for the Expedite Access to Care and Support for People Living with HIV/AIDS". During the following years, negotiations were held in order to reduce the annual cost for patient care from 73 000 Mexican pesos to 51 000.<sup>64</sup> Along

<sup>62</sup> Jorge A. Saavedra y Carlos Magis, *AIDS medical treatment costs and spending in Mexico*, AIDS Perspectives Series No 1. CONASIDA, Mexico, 1998.

<sup>63</sup> José A. Izazola, Ed., *Flows of financing and expenditures on HIV/AIDS. National AIDS Accounts. Mexico 1999-2000*, Funsalud, Mexico, 2002, p.18.

<sup>64</sup> Health Ministry, *Prevention programmes and health promotion in action...HIV/AIDS Bulletin. 2001-2002 update*, SSA, México, 2003.



with ten other Latin American countries, Mexico concluded negotiations with the pharmaceutical industry to lower the cost of first-line antiretroviral therapy, which is the most common treatment for people living with AIDS. The cost of this therapy, which initially varied between US\$1 000 and \$5 000, was reduced to between \$350 and \$690. The price of chemical agents was also substantially reduced.

### Programmes and legislation

The Mexican Official Norm (NOM) for AIDS Prevention and Control was published in 1995. This norm, revised and modified in 2000, is binding for the entire health system and includes the following elements:

- Unified criteria establish when a person is infected with HIV.
- There are elements that allow for an antiretroviral (ARV) treatment to be initiated. The norm stipulates that the treatment has to be carried out without interruption in order to avoid creating resistance to it and diminishing its effectiveness.
- The design of the treatment for a person infected with HIV/AIDS needs to follow the guidelines established in the “Guide for Medical Care of Patients Infected with HIV/AIDS Both in Outpatient Care and in Hospitals”. The treatment basically consists of different antiretroviral combinations, which are included in the health sector’s Basic Medication Catalogue. This means that antiretrovirals have to be available for distribution across the entire health system. The guide emphasizes that once the treatment begins, there should be a clinical follow-up for each patient, and every six months blood samples should be taken to measure CD4 lymphocytes and the viral load (CV).

It is important to note that the NOM states that only fully accredited doctors are authorized to carry out this treatment. However, due to the scarcity of qualified medical personnel in many of the poorest and rural regions of the country, this rule has a direct impact on the ability of some sectors of the population, i.e. the marginalized, to access the service.

The current federal administration (2000–2006) has drawn up the Action Programme for HIV/AIDS and STDs, a national guiding programme. This programme is both operational and aimed at regulating the activities of all public institutions that offer health services. It outlines three components: prevention (in turn divided into sexual, perinatal and blood-related), care and damage mitigation. Each component contemplates specific goals that seek to stop the spread of the epidemic, in Mexico at least, by the year 2015.

The National Centre for the Prevention and Control of HIV/AIDS (CENSIDA) designs programmes and strategies linked to these components. Each state is responsible for implementing and developing the best strategies for its region. In order to achieve this goal, the state councils (COESIDAS) are in charge of carrying out the necessary prevention and control actions, and operating the state's HIV/AIDS programme.

It has to be said, however, that even though the Action Programme proposes a series of goals and activities, these are not binding, either for state governments or for the federal ministries considered to be collaborating entities. The programme is simply seen as a normative guide and a time frame for operating. The legal instrument that regulates HIV/AIDS prevention and control is the NOM.

### 5.3 HIV/AIDS in the budget

Value of 1 USD in Mexican Pesos from 1999 to 2003

1999	2000	2001	2002	2003
9.5143	9.5722	9.1423	10.3125	11.236

CENSIDA is the entity responsible for coordinating the Action Programme for HIV/AIDS and STDs. Although the general strategy has been designed to be comprehensive and multidimensional, and includes different aspects that fall under the authority of a variety of government offices, the fight against HIV/AIDS is concentrated in the health sector. Even though there are representatives from the Labor Department, the Ministry of Education and the Ministry of Social Development in CONASIDA's governing body, their contributions to the Action Programme can be traced neither in their programmes nor in their budgets. Even more important to note is that it is impossible to identify the resources earmarked by each institution for the achievement of the Action Programme's goals within the different health entities involved in the fight against HIV/AIDS.

Therefore, trying to calculate the amount of funds allocated for the prevention, treatment and control of HIV/AIDS is a complex task. Additional complications stem from the fact that data is limited and an under-registration of cases prevails. The Federal Law for Transparency and Access to Public Information<sup>65</sup> was used to request budgetary information from public health institutions regarding resources allocated to HIV/AIDS. In addition to that, analysis was carried out on the basis of Public Expenditure Reports, Federal Budget, SIDALAC's study on National AIDS Accounts<sup>66</sup> and financial reports that IMSS had presented to Congress.

<sup>65</sup> The channeling of a request for public information through the Transparency and Access to Public Information Law is a recent innovation in Mexico. For this particular study, we resorted to that tool as a mean of getting information which was not included in the budget.

<sup>66</sup> José A. Izazola, Ed., *op. cit.*

Table 5.1: Budget of public health institutions for HIV/AIDS  
(2001 constant pesos)

	1999	2000	2001	2002	2003
<b>General public</b>	<b>142,853,292</b>	<b>126,661,428</b>	<b>262,210,840</b>	<b>449,129,943</b>	<b>386,451,138</b>
<b>CENSIDA (Federal) /1</b>	86,992,688	47,003,609	76,082,221	204,165,553	386,451,138
<b>State programmes /2</b>	55,860,604	79,657,819	186,128,619	244,964,389	No data
<b>Social security</b>	<b>72,487,853</b>	<b>64,528,263</b>	<b>789,043,654</b>	<b>1,209,872,396</b>	<b>123,728,927</b>
<b>IMSS /3</b>	No data	No data	680,744,000	1,098,510,749	No data
<b>ISSSTE /4</b>	72,487,853	64,528,263	108,299,654	111,361,647	123,728,927

Source: /1 Public Expenditure Report 1999 and 2002 and Federal Budget 2003.

/2 Data from CENSIDA obtained through a formal petition of information.

/3 IMSS Reports to Congress 2002 and 2003.

/4 This information was obtained after a formal petition had been filed with the Institute for Services and Social Security for State Workers (ISSSTE).

Two issues that need careful analysis can be highlighted in this table: on the one hand, there is a clear problem of access to and integration of information concerning the HIV/AIDS budget. On the other hand, the inequality between people benefiting from social security and the rest of the population is obvious.

The lack of quality and access to information regarding public resources for the epidemic is alarming. The amounts provided by CENSIDA regarding the expenditures at state level are, by far, superior to what could be expected. The bulk of the increase of resources for sub-national programmes throughout the last years stems from the purchase of ARV treatments. Nevertheless, the funds for this line item are concentrated, mainly, in the federal programme. As such, despite the fact that the sharp increase of resources for state programs in 2001 and 2002 would be a pleasant surprise, it does not seem to be sustained in reality.

Second, the Mexican government has allocated budget resources to actions and programmes aimed at fighting HIV/AIDS since the 1990s. But the largest health care provider in the country, IMSS, does not provide the allocations for HIV/AIDS in its budget. When formally petitioned regarding this information, IMSS responded that there was no disaggregated budget concerning what the institute spent on individual diseases, including HIV/AIDS.

The absence of information regarding HIV/AIDS is alarming. The Mexican government has allocated budget resources to actions and programmes aimed at fighting HIV/AIDS since the 1990s. Even though CENSIDA is the guiding body on this topic, the logic of the Mexican health system requires the two largest social security institutions (ISSSTE and IMSS), as well as other social security

institutions, to allocate funds to the prevention and treatment of the epidemic. It is incomprehensible that IMSS, the largest health care provider in the country, should be unable to determine the amount of resources spent on HIV/AIDS. When formally petitioned regarding this information, IMSS responded that there was no disaggregated budget concerning what the institute spent on individual diseases, including HIV/AIDS.

Neither is there precise information regarding resources spent at the subnational level on implementing and following up on the goals and actions outlined by the federal programme. The fact that the only information that we possess on the topic – or that the public is provided with – is put together by SIDALAC, a nongovernmental body, indicates that CENSIDA's governing role has not necessarily implied clear channels of cooperation between the different levels of government. Due to this, and to the high level of decentralization of the health sector, it is almost impossible to find out to the degree to which state-level programmes adopt and respond to the goals established by the federal government in order to face the epidemic.

