

## Health and human rights

### Basing treatment on rights rather than ability to pay: 3 by 5

"If 3 by 5 fails, as it surely will without the dollars, there will be no excuses left. Only the mass graves of the betrayed" said Stephen Lewis, UN Secretary-General's special envoy for AIDS in Africa at a press briefing on March 3, 2004. The WHO/UNAIDS "3 by 5" initiative aims for 3 million people to be started on anti-retroviral treatment by the end of 2005.<sup>1</sup>

WHO estimates that US\$5.5 billion will be needed to meet the aims of 3 by 5. Yet, to date, less than \$2.3 billion has been paid to the Global Fund.<sup>2</sup>

Although AIDS is now treatable, less than 5% of the 40 million people living with AIDS have access to anti-retrovirals. The 34 countries targeted by the initiative are home to 94% of people needing treatment in the developing world.

An honest assessment of the global situation today shows that it is the market that decides who lives and who dies. The de-facto criterion for receiving antiretroviral treatment is the ability to pay for treatment.

To address the greatest health crisis in the past 500 years, a human-rights based—rather than market-based—approach is the only realistic strategy for an epidemic that is concentrated in poor and marginalised communities who have neither access to health care nor the ability to pay for treatment.

The 3 by 5 initiative proposes that governments consider universal access to AIDS treatment to be a basic human right in accordance with the Universal Declaration of Human Rights, which recognises the right to health care and the right to share in the advances of science. The 3 by 5 initiative also emphasises that these rights must be extended to vulnerable groups who risk being excluded from treatment because of social, economic, or geographical barriers.

A striking aspect of the 3 by 5 initiative is that it recognises that highly HIV-burdened countries cannot succeed in tackling the epidemic without massive support from international agencies, donors, and other non-state

entities.<sup>1</sup> Such support must include sustained financial assistance, not only for drugs, but also for medical staff and for capital investment in health infrastructure in heavily burdened countries. Donor countries must also allow generous interpreta-

in the health sector emphasised user fees, privatisation, and other cost-recovery measures. Although some studies reported the success of such reforms, many documented the deleterious effects of these policies.<sup>3</sup> Interestingly, the fact that the economic ideology of health sector reform was not based on human-rights, but rather on the ability to pay, was never criticised as naive.

To meet the goals of 3 by 5, governments must take responsibility for the health of their people by setting rational, stable, and rights-based policies that guarantee health care for even the most poor and vulnerable citizens.

Governmental structures must reflect the needs of the population. Poorly planned, sweeping reforms of developing country health structures have often resulted in chaotic implementation of services, unclear lines of

authority for specific tasks such as purchasing drugs, and a lack of institutional memory. Effects of poor planning and health-system changes have been documented in the treatment of tuberculosis in which case detection and outcomes have been negatively affected.<sup>4</sup>

Although the responsibility for assuring rights to health care, non-discrimination, and a share in scientific advancement rests on individual nations, success in this enormous task will require a coordinated effort from the donor community, international financial institutions, and communities at large, including people living with AIDS. The donor community has to act on a larger scale and in a more sustained way than ever before. Donor countries should put aside their need for the political recognition that comes from bilateral aid programmes and support the Global Fund. International financial institutions must grant further debt relief and reconsider the pervasive recommendations to use a market-driven framework for delivering health care to the world's poorest people.

As increasing assistance for AIDS treatment and prevention has become

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Chief of Akyem Abuakwa, Ghana, receives the results of his HIV-test during a Royal ceremony to encourage voluntary HIV testing

tion of intellectual property rights with respect to AIDS-related treatment.

The 1978 Alma-Ata declaration<sup>3</sup> for "health care for all by the year 2000", was perhaps the last time we heard such an ambitious and rights-based call for access to health care. The rights-based goals of Alma-Ata were modest; 90% of children should have weight for age that corresponds to reference values, every family should be within a 15-minute walk of potable water, and women should have access to medically trained attendants for childbirth. Moreover, there was unanimous agreement that these goals could not be achieved without increased international aid.

However, this proposed right to universal basic health care was attacked by international experts as naive and too expensive. In the next few decades distribution of limited resources for health was determined more by markets than by rights. With foreign debt mounting, poor countries were called upon by international financial institutions to decrease the proportion of gross national product spent on health as they moved towards market economies. Reforms

available to heavily burdened countries such as Uganda, demands by international financial institutions for decreases in health expenditure in favour of investment in the financial sector as a precondition to loan disbursement, have been called into question.<sup>5</sup> Countries should be lauded, not punished, for investment in health. Moreover, investments in health are not incompatible with economic development. AIDS is now affecting the economies of countries such as Botswana and South Africa. As more people start treatment, the economy will probably be strengthened by retaining a work force, increasing agricultural production, and revitalising the education system—all of which have been greatly affected by the AIDS epidemic.

