ARGENTINA

Human Rights and access to treatment for HIV/AIDS

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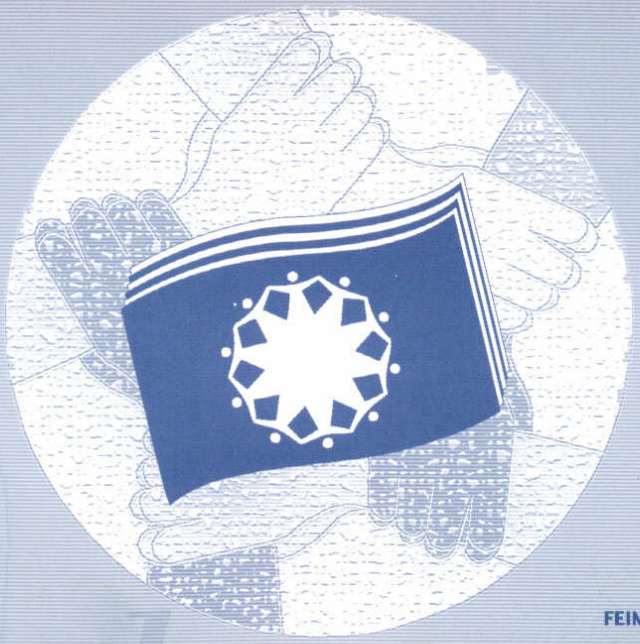

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HUMAN RIGHTS AND ACCESS TO TREATMENT FOR HIV/AIDS IN ARGENTINA

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CASE STUDY DEVELOPED UNDER THE LACCASO'S HUMAN RIGHTS PROJECT AND IN COLABORATION WITH UN AIDS OFFICE – 1998

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I GENERAL CHARACTERISTICS OF ARGENTINA

The Argentine Republic is situated in far south of the American continent. It has a land area of 3,761,274 km^2, including its part of Antarctica. It is a federal country, made up of 23 provinces and the city of Buenos Aires. Each district has its own constitution and government, self-funded but also receiving budgetary contributions from the national government and payments from the federal budget. It is a country predominantly reliant on primary production.

The total population according to the last National Census in 1991 was just over 36 million inhabitants, with a very heterogeneous geographical distribution. The metropolitan area: the city of Buenos Aires and Greater Buenos Aires contains more than a third of the country's population. The most heavily populated province is Buenos Aires, and in the following order, but much less populated, come Santa Fe, Cordoba and Mendoza. The least populated provinces, in the far south of the country are Chubut, Santa Cruz and Tierra del Fuego. The provinces are subdivided into departments and those in turn into municipalities dependent upon the provincial government.

II HISTORICAL AND POLITICAL BACKGROUND TO HEALTHCARE

a) Background

The first signs of the structuring of the Argentine healthcare sector go back to the beginning of the 19th century, with the creation of charities run by prominent people in society - and coordinated by the Catholic Church – which took in the ill and orphans. In 1815 the government transferred the management of hospital from the church to civil committees, and in 1822 the law of church reform was approved, which placed the assets belonging to religious orders in the hands of the state. The state found it impossible to answer all of the demands, and thus created the Charity Society, a private entity funded by the state.

In the mainly European immigration period - 1860/1910 – there appeared organizations, which provided assistance for immigrants and trade unions. Both aiming to protect workers' rights and to promote the quality of healthcare for communities of foreigners.

While the Declaration of Human Rights and the post-war consequences gave rise for the first time to the idea of the "right to healthcare" in many European countries, the people and the healthcare institutions in Argentina considered healthcare of the poor as a hand-out.

From 1946, there was in Argentina an extension of the social benefits to cover the widest parts of society, in line with the populist post-war tendency of other Latin American countries, and which brought a number of contradictions to the development of the healthcare sector, promoting the role of the state and state healthcare schemes. The healthcare schemes, run by the trade unions, became a powerful political tool.

In 1948, the Charity Society was transferred to the National Office for Social Security, which in 1949 became the Ministry for Public Health. The population began to be considered as "human assets" and due to their worth as workers, their care and

development – including healthcare – became a responsibility of the state. From 1949-1953, a large number of public hospitals were built. In the 1960s the Ministry of Public Health promoted the training of its staff and a certain degree of de-centralization in each province.