The distribution of resources between the general population and people benefiting from social security is another source of major concern – especially from the perspective of the right to health. The data point to divisions within the fight against HIV/AIDS and allow one to assume the existence of underlying inequalities. Regarding 2001 and 2002 (years for which information is more complete), we can observe that funds available for social security entities to treat people living with HIV/AIDS were three times higher than those allocated to health services dealing with the general population. Here it should be noted that of the 28 068 persons registered as living with AIDS, 10 052 (36%) are cared for by the Health Ministry.<sup>67</sup>

A sustained increase in resources allocated to HIV/AIDS is apparent for all government levels and entities, especially after 2001. This increase is due to the pressure exerted and negotiations conducted by gay rights organizations and people living with HIV/AIDS to guarantee the supply of antiretrovirals. In line with international human rights law regarding health services, the government is obliged to provide ARVs to people living with HIV/AIDS, thus guaranteeing their right to life and to the highest attainable level of health.

This has greater implications than the mere need to guarantee access to medication, especially if we consider the Guide for Medical Care of Patients with HIV/AIDS, which is based on the NOM. To guarantee the best results from antiretroviral therapy, it is important for it to be combined with regular (every six months) CD4 lymphocytes and viral load (CV) testing.<sup>68</sup> Furthermore, adequate care includes treating all other ailments associated with antiretroviral therapy, HIV/AIDS, hospitalization and psychological therapy.

<sup>67</sup> NotieSe, "AIDS sub registry reaches 68 thousand cases", *Letra S monthly supplement in La Jornada daily*, August 7th 2003.

<sup>68</sup> CONASIDA, *Hospital medical attention guide for patients living with HIV/AIDS*, Patricia Uribe and Samuel Ponce de León project coordinators, fourth edition, CONASIDA, Mexico, 2000. p 52.

Consequently, two major challenges must be faced if good results from this therapy are to be guaranteed. Firstly, health institutions must be able to prescribe treatment and follow up on it in marginalized areas, which have traditionally lagged behind in access to health care since the NOM specifies that only qualified doctors may dispense this treatment. Social security institutions must also be able to go beyond the simple prescription of drugs and hospitalization, since many of the patients currently under their care do not receive adequate follow-up care.<sup>69</sup> "The inadequate prescription of such medication can be very harmful, not only to the patient, but also to the whole community affected (by the epidemic), due to the emergence of resistant agents that will gradually complicate the treatment of the disease".<sup>70</sup>

The second challenge is whether the cost of this comprehensive treatment for people living with HIV/AIDS can be guaranteed and sustained. In 2002, the annual cost for each patient was of 51 000 pesos, excluding hospitalization, laboratory tests, etc. In comparison, the annual Mexican household expenditure on health care was 3 612 pesos<sup>71</sup>, which is way below the cost of treating a person with ARV.

The comprehensive treatment of HIV/AIDS patients represents a heavy financial burden. This is evident in SIDALAC's calculations regarding the distribution of resources allocated to the epidemic. In 1999 and 2000, caring for people living with HIV/AIDS absorbed 69% of total HIV/AIDS expenditure.

**Table 5.2: Percentage of total public spending on HIV/AIDS by activity type**

	1999	2000	2001	2002
Spending on care	61.13	67.65	72.60	74.95
Spending on prevention	22.43	18.77	14.83	13.75
Others	16.44	13.58	12.57	12.30

Sources: Table prepared by the authors using for 1999-2000 data from SIDALC and for 2001-2002 data from formal information petition to CENSIDA.

Considering the fact that during the last three years there has been an exponential increase of resources allocated to the epidemic, coupled with negotiations in the Chamber of Deputies, it can be assumed that most of these new resources are allocated to the treatment of HIV/AIDS. In this context, it is important to stress that one trend that has not changed is the insufficiency of funds available for the prevention of the epidemic, especially to reduce its sexual transmission. According to data provided by CENSIDA, between 1999 and 2002 state governments increased their spending both on ARV and on condoms. Nevertheless, the relative proportion of the increases was extremely unequal: for ARV, spending in 2002 totaled 43 times that of 1999; for condoms, spending went up only 4.6 times.

<sup>69</sup> Jorge Saavedra, "Access to antiretrovirals in Mexico", in José, A., Izazola, Ed., *Access to antiretrovirals in middle income countries from Latin America*, Funsalud, Mexico, 2000, p. 154.

<sup>70</sup> CENSIDA, *Antiretroviral treatment guide for people living with HIV/AIDS, SSA, Mexico*, 2003, p.1.

<sup>71</sup> INEGI, *National Income and Expenditure Household Survey*, 2002, Mexico, 2002.

**Table 5.3: State governments spending divided by activities**  
(constant pesos 2001)

	1999	2000	2001	2002
Treatment	11,119,970.8	12,936,414.1	15,539,507.4	16,605,753.1
Tests and monitoring	4,283,329.7	4,397,028.8	17,824,736.1	18,165,752.4
ARV and medication	3,423,677.4	14,988,901.1	94,739,727.3	150,250,189.6
Condoms	4,268,164.5	8,325,272.7	19,308,140.4	19,614,852.4

Source: Prepared using data elicited by a formal petition for information to CENSIDA.

Prevention policies need to be strengthened and appropriate mechanisms designed to decrease the sexual transmission rate of HIV/AIDS. If this is not the case, Mexico will reach a point where resources do not cover the costs of treatment and medication required for people living with HIV/AIDS. It is not feasible to increase the resources allocated to catering for antiretroviral demand indefinitely and not make a real effort to contain the epidemic. According to the Executive Coordinator of the Regional Initiative for AIDS in Latin America and the Caribbean, Mexico needs to invest between \$4 and \$5 per capita for HIV/AIDS prevention. Likewise, if the scarce resources already allocated to prevention are not geared towards the most vulnerable groups, in the medium term the epidemic could get out of control.<sup>72</sup>

It is alarming to note that many of the programmes to fight AIDS do not include adequate provision for addressing men having sex with men, who still constitute the group with the highest infection rates. For example, educational material directed at men who identify themselves as gay may be too explicit for men who do not consider themselves gay, yet have sexual intercourse with other men.

#### Fiscal transfers among the different levels of government

As mentioned above, there are a number of institutions involved in caring for people living with HIV/AIDS. It is through this range of health service and social security institutions that HIV/AIDS funds flow.

CENSIDA is responsible for establishing the national guidelines for addressing and controlling HIV/AIDS. In terms of resources, however, CENSIDA is only responsible for those used at the federal level by the Health Ministry. Since this institution holds normative authority over the Action Programme, funds aimed at providing antiretrovirals to state health systems are included in its budget. CENSIDA's resources are also used for carrying out the national prevention campaign; state programmes receive resources for their local campaign, mainly in the form of printed materials.

<sup>72</sup> A. Brito, "Discriminatory the public decision on prevention expenditure" interview with José Antonio Izazola, *Letra S monthly supplement in La Jornada daily*, November 6th 2003, p.9.

The majority of the resources channeled to state health systems to deal with the population's health needs are federal contributions. Federal funds are distributed among the states, taking into account existing infrastructure, the number of medical personnel and equity criteria. States decide what proportion of these funds they will use to complement the HIV/AIDS Action Programme.

Social security institutions (IMSS and ISSSTE) have different financing mechanisms: IMSS's budget is made up of contributions from the federal government, employers and workers, whilst ISSSTE receives its funds from the federal government and state workers. Using these contributions, each institution allots resources to care for members living with HIV.

Regarding foreign funding, the Mexican government hardly receives any contribution for HIV/AIDS programmes. If the epidemic were to be declared an emergency situation, Mexico would be able to receive international funds, which could be used to strengthen prevention efforts.

#### ***5.4 HIV/AIDS expenditure and human rights***

For the past ten years, the Mexican government has tried to offer a consistent response to the challenges posed by HIV/AIDS. Although there have been significant improvements, especially regarding the availability and allocation of resources for the treatment of people living with HIV/AIDS, from a human rights perspective there is still a lot to be done.

##### *Universality*

The term "universality" is generally understood to mean that ARV must be provided to all people requiring medication. It is important to stress that Mexico, just like other countries of the region, has made considerable efforts to guarantee access to ARV to all people identified as living with HIV/AIDS, be it through health services for the general population or through social security institutions.

Nevertheless, limiting universality to the extent of ARV treatment fails to take cognizance of two relevant factors. First of all, the entire population living with the disease has not been identified. As in other countries of the region, there are no accurate records in Mexico for estimating the actual number of people living with HIV/AIDS. Secondly, universality cannot be achieved until public health strategies and actions for the prevention of the epidemic are successfully established. It is important to note that infection rates have not decreased, and that sexual transmission continues to predominate.