Lastly, the public-health, medical, and human-rights communities as well as people living with AIDS, their families, and neighbours must keep pressure on international donors and

governments to realise the ambitious goals set out in the 3 by 5 framework. The AIDS community has a history of fighting for human rights. The struggle for the right to non-discrimination has been ongoing since the beginning of the epidemic in both developed and developing countries. More recently, legal battles for governments to fulfil the right to health care by providing antiretrovirals have been won by activist groups in Central America and South Africa.

AIDS care must be provided on the basis of the right to health and the right to share in the remarkable advances in AIDS medicine that have turned the disease from a death sentence to a manageable chronic condition. In fact, the ambitious targets in the 3 by 5 initiative will be met only if a rights-based framework is undertaken. It would be naive to assume that anything less will be enough to ease the social

and economic consequences of the epidemic.

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- 2 The Global Fund to Fight AIDS, Tuberculosis, and Malaria. Pledges. <http://www.theglobalfund.org/en/files/pledges&contributions.xls> (accessed March 16, 2004).
- 3 Hall JJ, Taylor R. Health for all beyond 2000: the demise of the Alma-Ata Declaration and primary health care in developing countries. *Med J Aust* 2003; **178**: 17–20.
- 4 Kritski AL, Ruffino-Netto A. Health sector reform in Brazil: impact on tuberculosis control. *Int J Tuberc Lung Dis* 2000; **4**: 622–26.
- 5 Wendo C. Uganda and the Global Fund sign grant agreement. *Lancet* 2003; **361**: 942.

### 3 by 5, but at what cost?

The disaster of the HIV epidemic demands an emergency response. WHO's recent call to action, the "3 by 5" initiative, builds on the work of HIV and human-rights activists who fought for lower prices to enable treatment on the basis of need rather than wealth or geography. Ironically, the urgency and narrowly defined objective of 3 by 5 have implications for human rights and equity.

It is difficult to question an initiative that seeks to save the lives of people with a fatal illness, but it is important to consider potential hazards. The DOTS campaign for tuberculosis showed how branding a programme could help to disseminate a new policy and mobilise resources.<sup>1</sup> 3 by 5 has captured the attention of international agencies; their priorities in turn are influencing the policy agendas of recipient governments, including many in Asia and southeast Asia.

In some countries, targets for treatment far exceed the number of people who know they are HIV positive. For example, in Indonesia the government has pledged to provide treatment for 10 000 people by the end of 2005, yet fewer than 4000 have been identified with HIV infection. Many Asian countries are still in the early stages of establishing voluntary counselling and testing services, which can play a vital part in prevention, as well as being an entry point to care.

However, the pressure to identify those eligible for antiretrovirals threatens to skew counselling and testing towards screening those with symptoms, and to weaken principles of consent and confidentiality. Once these safeguards are diluted, vulnerable sections of the community—such as prisoners, injecting drug users, and sex workers—might be coerced into testing.

On Feb 10, 2004, Richard Holbrooke suggested in *The New York Times* that testing should be required at marriage, before childbirth, and on any visit to a hospital. Stephen Lewis, UN special envoy for HIV/AIDS, urged that routine testing be required "whenever someone presents at a medical facility, with the option of course to opt out". Reports from antenatal clinics show that women rarely opt out of HIV testing, but often fail to return for results. If testing becomes required, mothers and children may miss out on health care. A study of 764 HIV-positive people in India, Indonesia, Philippines, and Thailand<sup>2</sup> noted that more than half reported discrimination in the health sector. Those who were unprepared for testing or who were coerced were more likely to report discrimination. Breaches of confidentiality were common.

In much of Asia, most of those who test positive will not yet need antiretrovirals, but there are often no

other supports in place. The effects of HIV infection are not confined to early death after debilitating illness, but include difficult decisions about child-bearing, and the loss of livelihood associated with discrimination. The least powerful, especially women, are most vulnerable to the effects of this stigma.<sup>2</sup>

Experiences in Brazil and Botswana show that people in resource-poor settings are able to follow strict treatment regimens. However, weaknesses in drug ordering and supply systems in poorer Asian countries lead to interruptions in treatment that will contribute to resistance and treatment failure. Also, antiretrovirals are already for sale in many pharmacies—planning for 3 by 5 should not distract health officials from the urgent need to strictly regulate distribution. The haste to reach treatment targets could compromise the chance of many with HIV infection to access effective antiretrovirals in the future.

Freedman and colleagues<sup>3</sup> have suggested that the Millennium Development Goal to reduce child mortality could, paradoxically, increase inequality, because the goal is easier to achieve by improving the health of the relatively better off. Likewise, the emphasis on the target-based goal of 3 by 5 could reverse the equity lens that should focus strategies prioritising the health of the