In 1970, Law No. 18610 was approved. which "rationalized the healthcare scheme model, making healthcare coverage universal and declaring it compulsory for all employees…; it will be the responsibility of the Social Security Secretariat in the Ministry of Economy, but in a de-centralized form"[1]. The public health sub-sector began to lose momentum, due to the growth of the social security systems which hired services from the private sector, leading to the latter's expansion.

The last military dictatorship – 1976-1983 – favored the external market, leading to into a halt in economic growth, as shown by the drop in investment, the outflow of capitals and the disproportionate increase of the external debt. This led to a decline in the state's presence, increasing the regressive nature of the tax structure, by concentrating the productive and financial resources in a few economic groups. To the problem of job insecurity was added the "contraction" of the state. The economy was weakened and it worsened the degree of fragmentation and social exclusion, including the question of access to healthcare.

Argentina regained democracy in the 1980s but the economic and social crises worsened. For some years, after the return of democracy, the regulatory capacity of the state, especially in the areas of technology and medicine, and a medical insurance model aiming to integrate healthcare services model were promoted.

Since the end of the 1980s the new government began a rapid process of privatization of responsibilities and functions previously carried out by the state in the area of health, and the de-centralization of the national administration's services to provincial and local authorities. In 1992 the responsibility for national public hospitals was transferred to the provinces through de-centralization, but not the economic resources. The de-centralization process in Argentina was more than just an abrogation of responsibility by the national government. Therefore, the service in public hospitals deteriorated.

In 1992, the social welfare system started a process of reform which, with the pretext of improving efficiency, reduced the quantity and quality of healthcare. According to Cetrangelo, this system was based in the laws of the market and supposed that the freedom of choice of the beneficiaries would automatically bring improvements in efficiency[2]. CEPAL said that in the Argentine healthcare sector the optimization of public-private competence is still pending, perhaps due to the emphasis placed on financing without considering other characteristics of markets which provide healthcare services[3].

[1] Neri, A. "Health and Social Policy". Hachette Publishers. Buenos Aires, Argentina.1982.
[2] Cetrángolo, O: "The Healthcare System in Argentina", Katz J. Et. al. Fundación Omega Publishers
[3] Social Expenditure in Latin America. CEPAL Publications

In recent years, universality, justice and equality in healthcare systems have been lost, giving way to the law of supply and demand. At the same time, the impoverazation of the population, more evident since 1992, has increased the multiple and combined uses of different sanitary resources and led to a general deterioration in the quality of healthcare, especially in the public arena.

Due to the state's inability to respond to healthcare needs, the population have increased their direct spending, implying a greater inequality because those with the lowest income spend a much larger proportion on healthcare, and generally receiving a lower level of healthcare.

b) Current structure of the healthcare system.

The Argentine healthcare model can be characterized by fragmentation and heterogeneity, which can be seen by the lack of integration and coordination among the three sub-sectors: public, private and social medical security.

1. Public sub-sector.

This is made up of public hospitals (most of them under provincial and municipal authority) and centers for primary care. This sector contains the largest number of hospital beds as well as the best geographical distribution. While some areas could offer a potentially high level of healthcare, due to the current reduction in economic resources which fundamentally affects supplies and medical technology, the reality is much worse.

It is primarily to help the poor and those with few economic resources who do not have medical cover, due to growing unemployment and/or the black economy, and the lack of economic means necessary to access the private sub-sector. In recent years there has been a significant increase in the demand for public healthcare due to unemployment and workers therefore losing the healthcare benefit that came with their job. This sub-sector is the focal point for the treatment of infectious, contagious and chronic diseases, as well as prevention.

2. Sub-sector of Social Medical Security

This sector is aiming to help employees and their families. It also offers services to pensioners through an special entity. Its current structure goes back to 1970 when the Law 18.610 was approved.

At the beginning this sub-sector developed a poor infrastructure and hired services from the existing private sub-sector. The Workers' Healthcare Schemes include the Armed Forces, with their own hospitals and offices to offer healthcare to their patients. Since 1996 the obligatory medical program is in force where the Workers' Healthcare Schemes should offer healthcare to HIV/AIDS sufferers.