If we consider universality in the context of sexual prevention, the number of sexual encounters of people between the ages of 15 and 24 is around 300 million a year, according to CENSIDA's estimations. However, only 85 million condoms are distributed annually (55% by the public sector and 30% by the private sector), and it is calculated that only 10% are used as protection from STDs and HIV.<sup>73</sup>

If we consider treatment, although the government claims to have been successful in achieving full antiretroviral coverage for people living with HIV/AIDS – either through CENSIDA<sup>74</sup> or through social security – other actions need to be considered in order to guarantee comprehensive treatment of HIV/AIDS. The mental health dimension of living with HIV/AIDS, for instance, has not been consistently recognized. Despite the existence of damage mitigation policies on paper, there has been no consistent budget allocation in this regard.

#### *Physical accessibility*

About 36% of people living with AIDS in Mexico rely on state health systems; in other words, they form part of the population with no access to social security. Because, historically, public health services have lagged behind in financing and infrastructure, it is difficult to see how they can offer comprehensive care, in a universal and satisfactory manner, to the people living in the most marginalized regions of the country.

One clear measure of access to health care is the availability of doctors in any area. Chart 5.1 shows the number of doctors for every 100 000 inhabitants, separating states into categories based on the degree of marginalization<sup>75</sup> as measured for 2000 by the National Council on Population (CONAPO). It is clear from the chart that the five states with the highest level of marginalization have, on average, fewer than 100 doctors available for every 100 000 people.

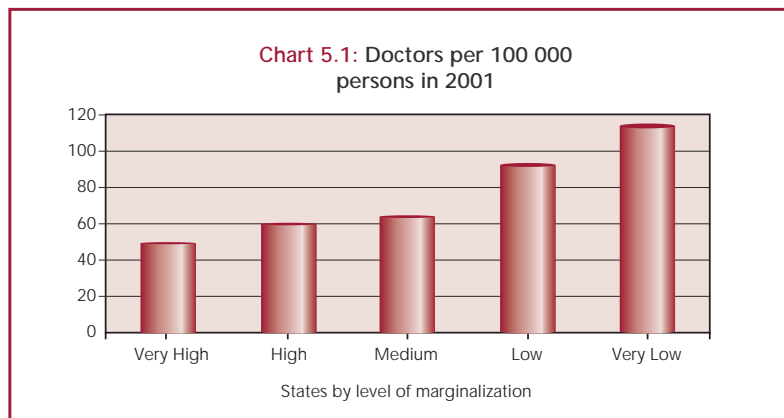
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<sup>73</sup> This data is included in the presentation "How to speak on sexuality", AIDS National coordinated body, obtained through an interview with Guillermo Egremy, Director of Prevention and Social Participation at CENSIDA (April 2004).

<sup>74</sup> According to an interview with Guillermo Egremy, Director of Prevention and Social Participation at CENSIDA (April 2004).

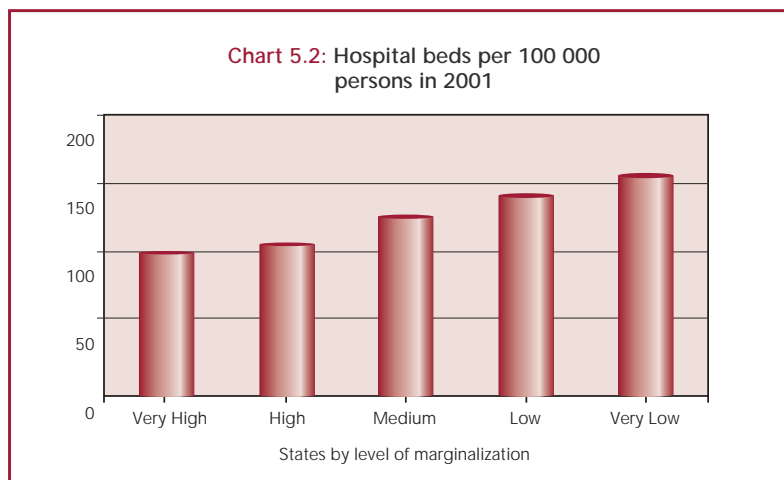
<sup>75</sup> Index for measuring the 'marginalization' of each state, using many socio-economic variables.





Source: Created with data from *Statistical Information Bulletin No 21*, Ministry of Health, 2002; and *Municipal Marginalization Index*, National Population Council (CONAPO), 2000.

Chart 5.2 shows a similar pattern for the number of hospital beds. The poorest states have just over 50 hospital beds for every 100 000 persons, while people living in higher-income states have access to more than twice that number. This is strong evidence that those living in poorer states have reduced access to secondary and tertiary health care. This plays a relevant role in HIV/AIDS treatment.



Source: Created with data from *Statistical Information Bulletin No 21*, Ministry of Health, 2002; and *Municipal Marginalization Index*, National Population Council (CONAPO), 2000.

Furthermore, antiretroviral treatment for a person without social security has to be requested by the patient, following a series of medical exams. Even though the effort made by CENSIDA to guarantee sufficient ARV therapies is an important step forward, the general situation of the public health system acts against it: people have to go to a health centre where a qualified doctor can determine the HIV-positive condition of the patient. After that, the doctor has to consider whether or not to start ARV therapy. This process requires several appointments, which represent time and transport costs for people living in remote areas. Due to the degree of marginalization in the country, a large proportion of the population cannot sustain such a situation.

The prevention of sexual transmission through the distribution of condoms at health centers – which is generally carried out in a family planning context, more than as part of an STD prevention mechanism – presents similar problems. Accessing such centers loses significant challenges to people living in marginalized and remote areas.

#### *Economic accessibility*

Although patients in the public health system do not have to pay for ARV treatment, divisions within the system result in patients facing a complicated prospect when they need to be treated for other opportunistic illnesses or get to the appropriate health centers: a large proportion of those living with HIV/AIDS, but lacking access to social security, do not have the resources to cover the costs of these situations. Since these patients are not formally employed, falling ill exposes them to the loss of their source of income. Therefore, when health complications happen, they are generally accompanied by a range of other issues, such as patients losing all opportunity for generating income.

On the prevention side, buying condoms is not an option for the low-income or marginalized population, and the use of condoms is not a common practice in AIDS prevention, due to prejudices and inadequate information. Despite the efforts of state governments to purchase and distribute condoms, much still has to be done, both in budgetary terms and in promoting their use among the public.

It is important to highlight CENSIDA's recent actions in support of prevention. In 2003, 16 HIV/AIDS state programmes participated with the United Nations Population Fund in consolidated purchases of male condoms, which meant they could be bought at a lower price. This allowed for a significant increase in the distribution of condoms in 2003.<sup>76</sup>

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<sup>76</sup> This information is contained in a CENSIDA document "Report on HIV and STD prevalence rates among people from 15 to 24 years old" obtained through an interview with Guillermo Egremy, Director of Prevention and Social Participation at CENSIDA (April 2004).

### Progressiveness

As can be seen in table 5.4, CENSIDA's expenditure increased considerably from 2002.<sup>77</sup> This increase is attributable to the distribution of antiretrovirals, which is obligatory for the government.

Source: created with data from the public expenditure reports.

**Table 5.4: CONASIDA<sup>78</sup> /CENSIDA Expenditure**  
(2001 constant pesos)

	Spent
1999	86,992,688
2000	47,003,609
2001	76,082,221
2002	204,165,553

Nevertheless, considering the health sector's proportion of total government expenditure (table 5.5), there is no clear tendency of a progressive increase in the resources allocated to treat the general population. This means that although there is a greater distribution of antiretrovirals, people living with HIV/AIDS will not necessarily experience improved quality in the attention they receive. This situation is even more complicated for those individuals who do not enjoy social security, due to the limitations of the public health system mentioned above.

The total national health expenditure figures used below include the Federal MOH budget, the Federal transfers to State MOHs and the Social Security Institutions' health-related budgets.

**Table 5.5: Expenditure percentages for HIV, Health and GDP**

	1999	2000	2001	2002	2003
Spending on health/GDP	2.40	2.22	2.32	2.16	2.43
Spending on health/ Total spending	10.84	9.82	10.21	8.95	10.45
HIV/GDP	0.03	0.03	0.02	0.03	n/a
HIV/Spending on health	1.09	1.26	0.78	1.31	n/a
HIV/Total spending	0.12	0.12	0.08	0.12	n/a

Source: Prepared by author. GDP data for 1999–2001 in “GDP historic series adjustment” CEFP; for 2002–2003 in “Macroeconomic policy general criteria” SHCP. Information for the total spending and the health spending 1999–2002 in “Public Expenditure Report”, Ministry of Finance; for 2003 in “Federal Budget”, Ministry of Finance. Data on HIV/AIDS spending: for 1999–2000 “Flows of financing and expenditures on HIV/AIDS. National AIDS Accounts”, SIDALAC; for 2001–2002 total amount on the figures for public health institutions described in table 5.1.

