

Scaling Up Anti retroviral Therapy in Central America: Lessons Learned from the Field, Central America.

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Country	Population (2006)	UNDP Human Development Index (2004)	Year that Anti-retrovirals first became available
Costa Rica	4.5 million	42	1997
Panama	3 million	59	1999
El Salvador	7 million	105	2000
Guatemala	12.5 million	119	2001
Honduras	7.5 million	115	2002
Nicaragua	5.5 million	121	2003
Belize	300,000	67	2003

	Estimated number of HIV+ people (2004)	Estimated number of PLWA with ARV access (2006)	Estimated Number of PLWA without treatment who need it (2006)	Number of PLWA whose treatment is currently supported by the Global Fund In 2006
Belice	5,000	180	600	0
Guatemala	75,000	5,100	5,500	1,000
El Salvador	40,000	2,900	2,000	800
Honduras	70,000	3,900	5,000	3,500
Nicaragua	6,500	200	1,000	200
Costa Rica	15,000	2,600	0	Not applicable
Panamá	20,000	2,800	500	Not applicable
Total	231,500	17,680	14,600	5,500

Notes

- Combination of our own estimates, those from WHO, and those from National AIDS programs.
- These estimates include semi-private social health care systems available to only a small percentage of the population in Guatemala, El Salvador, and Panama. In Costa Rica 100% of the population is covered by the public Social Health Care system.



Notes

- This total indicates that about 60% of all people who need treatment now, have it.
- According to our estimates, in 2001, only about 10-15% of all people who needed treatment had it.
- The above figures are disputed by countries such Nicaragua and Guatemala have very poor surveillance systems. UNAIDS and WHO do not have the resources to obtain accurate figures, although they are always having press conferences and releasing figures to the media, but we are dubious about the accuracy of their figures, including 3 x 5 figures.

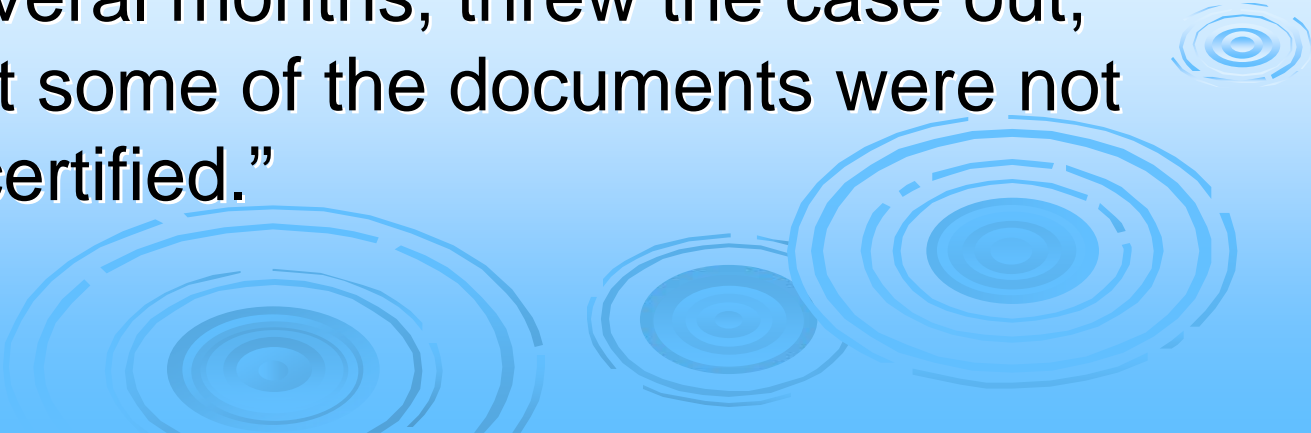
First ARV access in the region was in Costa Rica in 1997

1. First step was informing Costa Rican PLWA of existence of the “new” medications after Vancouver Conference in 1996
2. Meetings were held and an informal Coalition was formed.
3. Negotiations with the National Health Care System proved useless
4. Consultant brought in by National Health Care system claimed the system would go bankrupt by 2000 if ARV’s were provided to PLWA. He later admitted that his estimates were based on African incidence projections.