3. Private sub-sector

This sector is well established in Argentina and can be characterized by a large number of outpatient practitioners very well spread throughout the country. The number of private hospitals or clinics has shot up in last 30 years. But they vary in terms of sophistication and the number of beds. In general they are only geared towards the treatment of non-infectious serious illnesses. Since the 1980s but especially since the 1990s new and varied forms of private medical insurance have been developed. Due to the deterioration in the level of care offered by workers' healthcare schemes, those able to afford it opted for private medical cover. The obligatory medical program, which includes care for HIV/AIDS sufferers, is also obligatory for the private sub-sector.

c) Coverage for the sub-sectors

According to the INDEC, the Argentine National Statistics Office, between 1985 and 1991, the population having social medical security diminished from 73.6% to 62.2%, while in 1993 the Ministry of Economy's figures for the social medical security were 58.2%. According to Bianco[4] between 1986 and 1992 the social security coverage diminished from 82% to 56.8%. The private medical insurance increased, in some cases, as a respond to unemployment or black economy or to increase the quality of the service offered by the social security.

According to Gonzalez Garcia and Tobar[5] , workers' healthcare schemes cover 16.2 million people, while the public sub-sector covers 15.9 million and the private sub-sector 1.4 million. Nowadays, Argentina has an important range of human professional resources and a high installed capacity. The country has 3 practitioners and 4.5 beds every 1,000 inhabitants, similar to the developed countries. However, the system does not show equality or universality, and the quality of service is clearly deteriorating.

According to Bianco "the population between 20 and 29 years old represents the lowest percentages of social medical security" [6]. And this is the group that shows the high indicators of HIV/AIDS. Due to their low social medical security coverage, the public sector is responsible for their healthcare.

d) Healthcare expenditure

Argentina is one of the American countries which spends the greatest amount of money in its healthcare sector, behind the United States and Canada. According to Gonzalez Garcia & Tobar [7], health expenditure in Argentina in 1995 accounted for 7.21 % of GDP and of this figure 66% is made up of social security and direct expenditure.

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[4] Bianco,M "Fecundity, Health and Poverty in Latin America. The Argentina Case." FEIM/FNUAP. Buenos Aires, Argentina, 1996.
[5] Gonzalez Garcia, G. and Tobar, F. "Better Healthcare for the same money. Health System Reform in Argentina. Isalud – Latin American Publisher Group. Buenos Aires, Argentina, 1997.
[6] Bianco, M. (already quoted)
[7] Gonzalez Garcia, G. and Tobar, F. (already quoted)

In 1995 the expenditure per capita was US$ 583. As regards the expenditure, according to Gonzalez Garcia & Tobar [8], taking into account that promotion, prevention, fiscalization and regulation are exclusive to the public sector, 20% of public expenditure was allocated to prevention and regulation. The monthly per capita expenditure for prevention is estimated at US$ 2.4 and for treatment it is US$ 19.4 for those people who only have access to the public sector, US$31.6 for those covered by social security, and US$ 55.3 for those with private medical insurance. With respect to expenditure on medicine, they indicated that in 1995 this rose to 29% of total expenditure on health. However, only 25% of the population enjoyed real access to essential medicines.

III THE LEGAL BACKGROUND TO HIV/AIDS TREATMENT

Access to healthcare is a fundamental human right and is a basic component of social welfare and human development. The health/sickness process has been constructed historically, socially and culturally, and includes: the biomedical aspect, the quality of life and access to healthcare services, to a home and to education. Therefore, healthcare represents a social asset, which the state should guarantee to all of society, with equality and universality standards.

In Argentina, the concept of healthcare as a basic human right has not been incorporated into the culture of the population. In Argentina when one speaks of human rights they are mainly referring to civil and political rights. Even though society says that access to healthcare should be a right, for which the state ought to pay, it is not defended like a basic human right. This has partially determined the scant participation by civil society in the struggle for improvements related to the right to healthcare.