<sup>77</sup> This sustained increase has continued in 2003 and 2004.

<sup>78</sup> CONSIDA/CENSIDA is the national AIDS coordinating body, now known as CENSIDA, formerly CONSIDA.

Improvement in prevention has not accompanied the increase in antiretroviral therapy. Taking this into account, two aspects should be mentioned: in practical terms, prevention is not given the importance that the National Programme for HIV/AIDS Prevention and Control aims at. Moreover, state expenditure on prevention through the use of condoms does not follow the same trend as antiretroviral spending (see table 5.3 above). Investment in prevention has to become a priority and enjoy immediate attention from all levels of government and public health institutions.

## 6. Nicaragua

Nicaragua's population amounts to about 5 482 340, of whom 49.8% are men and 50.2% women.<sup>79</sup> In the last 20 years, there has been an increasing trend towards urbanization. Today, 58% of the population lives in urban areas. Politically, the Republic of Nicaragua is divided into two autonomous regions, 15 departments and 152 municipalities.

### 6.1 The economic situation

The Nicaraguan economy is still not very solid: it has not been able to maintain the growth of its GDP, nor is it certain that current levels are sustainable.<sup>80</sup> The high growth rate in 1999 coincided with the arrival of international funds for the reconstruction of the country in the aftermath of Hurricane Mitch. The GDP fell 1.5% from 1999 to 2000, and job creation fell 9%. Continuing this trend, GDP growth fell 2.7% in 2001, and new jobs witnessed a dramatic 29% decline.

After a period of sustained increase, GDP per capita also began a downward trend in 2002: it went from US\$448 in 1999 to 478 in 2000 and \$486 in 2001. In 2002, however, it decreased to \$472<sup>81</sup>, and analysts calculate that the year 2003 will see an even greater decrease.

### 6.2 Institutional arrangements concerning HIV/AIDS

The Ministry of Health (MINSA) created the National Programme for the Prevention and Control of STD/HIV/AIDS in 1987, the year in which the first HIV/AIDS case was reported in Nicaragua. The HIV/AIDS programme was added to the existing STD control programme, and the full programme

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<sup>79</sup> National Institute for Statistics and Census, 2003.

<sup>80</sup> Central Bank of Nicaragua, May 2003.

<sup>81</sup> Central Bank of Nicaragua, May 2003.

was implemented, on a short-term basis, in 1988.<sup>82</sup> The National Programme for the Prevention and Control of STD/HIV/AIDS is currently under the administration of the General Office for Environmental Health and Epidemiology in the Ministry of Health (MINSa), which is the normative office in charge of health sector initiatives.

The fundamental task of the programme is to design policies and norms for the sector in order to ensure the fulfillment of the goals of HIV/AIDS epidemic reduction, prevention, control and monitoring. The 2000–2004 National Strategic Plan for the Fight against STD/HIV/AIDS is the instrument used to achieve this goal. It reflects a comprehensive, transversal vision, with strategies that take into account human rights, ethics, gender, decentralization, sustainability, education and communication, as well as institutional, inter-institutional and information strengthening.

Law 238 for the Promotion, Protection and Defense of Human Rights in Case of AIDS, passed in 1996 and regulated in 1999, is another instrument used to guarantee institutionalization of AIDS prevention policies. Both instruments are the result of pressure from a variety of nongovernmental organizations. To ensure compliance with Law 238, the Nicaraguan Commission for the Fight against AIDS (CONISIDA) was created in September 2000.

### 6.3 The HIV/AIDS budget

Value of 1 USD in Nicaraguan Cordobas from 1999 to 2003

1999	2000	2001	2002	2003
12.3183	13.0573	13.8408	14.6712	15.5515

The financial allocation for CONISIDA is included in MINSa's budget. Its objectives are: to establish actions for HIV/AIDS prevention; guarantee the correct enactment of Law 238 and its subsidiary laws; decide over the design of strategies and HIV/AIDS prevention, support, service and control policies; and support interagency coordination (Law 238).

Even though a clear normative structure exists, HIV/AIDS does not appear as a programme, subprogramme or specific activity in the budget that MINSa sends to the Ministry of the Treasury, and therefore HIV/AIDS spending is not included in the budget expenditure reports. Neither at the level of the Local Systems for Comprehensive Health Services (SILAIS) or at central level does the programme have participation in the MINSa budget-formulation process. This can be ascribed, in practical terms, to the fact that the HIV/AIDS budget is drawn up by the General Office for Planning and Budget.

<sup>82</sup> MINSa, National Strategic Plan, 2000.

It is evident from interviews with government officials that the nonexistence of a specific budget for HIV/AIDS produces a series of difficulties when it comes to analyzing the consistency of government actions. Hence it is important to point out that it was not until 2003 that the programme was formally included in the budget. This also confirms that a large proportion of the funds invested in the programme came not from MINSA's general budget, but from international donors.

Regarding budgetary flows, the SILAIS receive funds from the central health budget each trimester; nevertheless there is no specific allocation for STDs and HIV/AIDS. The funds for HIV/AIDS are diluted in various sectors of the institutional budget.<sup>83</sup> The medication specified there is for general use, and these documents do not specify how much is to be invested in or spent on the epidemic. For instance, the quantity of antibiotics used to treat people living with HIV/AIDS is not included in the reports. Concerning the use of ARVs, however, data does exist because this type of medication is used solely for treating HIV/AIDS. In spite of this, ARVs are not included in MINSA's medication lists, because the programme does not have a budget allocation for this purpose and therefore depends on international cooperation and the Global Fund for their purchase.

Consequently, the only way to examine the state's spending trends for HIV/AIDS is by analyzing the general health budget. MINSA's budget equaled 5.4% of GDP in 1999 when, due to the flow of international aid for post-Mitch reconstruction, health spending increased the most.

**Table 6.1: MINSA's budget with respect to GDP**  
(cordobas)

	1999	2000	2001	2002
MINSA/GDP	5.43%	4.98%	4.53%	4.61%
MINSA actual budget	1,419,610,735	1,536,679,561	1,548,919,978	1,657,685,293
GDP	26,143,900,000	30,883,600,000	34,199,500,000	35,937,000,000

Source: Ministry of Health Budget Execution Reports.

Regarding general health spending, the private sector has increased its investment significantly. This includes spending by households, payments to the Nicaraguan Institute for Social Security (INSS), insurance companies and NGO spending. There is a clear trend towards a decrease in public health financing.

<sup>83</sup> This explains why the present study relies heavily on the estimates of National Accounts on HIV/AIDS, produced by MINSA during 2000 and 2002, in collaboration with PAHO and SIDALAC. These documents analyze the state's estimated spending, along with international cooperation and household spending.

**Table 6.2: Health sector financing sources**  
(millions of cordobas)

	1998	1999	2000	2001
Public	816	789	1,200	1,205
Private	1,189	1,535	2,082	2,654
International cooperation	250	259	273	321
<b>Total</b>	<b>2,255</b>	<b>2,583</b>	<b>3,555</b>	<b>4,180</b>

Source: National Health Accounts, MINSA. <http://www.minsa.gob.ni/cuentas/cuentafin.htm>

In 2002, there was a 0.47% increase in MINSA's budget with respect to the republic's general budget (PGR). This relative increase was due to the fact that, from that year, the health budget was included in the Reinforced Strategy for Economic Growth and Poverty Reduction (ERCERP), which channels additional resources towards health in the 11 poorest municipalities.

According to the data in table 6.3, of total HIV/AIDS spending, the public sector contributed 47%, the private sector 18% and international funds the remaining 35%. These percentages show a constant level of contributions by the private sector from 2000 to 2002, while public investment fluctuated significantly. International funds came entirely from bilateral sources in the period 2000–2002.

**Table 6.3: HIV/AIDS spending by financing sources**  
(cordobas)

	2000	2001	2002
Public	30,088,230	46,553,543	48,049,924
Private	17,610,900	17,440,330	19,516,213
International	28,788,840	34,524,244	47,083,427
<b>Total</b>	<b>76,487,970</b>	<b>98,518,117</b>	<b>114,649,564</b>

Source: National Accounts on HIV/AIDS, MINSA.