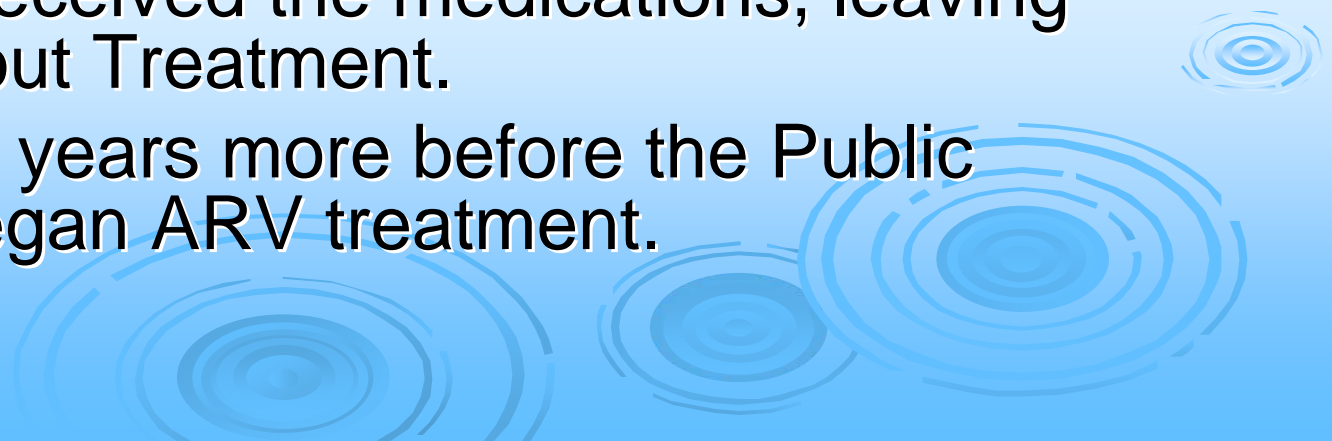
First ARV access in the region was in Costa Rica in 1997

5. Finally, four people, including Guillermo Murillo and William Garcia, decided to take the case to the Supreme Court
6. Supreme Court decided in favor of William Garcia on September 26, 1997.
7. Within two months, access became universal and 300 PLWA were receiving treatment. This was at a time when neither UNAIDS nor PAHO believe that ARV access was feasible in Latin America.
8. Prices in 2006 for 2,300 people on treatment are almost identical to the price for 300 people in 1997, indicating a price reduction in ARV's of 800 percent

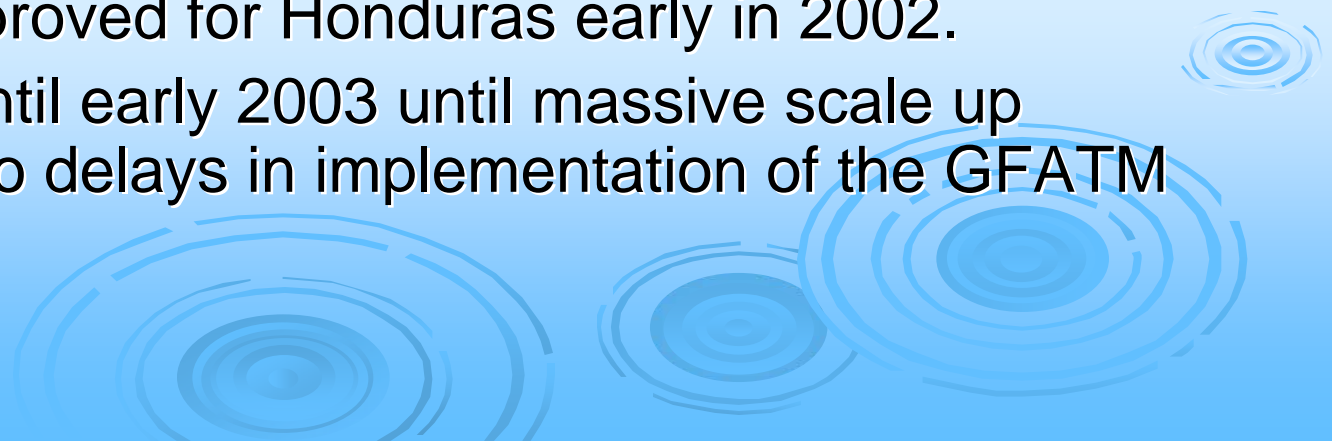
In early 1998, this presenter was asked by Panamanian PLWA to go to Panama.