In recent years, and specially in the period from 1991-94 there was a deep political, economic and social change in Argentina, which accelerated the process of withdrawal by the state, and with the privatization of a considerable part of the public health sub-sector, and the national, provincial and municipal de-centralization of the management and administration of health services. This de-centralization caused inequality in access to healthcare for the people because of the delegation to the provinces of responsibility for promotion and healthcare while budget contributions from the central administration were not transferred or remained dependent to a large extent on political and economic issues. This had repercussions for healthcare in general and HIV/AIDS in particular, because the epidemic saw a marked increase and a change in its epidemiological profile, raising its profile among the young and poor.

The National Constitution of the Republic of Argentina, approved in 1853 and reformed most recently in 1994, did not make explicit reference to the right to healthcare, but made implicit reference in its articles 33, 42 and 43 [9]. Argentina is a federal country and the

[8] Gonzalez Garcia, G. and Tobar, F (already quoted)

[9] National Constitution, Article 33: "The declarations, rights and guarantees which the Constitution enumerates, shall not be construed as a denial of other rights and guarantees not enumerated, but raising from the principle of sovereignty of the people and from the republican form of government.

provincial constitutions are the ones that guarantee and regulate the right to healthcare. The fragmented structure of healthcare favors heterogeneity and inequality in the type, quantity and quality of healthcare according to area.

After the 1994 reform, the constitution indirectly states that there should be recognition and obligation on the part of the nation to the right to healthcare and social medical security in articles 75, clause 22, which gives constitutional status to International Declarations, Conventions and Agreements, specifying that they should be construed as complementary rights to those rights and guaranties recognized by the constitution. These international documents included the Right to Healthcare. Moreover, in its articles 14bis and 75 clause 23 [10], the constitution states the obligation of the state to guarantee social medical security for all the citizens.

As regards specific legislation on HIV/AIDS, in 1990, Law 23798 against the Acquired Immune Deficiency Syndrome was passed. Unlike the healthcare de-centralization policy stated in the National Constitution, the fight against AIDS was declared of national interest by virtue of Law 23798 which also appointed the National Ministry of Health and Social Welfare as the authority in charge of its application. This means that the Ministry would be in charge of the diagnosis and treatment as well as the information and prevention[11]. The law obliged the Ministry to promote investigation, training of human resources and international cooperation. It establishes the Ministry's responsibility for biosecurity

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Idem, Article 42: As regards consumption, consumers and users of goods and services have the right to the protection of their health, safety and economic interests; to adequate and truthful information; to freedom of choice and equitable and reliable treatment.
Idem, Article 43: Any person shall file a prompt and summary proceeding regarding constitutional guarantee, provided there is no other legal remedy, against any act or omission of the public authorities or individuals which currently or imminently may damage, limit, modify or threaten rights and guarantees recognized by this Constitution, treaties or laws, with open arbitrariness or illegality. In such case, the judge may declare that the act or omission is based on an unconstitutional rule. This summary proceeding against any form of discrimination and about rights protecting users and consumers, as well as about rights of general public interest , shall be filed by the damaged party, the ombudsman and the associations which foster such ends registered according to a law determining their requirements and organization forms.
[10] Idem, Article 14 bis: The State shall grant the benefits of social security, which shall be of an integral nature and may not be waived. In particular, the laws shall establish: compulsory social insurance, which shall be in charge of national or provincial entities with financial and economic autonomy, administered by the interested parties with State participation, with no overlapping of contributions; adjustable retirements and pensions; full family protection; protection of homestead; family allowances and access to a worthy housing.
Idem, Article 75. Clause 23: To legislate and promote positive measures guaranteeing true equal opportunities and treatment, the full benefit and exercise of the rights recognized by this Constitution and by the international treaties on human rights in force, particularly referring to children, women, the aged, and disabled people.
To issue a special and integral social security system to protect children from abandonment, since pregnancy up to the end of elementary education, and to protect the mother during pregnancy and the period of lactation.
[11] Law 23798. Section 1: The fight against the Acquired Immune Deficiency Syndrome is hereby declared of national interest, this shall be construed as the detection and investigation of its causes, illness diagnosis and treatment, its prevention, assistance and rehabilitation, including its related diseases, as well as those measures aiming to avoid the spreading of the disease, mainly through education.
Idem. Section 4. Clause f): The Executive Power shall carry out those measures in order to let the population know about the characteristics of AIDS, the possible causes or forms of transmission, the advisable prevention forms and the adequate treatment, in such a way as to avoid interested unscrupulous publicity.