With regard to MINSA's budget, resources spent on HIV/AIDS have increased slightly because the ministry is fitting labs with the equipment required to carry out Elisa testing. This means that, having been 1.96% in 2000, the allocation for HIV represented 2.9% of MINSA's total budget in

2002. Furthermore, this percentage might increase in the coming years, not because of AIDS being recognized as a priority in the allocation of public funds, but as a consequence of the availability of funds from the Global Fund.

**Table 6.4:** HIV/AIDS spending related to total government spending and Ministry of Health spending (MINSA) (cordobas)

YEARS OF EXECUTION	2000	2001	2002
HIV/AIDS public spending	30 088 230.00	46 553 543.00	48 049 924.00
MINSA actual spending	1 536 679 561.00	1 548 919 978.00	1 657 685 293.84
Total govt. spending	11 646 375 409.00	12 408 570 390.00	13 176 168 422.00
MINSA/Total govt. spending	13.9%	12.48%	12.58%
HIV/MINSA	1.96%	3.01%	2.90%
HIV/ Total govt. spending	0.26%	0.38%	0.36%

Source: National Accounts on HIV/AIDS (prepared by SIDALAC), Budgetary Execution Report 2000, 2001, 2002.

In table 6.5 we can see the distribution and allocation of resources earmarked for HIV/AIDS. In 2001, for example, 54% of the resources were allocated to personal health (treatment, other providers of auxiliary goods and services, and pharmaceuticals), and the remaining 46% were allocated to public health – 38% to promotion and prevention and 8% to STD/HIV/AIDS programmes.<sup>84</sup>

**Table 6.5:** HIV/AIDS spending by general areas (cordobas)

	2000	2001	2002
Personal health	26 097 750	46 580 522	49 001 392
Prevention / Public Health	45 984 010	50 489 667	60763 772
Total	75 921 520	99 150547	114 649 562

Source: National Accounts (SIDALAC figures). This table does not include all of the areas set out in the budget, only the largest two.

It should be noted that just as patient care, one of the components of the National Programme for the Prevention and Control of STD/HIV/AIDS, lacks the necessary resources for the administration of antiretroviral medication, so does AIDS prevention. During 2000, a significant proportion of prevention spending, specifically for the purchase of condoms, was undertaken by the private sector – 45%. Within this particular spending sector, 25% of expenditure was made possible through international cooperation (mainly bilateral), while private households contributed about 20% of spending on condoms.

<sup>84</sup> Cuentas Nacionales (National Accounts).



Nicaraguan society does not have the capacity to invest in spending on HIV/AIDS treatment and care. It is obvious from table 6.6 that the bulk of spending on treatment occurs through the state and international cooperation; the private sector has not invested much, its highest participation being 2.81% in 2000. Most of the state's spending goes towards treatment for STDs and blood banks, while international funds are geared towards ARVs.

**Table 6.6:** Spending on treatment and care according to source of finance (cordobas)

	2000	2001	2002
State	5,480,410.00	6,155,262.00	8,553,303.00
Private	277,700.00	24,608.00	138,697.00
International cooperation	4,121,200.00	4,386,742.00	4,804,282.00
Total	9,879,310.00	10,566,612.00	13,496,282.00

Source: National Accounts on HIV/AIDS 2000, 2001 and 2002.

In none of the preliminary national account reports on HIV/AIDS is there any mention of spending on mitigating components. All that is recorded is spending on the public health component. Again, the role of international cooperation and private financing in this area is clear. Government spending is not significant compared with other sources. We can also see that the contribution from international cooperation is decreasing.

Essentially, in 2000 the public health spending component was financed by international funds and tended towards the payment of travel expenses, transport and other services. The bodies in charge of the expenditure of the public health component are the National Programme for the Prevention and Control of STD/HIV/AIDS and the promotion and prevention organizations.

**Table 6.7:** Prevention Expenditure: campaigns and condoms (cordobas)

	2000	2001	2002
State	166,300.00	163,200.00	339,970.00
Private	15,121,700.00	15,501,042.00	17,408,818.00
International cooperation	20,598,900.00	24,155,313.00	29,518,702.00
Total	35,886,900.00	39,819,555.00	47,267,490.00

Source: National Accounts on HIV/AIDS 2000, 2001 and 2002.

In the private sector, the greatest expenditure for HIV/AIDS has been made by private households and NGOs, and the latter experienced a decrease in spending from 2000 to 2002. This means that, in the medium term, both state and NGO resources may diminish, owing to their international origin, and that the spending will have to be absorbed by private households. Considering the levels of poverty in the country, it is reasonable to predict that the resources available will not be sufficient to avoid the spread of the epidemic.

#### **6.4 HIV/AIDS expenditure and human rights**

In general terms, with regard to human rights and AIDS, Nicaragua faces greater challenges than other countries in the region. The principles established in Law 238, along with the guidelines in the National Strategic Plan, are not reflected in MINSAs or the PGR's resource allocation. Therefore these demands are often reduced to wishful thinking, in the absence of concrete backing – i.e. resource assignment – for their implementation.

##### Universality

There are serious limitations to compliance with this principle in Nicaragua in relation to AIDS. There are factors that make it nearly impossible for everyone to benefit from the services, whether in the form of medical attention, prevention or mitigation. Some of the problems are the following:

- Not all of the country's SILAIS have been allocated the necessary resources to diagnose the disease.
- Only the Roberto Calderón Hospital (previously Manolo Morales), situated in the country's capital, has a ward equipped to receive and treat people living with AIDS. People in other regions do not have easy access to the services provided there.
- Access to antiretrovirals is limited to a small group of people; around 80% of people living with HIV/AIDS cannot obtain such medication through the public health system.
- The specific benefits and actions that the population may obtain from the state and society, depending on their vulnerability to HIV/AIDS (for example women, girls, boys, gays), are not clearly defined by the specific policies enacted to fight the disease.
- Up-to-date and scientific information regarding AIDS and HIV is not universally accessible. This translates into heterogeneous and sometimes contradictory policies when it comes to sexual and reproductive education.

### Accessibility

Public policy has been limited to general statements regarding accessibility. There has not been a defined outline of responsibilities or of the availability of public resources and their territorial distribution. The limited influence that the SILAIS have in the budget allocation process produces problems in service accessibility: the epidemiological situation of HIV/AIDS is not taken into account when defining the amount of funding to be allocated to the SILAIS in a forthcoming fiscal year.

The public sector faces substantial obstacles when trying to satisfy the needs of the population, because most centers do not have the basic MINSA medication list at their disposal.

There is a marked inequality in access to public health services. The concentration of resources in the capital city is obvious, yet this is not necessarily where one finds most of the people who cannot afford such services, nor does this distribution coincide with the spread of the epidemic. Indeed, in the last couple of years, the Western region has had the greatest infection rate.

Access to medical attention and medication is not a reality. State resources are not sufficient and private spending on HIV/AIDS is concentrated in households. Given the poverty in the country, it follows that the households with access to treatments and medication are in the highest income brackets and do not represent the majority of Nicaraguan households. The cost of antiretroviral therapy is four times the minimum salary. It is also important to note that antiretrovirals are not part of the basic medication list, and therefore the public sector is not obliged to offer them.

Prevention, especially the use of condoms, is limited due to existing prejudices and the absence of an official and coherent policy in MINSA and the Ministry of Education, Culture and Sports. Moreover, the cost of condoms limits their use to a small part of the population. From 2000 to 2002, the government did not invest in condoms, so this cost had to be borne mainly by private households.

In 10 of the 17 SILAIS there is no access to Elisa testing. People must wait for their samples to be sent to Managua for analysis, and only seven SILAIS have an expedited service for this purpose.

### Access to information

Although Law 238 provides for the right to scientific information, compliance with this principle is seriously limited because information received by the general population lacks coherence. Prejudices

and the Catholic Church have a great deal of influence on the type of information available and the degree of truth in it.

In spite of the efforts that are made, there are significant discordant elements in the strategy. The education policies of the Ministry of Education, Culture and Sports on sexual and reproductive health convey a message influenced by religious principles. Much of the information circulated in schools tries to discredit the use of condoms as a means to prevent STDs and HIV/AIDS.

It is important to stress that MINSA has been improving its epidemiological monitoring system and producing periodically updated statistical information that is shared through e-mail and over the Internet. The information transmitted to the general population includes epidemiological aspects and promotes prevention. Nevertheless, problems in the registration process persist.

MINSA's spending on information, education and communication with regard to HIV/AIDS has increased from 11 million cordobas in 2000 to 17 million in 2002. Following this trend, spending on epidemiological monitoring has gone from less than a million cordobas in 2000 to 3.5 million in 2002.