1. Meetings were held with just two people, a Physician living with AIDS and his wife, but they agreed to go public and Norma Garcia held a Press Conference in May of 1998.
 2. Decision made to take the case to the Supreme Court as well, but the Court, after waiting several months, threw the case out, saying that some of the documents were not “officially certified.”
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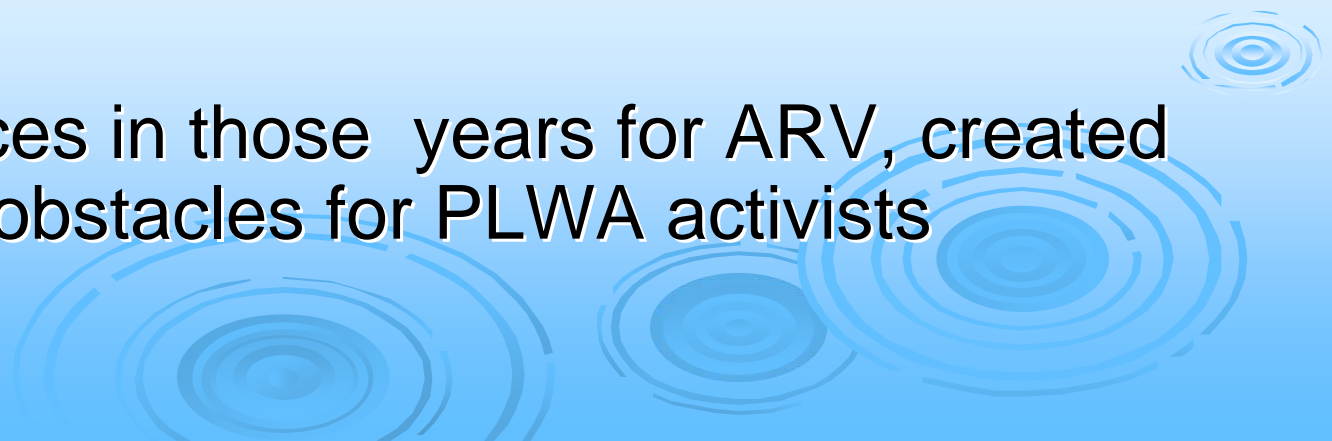
In early 1998, this presenter was asked by Panamanian PLWA to go to Panama.

3. Panamanian PLWA then demonstrated in front of the Social Security building, closing a main street and chaining themselves to the door.
 4. A week later the Social Security system Board of Directors held an emergency meeting, and decided to provide the ARV's.
 5. But in Panama, because of the "divided" Health Care system, only those who were affiliated received the medications, leaving 70% without Treatment.
 6. It was two years more before the Public system began ARV treatment.
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In Honduras, in 2001 a united coalition of PLWA groups held a demonstration in front of the National Assembly, demanding ARV access

1. As a result the Assembly invited an openly positive woman, Rosa Gonzales to speak to the Congress about the needs of PLWA.
 2. A week later, Congress voted an emergency allocation of \$200,000 to begin ARV therapy, early in 2002. This was only enough for 200 people to begin treatment but it established the precedent
 3. In the meantime, a \$27 million Global Fund project was also approved for Honduras early in 2002.
 4. Still it took until early 2003 until massive scale up began, due to delays in implementation of the GFATM project.
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Lessons Learned and Conclusions

1. Between 1997 until 2002, a kind of pure activism of united PLWA occurred in Central America which resulted in ARV access for a relatively small number of people but set important precedents in each country and created a region wide consciousness about the importance of ARV access. At the same time, this was a period of growth for PLWA led NGO's.
 2. Higher prices in those years for ARV, created additional obstacles for PLWA activists
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Lessons Learned and Conclusions

3. The arrival of the Global Fund in late 2002, beginning with Honduras, opened the doors for even greater region wide access, as reflected above.
4. But at the same time, previously “militant” NGO’s were faced with the possibility large disbursements of cash from the Global Fund, which created conflicts and also led to activism that was often “conditioned” by whoever dominated the CCM. NGO’s became divided and were afraid that more militant activism would cause them to lose needed resources.

Lessons Learned and Conclusions

5. This, along with cumbersome Global Fund procedures resulted in long delays in project implementation in countries such as Belize, Guatemala, and Nicaragua.
6. The Global Fund while creating opportunities, is a mixed blessing because projects have tended to stifle activism directed against government thereby affecting “sustainability” if and when the Global Fund leaves these countries.

Lessons Learned and Conclusions

7. Prices dropped dramatically from 1997 through 2003, in general more than 500% because of availability of generic medications, and because of the UNAIDS accelerated access negotiation held in 2002.
8. However prices are now on the rise again because of the prices of urgently needed “rescue” therapy including ARVs such as Kaletra, Truvada, Reyataz and others. We don’t know what the price will be of the Merck/Gilead combination pill, Atripla.