[12]regulations. Both the Law and its Regulating Decree No 1244, approved on the same year, provided for the legal requirements to be followed by health professionals in the detection and treatment of HIV/AIDS[13].

The Law and its Regulating Decree stated that the HIV/AIDS test should always be carried out with the voluntary consent of the interested party, except the Article 9, which stated that every foreigner applying for Argentine residence should have an HIV test.

In 1991, the Ministry of Health and Social Welfare adopted Resolution 787: Legal Policy related to HIV infection in Federal Prisons. That resolution, in accordance with the AIDS Law and its Regulating Decree, established that the HIV test should be voluntary and consented by the prisoners, and the obligation of the state to provide them with treatment and medicines[14]. However, the majority of the prisons do no comply with this law and the prisoners living with HIV/AIDS do not enjoy these rights.

In 1992, The Ministry of Health established the National Program against the Human Retrovirus (Leukemia and AIDS-Resolution 18/92) under the direct responsibility of the Ministry of Health and managed by an Executive Director[15].

In 1994, The Ministry of Health and Social Welfare established the "Basic Vademecum to treat HIV Patients" according to Resolution 169/94. This directory was updated in 1999

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[12] Law 23798, Section 12: The corresponding national authority shall establish the biosecurity regulations that should apply to the material described as disposable or non-disposable. Failure to comply with these regulations, shall be considered a serious offense and the responsibility shall fall on the people dealing with that material, the owners and the technical authorities.

[13] Idem Section 6: Those professionals assisting people belonging to groups of risk should prescribed those tests necessary for the direct or indirect detection of the infection.
Idem Section 8: Those professionals who detect HIV or have a justified presumption that one individual may be a carrier, should give information to the patient about the infecto-contagious character of the disease, forms of transmission and his right to adequate treatment.
Decree 1244. Section 6: The practitioner in charge shall decide the treatment that the patient should undergo, with his consent. The practitioner should guarantee confidentiality and also provide adequate advise after confirming the results of the tests.
Idem Section 8: This required information should be given by reliable means, delivered to the HIV carrier in person and shall be of a restricted nature.

[14] Resolution 787. Section 1: The tests shall be in all cases voluntary and shall be carried out upon the request of the prisoner or the practitioner with the prisoner's consent. The prisoner shall sign a form, which shall include all the rights vested in him by virtue of law 23798, expressing his consent The practitioner requesting the test should also sign said form. Medical and psychological assistance provided for in section 6 of the regulating decree should be guaranteed to the prisoner in all cases.
The results of the test should be secret as prescribed by the AIDS Law.
Idem Section 2: Asymptomatic, oligosymptomatic or infected symptomatic carriers that shall not required confinement in hospital shall not be separated from the rest of the prisoners. No measure shall be devised in opposition to the provisions of section 2. The prisoners mentioned in 2.1 shall not be excepted from carrying out the normal activities developed by other members of the community such as training, holidays, work in different areas, etc. in accordance with the psychophysic ability in each case as advised by the practitioner.
Idem Section 6: The prisoners shall receive the same medicines as those received by the rest of the community at National, Municipal and Provincial Hospitals.

[15] Resolution 18. Section 3: The Executive Director has authority to: elaborate a program of activities aiming to detect and investigate the human retrovirus and its related pathologies, their diagnosis and treatment, their prevention, assistance and rehabilitation, as well as avoid their spreading.

and it is attached as Annex I, together with Resolution 709/97 of the General Administration of Medical Insurance on monthly coverage of AIDS medicine (Annex II).

A few days after the signing of the "Declaration of Paris"[16], in early 1995, the Executive Power approved the Decree 906, which obliged all members of the Armed Forces and Security Forces, including civilians, to have an HIV test. This decree violated Law 23798.