### Progressiveness

Although there is a general trend towards an increase in HIV/AIDS spending, there is also a deepening relationship of dependency between public financing and international funds. The HIV/AIDS budget has grown in the same proportion as foreign financing, meaning that public efforts to deal with HIV/AIDS and implement a comprehensive policy depend on foreign resources.

It can be expected that with the monetary injection from the Global Fund, public financing will increase even more. Nevertheless, the state has still not defined how it will deal with the problem nationally. In private spending, which tends to be of an autonomous nature, we can observe progressive growth. This kind of spending is mainly attributable to private households and, to a small degree, to NGOs.

Another important element is the lack of investment in health infrastructure. While the spending trend generally is one of growth, infrastructure investment made up only 1% of total AIDS expenditure in 2000 and was nonexistent in 2001 and 2002.

Hospitals do not have adequate infrastructure to care for people who live with AIDS. The isolation wards in which such people are treated lack the hygienic conditions and equipment required for satisfactory treatment. This shortcoming reflects the need to carry out significant investment in order to set up adequate facilities for services that are required currently and which will be needed even more urgently in future.

## 7. Final considerations

This chapter has presented relevant information on the public policies and budgets relating to the HIV/AIDS epidemic in Argentina, Chile, Ecuador, Mexico and Nicaragua. Although a number of variables were considered, particular emphasis was given to the way in which governmental efforts are contributing – or failing to contribute – to compliance with human rights standards relevant to HIV/AIDS. Each country report therefore began with a brief description of the country's economy and health system, went on to examine current legislation, public programmes and budgets relating to HIV/AIDS, and then ended with a review of issues closely linked with human rights:

- the universality of implemented actions and programmes,
- the physical and economic accessibility of the services required for both the treatment and the prevention of the epidemic,
- nondiscrimination in government programmes and services.

Even though each country has its own set of specificities, the principles mentioned above are discussed in each case, and common elements can be discerned. This last section seeks to provide an overview of government policies and budgets, analyzing and singling out successful practices that may serve as a model for others, as well as identifying shared challenges.

As mentioned at the beginning of this chapter, the five countries selected share a number of characteristics with regard to the HIV/AIDS epidemic:

- The epidemic's incidence rate has risen over the past decade.
- In all five countries, the majority of people living with HIV are men. Women constitute a maximum of 26% of the total registered cases of HIV/AIDS in Nicaragua and a little less in Argentina.
- Nevertheless, there are clear signs that the gap between men and women is gradually closing: in both Chile and Mexico, for every six men infected one woman has the disease, and in

Ecuador and Nicaragua the ratio is 2.8:1. The infection rate among women who are housewives and have one partner is rising in Chile and Ecuador.

- Sexual transmission is still the most common means of infection, accounting for about 90% of cases, except in Argentina, where it only accounts for 50% of cases. Men have sex with men are particularly vulnerable to infection.

**Table 7.1: Epidemiological statistics and cases of HIV/AIDS**

	Argentina	Chile	Ecuador	Mexico	Nicaragua
Total cases of HIV/AIDS <sup>85</sup>	21,865	14,013	5,666	71,526	1,099
Men	76%	89.1%	76.3%	84.8	74%
Women	23%	10.9%	23.7%	15.2	26%
Man-woman ratio	3.3:1 (2003)	5.8:1 (1999)	2.7:1 (2002)	6:1 (2003)	2.9:1 (2003)
Estimated number of people living with HIV/AIDS	130-150 thousand	23,920	45,000 (2003)	150,000	-
Prevalence rate 15-49 years old (at end 2003) (UNAIDS 2004)	0.7%	0.3%	0.3%	0.3%	0.2%
Main Means of transmission					
Sexual	50.9	93.9	90.1	89.7	89
Blood	1.1	4.6	0.5	7.3	0.4
Intravenous Drug use	36.3	-	0.3	1.1	5
MTCT	6.7	1.5	1.6	1.8	3

Source: Data from the section "Characteristics and epidemiological profile of the HIV/AIDS epidemic in Argentina, Chile, Ecuador, Mexico and Nicaragua" earlier in this chapter.

<sup>85</sup> Total cases refers to the numbers of actual persons diagnosed with HIV/AIDS and captured in database, since HIV/AIDS is a notifiable condition in all these countries, but due to underreporting the numbers do not represent the total persons living with HIV/AIDS .

### *7.1 The legal and normative framework for HIV/AIDS*

The legal framework of HIV/AIDS of each country, including specific legislation, is a vital element in devising coherent policies on the epidemic. Of the five countries included in the study, only Mexico does not have a specific HIV/AIDS law. Argentina passed the National AIDS Law, in which it declares the fight against AIDS to be in the national interest, Ecuador has the HIV Comprehensive Prevention and Assistance Law and Nicaragua has the Law for the Promotion, Protection and Defense of Human Rights in Case of AIDS.

It should be noted that although this kind of legislation testifies to a political commitment that ought to withstand changes in government and regulate state actions, it does not necessarily result in the adoption of decisive strategies to fight HIV/AIDS. Yet one has to acknowledge that the existence of a legal system establishing shared criteria and state obligations with regard to the epidemic has allowed these countries to progress in terms of human rights, especially for people living with HIV/AIDS. This has resulted in successful judicial proceedings in Argentina, Chile and Ecuador.

In the case of Chile, cautionary measures were presented before the Inter-American Court of Human Rights, resulting in a resolution forcing the Ministry of Health to provide medication to the plaintiffs. In 1999, 21 protection petitions for ART were presented, all of which were accepted by the Supreme Court. These set a precedent and demonstrated the government's shortcomings in distributing medication.

In 2002, six people in **Ecuador** presented a petition for cautionary measures before the Inter-American Commission for Human Rights regarding the absence of medication distribution. This petition was accepted by the commission and extended to include 153 people. The Ecuadorian state complied with the petition, which served as a means for pressuring the government to provide a more consistent allocation of resources depending on the availability of medication.

**Argentina's** Ministry of Health began to undertake actions regarding HIV/AIDS after 1989. HIV/AIDS was incorporated into the Office for STDs, and the National Registry of Infected People was created. In 1990, the National AIDS Law, Law 23 798, was passed and, based on it, the National Programme for the Fight Against the Human Retrovirus (Leukemia and AIDS) was created and made the responsibility of the Ministry for Health and Social Action. In 1995 and 1996, Laws 24 455 and 24 754 were passed, legislating the compulsory nature of medical, psychological and pharmacological treatment (ART) for HIV/AIDS patients by private health care and Obras Sociales Nacionales (the public health care system).

In **Chile**, the National AIDS Commission (CONASIDA) was created in 1990 as part of the Health Ministry. It is responsible for the coordination and development of the AIDS Prevention and Control Programme. Resources earmarked for the epidemic are divided in two groups: those distributed to CONASIDA and those allocated to the National Health Fund (FONASA), which are channeled to antiretrovirals. CONASIDA therefore concentrates its budget on prevention, research, communication, international cooperation, coordination and administration.

In **Ecuador**, the HIV/AIDS and STD Prevention and Control Programme was created in 1987 as part of the Health Ministry. It was not until 2000 that the HIV Comprehensive Prevention and Assistance Law was passed, and in 2002, the Guidelines for Treating People Living with HIV/AIDS were approved. In the Napo province, the Institute for Tropical Medicine of the Amazon and for STDs and HIV/AIDS (IMTAETS) and the HIV/AIDS Institute for the Costa and Insular region were established.

In **Mexico**, the National Commission for AIDS Prevention and Control was established in 1986 and two years later became a national council. The country's current AIDS policy is included in the Action Programme for HIV/AIDS and STDs, which falls under the Secretary of Health and has the role of setting norms for the actions of all institutions of the public health system. The guiding institution is the National Centre for AIDS Prevention and Control (CENSIDA), which works with the 32 state councils. The Mexican Official Norm for AIDS Prevention and Control was published in 1995 and modified in 2000.

**Nicaragua's** Health Ministry incorporated HIV into its National Programme for STD Prevention and Control in 1987. Between 1990 and 1995, two different mid-term plans were implemented, focusing primarily on the strengthening of epidemiological monitoring, Elisa testing and information systems. Currently, the National Strategic Plan for the Fight against STD/HIV/AIDS determines actions to be taken in the areas of prevention and control of the epidemic. The entity in charge of coordinating the implementation of this plan is the Nicaraguan AIDS Commission.