Private and Public companies in Argentina usually request the HIV test to their employees or to those applying for a job. Not everybody knows that this request is illegal, and those who do know sometimes agree to have the test to avoid losing their jobs or in order to get a new one.

In 1995, Law 24455: "Workers' Healthcare Schemes: Healthcare Coverage for AIDS Patients and Drug Addicts" was passed. The author of this law was a congressman of the opposition party. The Law established which services Workers' Healthcare Schemes ought to provide to HIV/AIDS patients and drug addicts[17]. Workers' Healthcare Schemes expressed their disagreement to this obligation of providing medical and psychological treatment and medicines to HIV/AIDS patients and many of them did not or tried not to fulfill this obligation. The complaints and *amparo* actions [*legal proceeding for the protection of constitutional guarantees]* submitted by the patients were effective, especially to guarantee the supply of medicines.

In 1996 Law 24754 "Obligatory Medical Services" was passed and established that all private medical insurance schemes were obliged to provide treatment and medicines to HIV/AIDS sufferers.[18]

In 1996, The Ministry of Health and Social Welfare approved the Obligatory Medical Program (PMO) for social medical security, which included a complete coverage of treatment and medicines for people living with HIV/AIDS[19]. In 1997 the provisions of this law became also applicable to private medical insurance.

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[16] The Paris AIDS Summit, organized by the French Government, took place on 1st December 1994 and called together the Heads of State of all countries to sign a Declaration which resulted from the work of the governments, people living with AIDS and NGOs. This declaration states that governments should give priority to the fight against AIDS and to ensure that people living with AIDS are able to exercise completely and on an equal footing their fundamental rights and liberties". Among other commitments the declaration states: "To give NGOs, associations and people living with AIDS complete participation in the activities developed by public authorities; and to ensure that people living with AIDS enjoy equal protection before the law regarding access to healthcare, employment, education, freedom of circulation, housing and social protection".

[17] Law 24455. Section 1: Every Workers' Healthcare Scheme of the National System should include the following medical services: medical, psychological and pharmaceutical treatment for people infected with any of the human retroviruses and Acquired Immune Deficiency Syndrome (AIDS) and/or related diseases; medical, psychological and pharmaceutical treatment for people with a physical or psychological addiction to drugs; coverage for AIDS and drug prevention programs.

[18] Law 24754. Section 1. Ninety days after the passing of this law, those companies or entities offering private medical insurance should include in their medical schemes at least the same obligatory medical services prescribed by laws 23660, 23661 and 24455 and related regulations for Workers' Healthcare Schemes.

[19] Resolution 247. Section 1. The Obligatory Medical Program (PMO) for medical insurance agents included in section 1 of Law 23660 is hereby approved. Said section 1 shall be included herein as Annex I.

In 1997 by virtue of Resolution 346, the Ministry of Health and Social Welfare changed the HIV/AIDS medicine purchase and distribution system, which became the responsibility of the National Department of Services Regulations at the Undersecretariat of Medical Treatment. This resolution established the responsibilities of the National Program against the Human Retrovirus – AIDS as follows: a) the assessment of necessities; b) technical specifications of products to be purchased; c) technical report as regards the contents of offers during the purchasing process; d) determination of quantity and quality of products to be distributed in entities and jurisdictions. This resolution de-centralized the distribution of medicines on the grounds of " the necessity to supply medicines in those places where treatment is provided" and "the optimization of the services offered to patients avoiding moving and other inconvenient" . Moreover, the National Ministry of Health signed several agreements with provincial ministries, committing itself to provide drugs to treat those HIV/AIDS cases reported by each province. These agreements established joint responsibilities between the nation and the provinces. However, the main responsibility rested in the National Ministry according to the AIDS Law.

In 1998, the Ministry of Health and Social Welfare signed an agreement with the Universities of Buenos Aires and Rosario in Santa Fe province by means of which the University of Buenos Aires would be responsible for the viral charge tests of patients in the province of Buenos Aires and all the southern provinces and the University of Rosario would be in charge of those tests for the province of Santa Fe and northern provinces. This agreement is still in force.