It is important to note that in all of the countries included in this study, had formally established national coordinating bodies, exist to deal with the epidemic, even though they are all limited to the health sector. This situation has two specific disadvantages. One is that there is no possibility of establishing an entity above ministerial level that can design, coordinate and regulate in a way that allows for a comprehensive and global strategy, capable of dealing with the totality of the epidemic's social, economic and health repercussions. The other is that Health Ministries are responsible for negotiating the programmes' budgets, which limits their advocacy capacity before legislative bodies and results in their negotiating funds for the health sector alone.



## 7.2 The programmes and their budgets

As explained above, the response of governments to the HIV/AIDS epidemic is exercised through the health sector. It is therefore important to understand what has been accomplished by the health sector in budgetary terms.

According to table 7.2, out of the five countries studied, Chile allocates the largest percentage of its budget to health, amounting to almost 18% in some years. On the other hand, Ecuador and Argentina<sup>86</sup> allocate only 4% and 6%, respectively, of their total budgets to health. Nicaragua and Mexico are somewhere between these two extremes. However, these five countries share a common characteristic: their health systems do not have the capacity to treat their populations, especially marginalized groups. Furthermore, statistics demonstrate that none of these countries is increasing its resources in order to strengthen deficient health systems.

**Table 7.2: Proportion of health spending with respect to the national budget and the HIV/AIDS budget within health spending**

	1999	2000	2001	2002	2003
<b>Health budget/ national budget</b>					
Argentina/1	6.23	6.09	5.32	6.34	5.96
Chile/2	18.2	18.0	18.2	17.7	No data
Ecuador/3	<4.0	<4.0	<4.0	>5.0	No data
Mexico/4	10.84	9.82	10.21	8.95	10.45
Nicaragua/5	No data	13.19	12.48	12.58	No data
<b>HIV budget/ health budget</b>					
Argentina/1	2.77	2.21	2.31	3.48	5.7
Chile/2	0.81	0.73	0.81	0.87	No data
Ecuador/3	<1.0	<1.0	<1.0	<1.0	<1.0
México/4	1.09	1.26	0.78	1.31	No data
Nicaragua/5	No data	1.96	3.01	2.90	No data

/1 Authors' estimates based on the information available in the budget financial execution reports published by the National Budget Office.

/2 Own estimates based on: (1) Information Systems for AIDS National Responses: Financial Indicators (1999–2000), as well as the study's initial information for 2001–2002 released by CONASIDA. (2) DIPRES. Spending functional classification.

/3 Ministry of Public Health, Ministry of Finance: budget documents and budget execution reports. <http://www.ec-gov.net>. Central bank monthly statistical report. <http://www.bce.fin.ec>.

/4 Information for national budget and health budget 1999–2002 in "Public Expenditure Report", Ministry of Finance; for 2003 in "Federal Budget", Ministry of Finance. Data on HIV/AIDS public spending: for 1999–2000 "Flows of financing and expenditures on HIV/AIDS. National AIDS Accounts", SIDALAC; for 2001–2002 total amount on the figures for public health institutions described in table 5.1.

/5 National AIDS accounts and budgetary execution reports.

<sup>86</sup> Since Argentina is a federation, the largest part of health expenditure is concentrated in the provincial budgets. In general, each province allocates between 8% and 16% of its budget to health. The consolidated national and provincial budget for health has remained constant at 14% of total government expenditure.

Another element to be considered in this analysis is the existence of programmatic frameworks for the epidemic's prevention, control and treatment, with consistent allocation of resources. It is difficult to imagine systematic actions for HIV/AIDS in the absence of policies designed specifically for this purpose and resources available for their implementation.

Comparing specific HIV/AIDS budgets with general health budgets, it appears that Argentina is the country with the most consistent allocations, reaching 5%. Chile allocates less than 1%, while both Ecuador and Mexico fluctuate around 1%, and Nicaragua has shown progress. What may be observed from this analysis is that the increase in spending over the past couple of years has been primarily to greater expenditures on antiretrovirals and not on HIV prevention.

However, this statement warrants some qualification. In all five countries, consistent efforts have been made to prevent the epidemic by providing HIV testing for all pregnant women. In addition, there have been national campaigns to test all blood intended for use in transfusions.

It is important to note that even those countries that are trying to secure "universal" antiretroviral coverage are encountering obstacles in the form of the geographical concentration of health institutions and the marginalization of some sectors of the population. Although the Argentinean government is making a strong effort to provide comprehensive antiretroviral treatment, the availability and accessibility of the medication are impaired by bureaucratic procedures, coordination problems between national and provincial levels, and the poverty in which many HIV/AIDS sufferers live. This is also the case in Mexico and Chile.

The situation is considerably worse in Nicaragua and Ecuador, where universal ARV coverage is not guaranteed. In Ecuador, the resources allocated are insufficient for the proper treatment even of the numbers officially registered as living with HIV/AIDS, who are believed to comprise only 15% of the total infected population. In Nicaragua, meanwhile, access to ARVs is limited to a reduced group of people; more than 80% of people living with HIV/AIDS cannot access the medication through the public health system.

These five countries also share another condition: their health sector budgets have not grown in terms of extending physical access to health infrastructure. This is a disadvantage for people who live far from the existing health centers, especially when they seek more advanced medical attention. Regardless of the situation, the governments exculpate themselves by claiming to be in crisis, which, in practical terms, ends up harming the most vulnerable groups.

**Table 7.3: Earmarked spending on HIV/AIDS**  
(US dollars)

	1999	2000	2001	2002
Earmarked budget for HIV/AIDS				
Argentina/1	77,091,662	56,020,502	53,227,097	18,776,334
Chile/2	15,712,096	16,033,661	15,486,503	15,428,422
Ecuador/3	13,395	4,703	5,235	619,384
Mexico/4	126,367,321	160,220,271	114,987,967	168,594,856
Nicaragua/5	No data	2,304,322	3,363,501	3,275,119

/1 Authors' estimates based on the information in the budget financial execution reports published by the National Budget Office.

/2 Authors' estimates based on: (1) Information Systems for AIDS National Responses: Financial Indicators (1999–2000), as well as the study's initial information for 2001–2002 released by CONASIDA. (2) DIPRES. Spending functional classification.

/3 Ministry of Public Health, Ministry of Finance: budget documents and budget execution reports. <http://www.ec-gov.net>. Central bank monthly statistical report. <http://www.bce.fin.ec>.

/4 Data on HIV/AIDS public spending: for 1999–2000 "Flows of financing and expenditures on HIV/AIDS. National AIDS Accounts", SIDALAC; for 2001–2002 total amount on the figures for public health institutions described in table 5.1.

/5 National AIDS accounts and budgetary execution reports.

With respect to the spending that each of the countries in this study allocates to the HIV/AIDS epidemic, some issues need to be clarified. In the first place, it seems that the majority of actions against the epidemic take place within the health sector. This means that the way in which the governments are dealing with HIV/AIDS is far less comprehensive than is stated in their laws and action plans. Most available resources are used for the purchase of ARVs, and there are very few efforts focusing on sexual education and prevention. Additionally, in the cases of Chile, Ecuador and Nicaragua, the most conservative sectors of society have played a fundamental role in inhibiting massive prevention campaigns that include the dynamic reality of the epidemic's transmission and the sexual behavior of different groups.

In the case of **Argentina**, in all the years studied except 2003, the treatment and care of the infected population represented 90% or more of the National AIDS Programme's budget. In the period from 1999 to 2001, the next priority was prevention, including the AIDS and STD Control Project (LUSIDA) project, whose budget comprised between 4.5% and 10% of the total budget, depending on the year. This was modified in the 2002–2003 period because monitoring and research tasks became more important than prevention, amounting to 33% of the budget in 2003.

In **Chile's** spending, treatment for people living with HIV/AIDS also plays a leading role, as expressed in CONASIDA's prevention and treatment policies. This type of spending was increased during the period of this study, while the budgets for other components were decreased. On average, treatment for people living with HIV/AIDS absorbed 80% of public expenditure for HIV/AIDS from 1999 to 2002, while prevention was allocated 16% of the budget. The administrative costs absorbed around 2%.

Even though **Ecuador** experienced a substantial increase in the resources allocated to AIDS prevention and control in 2002, especially for medication and pharmaceutical products, it is evident that the state prioritized actions aimed at treatment over those aimed at prevention. In 2003, medication and pharmaceutical products represented 74% of the total AIDS budget, while the amount allocated to the National Prevention Programme represented only 11%. The Ministry of Public Health asked the Ministry of Economics and Finance for an allocation of \$2 000 000, of which it received a mere \$95 000 in 2003.

In the case of **Mexico**, one trend that has not changed is the insufficiency of resources allocated to prevent the sexual transmission of the epidemic. According to statistical information provided by CENSIDA, it is evident that local governments increased expenditure on ARVs as well as on condoms in the period from 1999 to 2002. However, the increase for these areas was markedly uneven: for ARVs the 2002 expenditure was 43 times the amount allocated in 1999, while for condoms it was 4.3 times higher.

In **Nicaragua**, evidence shows that in 2001, 54% of resources were destined for personal health (treatment, other providers of goods and auxiliary services, and pharmaceuticals). The other 46% was targeted at public health: 38% to promotion and prevention and the other 8% to STD/HIV/AIDS programmes. If patient care, as one of the main components of the STD/HIV/AIDS programme, lacks the necessary resources for the administration of ARVs, then prevention efforts cannot be considered a priority. During 2000, a significant part of the expenditure for prevention, mainly condom distribution, was in the hands of the private sector – 45% of the total. Of this percentage, 25% was attributable to foreign cooperation (mainly bilateral), while household expenditure contributed 20% of spending on condoms.

For those countries that have adopted a policy of free, universal distribution of ARVs, the budgetary increase for treatment is not a surprise. Nonetheless, this cannot be the only effort to act progressively on HIV. The increases are not balanced as regards the prevention of the epidemic. Epidemiological data suggests that there is a need to invest more resources in prevention, especially

of sexual transmission. In addition, prevention would include education and actions targeted at specific groups within the population. However, as mentioned above, programmatic and budgetary efforts are confined within the Ministries of Health, which do not have the competence to negotiate with, or redistribute resources to, other areas of government.

## 8. Regional recommendations

The country reports analyzed the facts discussed and summarized above from a human rights perspective. It is precisely this perspective that frames the recommendations outlined in the following paragraphs, which point towards concrete measures that the states can take to improve their response to the epidemic. Also, they aim to help states offer people better and wider access to health services.

1. The five countries analyzed here all have health systems that are incapable of looking after the needs of the whole population, especially the marginalized sectors. Yet a basic component of upholding the right to health is being able to guarantee health services, especially for the most vulnerable sectors of society.

A variety of reasons explain the failure of these countries to achieve this goal. These include the historic fragmentation of the health system, as in the Mexican and Chilean cases; the recurring crisis and insufficiency of resources, as in the Ecuadorian and Nicaraguan cases; and the recent economic crisis, as in the case of Argentina. Regional disparities, the lack of coordination between different jurisdictions and managerial problems also need to be noted. Despite all these differences, the end product is strikingly similar, although worse for Nicaragua and Ecuador.

It is imperative to advance, in the medium and long term, towards more equitable health services provision schemes that take into account the needs of the most vulnerable sectors.

*We recommend that efforts focus on progressively increasing the resources for health, taking into account geographic redistribution criteria and investment for infrastructure in marginalized areas. These increases need to be guided and sustained by criteria that foster equality.*

2. Even though it is a positive sign that HIV/AIDS budgets have risen, this is due to the increase in spending on antiretrovirals. Although states are complying with their responsibility to

guarantee people living with HIV/AIDS access to this medication – with the exception of Nicaragua – prevention seems to be lagging far behind.

In all five countries, with the exception of Argentina, the sexual transmission rate for HIV/AIDS is still too high. In spite of this, in at least three countries included in the study – Chile, Ecuador and Nicaragua – there are no consistent prevention campaigns in which the use of condoms plays a central role. It should be clear that whatever the amount of money invested in treating the disease, it will never be enough if prevention is not strengthened. One can readily imagine a time when no budget will be enough for treatment, as a direct result of insufficient resources having been invested in prevention.

Considering all these weaknesses, we can state that universality regarding HIV/AIDS is not guaranteed in any of the countries studied, simply because prevention has been neglected. In this context, it is further alarming that in some countries, including Argentina and Nicaragua, prevention depends entirely or largely on international funds and is not a consistent part of governmental programmes and budgets.

*To guarantee that governments assume their responsibility for prevention, we recommend that part of expenditure be earmarked for activities and goals relating to HIV/AIDS prevention.*

These activities can be directly related to other measures that are solely the government's responsibility, for example updating the epidemiological profile, which should help define the best prevention models.

3. Important obstacles to information access were found in virtually all the countries studied. In the Nicaraguan case, which is the most alarming one, there was no budget allocated for the implementation of the HIV/AIDS action programme until recently. In Ecuador the information is inconsistent. Argentina and Mexico are in similar situations, although the primary social security institution in Mexico does not provide information regarding its expenditure on HIV/AIDS. In Argentina, information regarding the registries of people infected and ill does not give the full picture, as there are high levels of under registration and delayed registration. There is very little epidemiological information, and furthermore there is no information regarding the funds provided by the Global Fund.

The absence of information is not merely a problem for exercises such as this study. It is an even bigger problem for the governments in their roles as leaders of the effort against HIV/AIDS. Without adequate information, it is impossible to design and implement the most appropriate

policies. If there is no disaggregated budgetary or programmatic information, there is no way to ensure that the funds allocated to fighting the epidemic are actually spent with that effect. For example, in Mexico, some of the resources for the HIV/AIDS programme were “redirected” to other entities, outside of budgetary legal framework.

*We recommend that clear criteria be established for identifying the resources that are allocated to the epidemic, their goals, the implementing agencies and the activities to be carried out with these funds. It is also necessary that the utilization of funds and execution of programmes that are a product of international cooperation, particularly the Global Fund, be made public.*

Since HIV/AIDS has powerful social and economic implications and impacts negatively on some of the most vulnerable groups in our society, we also recommend that the target population of the policies be identified in a disaggregated manner.

4. Because the effort against the epidemic is concentrated in the health sector, there is a vacuum in the resources allocated to HIV programmes outside of the health sector: although there are programmes that take into consideration other areas of government, the budgetary negotiations for HIV/AIDS resources are carried out by the health ministries.

*Taking into account the specific characteristics of the different government systems considered in this study, the entities responsible for HIV/AIDS programmes need to link themselves to other government offices besides health when negotiating their budgets so that the final product reflects the comprehensive nature of the fight against HIV/AIDS.*

*It is also necessary that governments assume responsibility and accountability for their policies and be required to present their results to their constituencies.*

Both of these elements are fundamental in offering a more complete and consistent accountability mechanism.

The scope of this study has been limited to analyzing the commitment and priority of governments in relation to HIV, not only from a budgetary perspective, but also from a more comprehensive human rights perspective. However, it has not attempted to evaluate the impact of policies and budgets on the epidemic. That is something for another study.

## Abbreviations

CASEN	Socioeconomic Characterization Survey (Chile)
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CENSIDA	National Centre for the Prevention and Control of HIV/AIDS (Mexico)
COESIDAS	State Councils for AIDS Prevention and Control (Mexico)
CONAMU	National Women's Council (Ecuador)
CONAPO	National Council on Population (Mexico)
CONASIDA	National Commission on AIDS (Chile)
CONASIDA	National Commission on AIDS (Ecuador)
CONASIDA	National Council for AIDS Prevention and Control (Mexico)
CONISIDA	Nicaraguan Commission for the Fight against AIDS
ENDEMAIN	Demographic Survey of Maternal and Child Health (Ecuador)
ERCERP	Reinforced Strategy for Economic Growth and Poverty Reduction (Nicaragua)
FONASA	National Health Fund (Chile)
FONOSIDA	AIDS telephone information service (Chile)
ICESCR	International Covenant on Economic, Social and Cultural Rights
IDU	intravenous drug users
IMSS	Mexican Institute for Social Security
IMTAETS	Institute for Tropical Medicine of the Amazons and for STDs and HIV/AIDS (Ecuador)
INDEC	National Institute of Statistics and Censuses (Argentina)
INEGI	National Institute for Statistics, Geography and Informatics (Mexico)
INNFA	National Institute for the Child and Family (Ecuador)
INSS	Nicaraguan Institute for Social Security
ISSFAM	Mexican Armed Forces Institute for Social Security
ISSSTE	Institute for Services and Social Security for State Workers (Mexico)



LUSIDA	AIDS and STD Control Project (Argentina)
MCE	Coordination Mechanism for Ecuador (Ecuador)
MINSA	Ministry of Health (Ecuador)
MSP	Ministry for Public Health (Ecuador)
NOM	Mexican Official Norm
PAHO	Pan-American Health Organization
PEMEX	state-owned oil company (Mexico)
PGR	Republic's general budget (Nicaragua)
PNS	National AIDS Programme (Ecuador)
SIDALAC	Regional AIDS Initiative for Latin American and the Caribbean
SILAIS	Local Systems for Comprehensive Health Services (Nicaragua)
SSA	Ministry of Health and Assistance (Mexico)

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