IV THE ROLE OF SOCIETY AND THE RIGHT TO HIV/AIDS HEALTHCARE

Even though in Argentina has been an important tradition of associations dating back to the 19th century, it is in the last twenty years – especially after the last military dictatorship – that the NGOs acquired their current structure and became visible players on the national scene. In the healthcare sector this owes itself to a role change among many of them. Before they provided support to services provided by the state but now they are more involved in the protection of rights, for example the right to healthcare.

The majority of NGOs involved in HIV/AIDS in Argentina have been established during the second half of the 1980s or at the beginning of the 1990s, focussing their activities on prevention, training of different social groups, helping people living with HIV/AIDS, raising awareness of the population and political decision makers, strategic lobbying,

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Resolution 625. Section 1. The HIV/AIDS Coverage Program for those people infected with any of the human retroviruses and Acquired Immune Deficiency Syndrome (AIDS) and/or related diseases provided for in Law 24455 and its Regulating Decree No 580 of 12 October 1995 is hereby approved and attached to this law as Annex I.
Resolution 709. Section 2: Insurance agents shall provide coverage to their beneficiaries who are affected by HIV/AIDS or have a physical or psychological drug addiction. Said coverage shall include the drugs included in the Vademecum and authorized by the National Ministry of Health and Social Welfare, according to the therapeutic doses recommended by medical prescription and the modules and values specified in Annex I and II of this resolution.

activism and research. According to Biagini and Sanchez [20], the NGOs involved in HIV/AIDS introduced into Argentina "a speech which defends sexual freedom, annuls discrimination, demands equal sexual education and promotes prevention and self-care practices…"

Moreover, since the end of the 1980s, the NGOs involved in HIV/AIDS have developed an important activism, although not very articulate at first but with better co-ordination in recent years. In 1994/1995, several NGOs relayed the Paris Declaration [21], as a formal commitment from the government to take specific steps on HIV/AIDS. In 1995, some NGOs advised and supported the passing of law 24455: "Workers' Healthcare Schemes: Healthcare Coverage for AIDS Patients and Drug Addicts"

Concerned by the lack of official prevention activities and the low budget for the national AIDS program, in 1995 several NGOs lobbied the national congress when the health commission of the lower chamber was holding meetings to discuss the budget for the HIV/AIDS program. The NGOs' main demand was that a specific part of the national budget for HIV should be allocated to prevention and education, and that the provisions of medicines should be regulated because the supply from the Ministry of Health was irregular and the workers' healthcare schemes did not cover for them. The NGOs were unsuccessful and the 1996 budget was clearly insufficient.

By the middle of 1996, the national AIDS program budget in Argentina - $19 million – was insufficient to meet the needs of a growing requirement for medicine and healthcare for AIDS sufferers, due to a marked increase shown by the epidemic that year. Nevertheless, a few months later, the Ministry of Economy twice cut the national AIDS program budget again, which amounted to a decrease in the purchase of medicines resulting in a number of serious consequences for HIV/AIDS sufferers. One can say that this is considered to be the most critical and most inconvenient period in the supply for such medicines.

The expectation of combined therapies, which arose from the XI International Conference on AIDS, held in Vancouver in July 1996, increased the tension at national level between people living with HIV/AIDS and the national government. The auspicious results of this "cocktail" were widely spread and generated a popular demand and increased tension because of the inability of the Ministry of Health to provide this form of medication due to the small budget.

Although there were previous formal attempts to establish networks of organizations working with AIDS, at the beginning of 1996 the Meeting of NGOs working in the field of HIV/AIDS was created, a coalition of NGOs that nowadays has up to 60 organizations countrywide and has held two national meetings.

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[20] Biagini, G. y Sánchez, M: "Social Players and AIDS. New social movements? New health agents? Non governmental organizations in Argentina and the HIV/AIDS Complex". Espacio Publishers. Buenos Aires, Argentina. 1995.

[21] See Note No 16

During 1996, the AIDS NGOs attended several meetings with national congressmen to discuss a draft law which made it compulsory for private medical insurance companies to cover the provision of care and medicines for HIV/AIDS. This law was presented and passed during that year under number 24754.

On 29 November 1996, eight of the NGOs belonging to the Meeting of NGOs working in the field of HIV/AIDS– Asociacion Bengalensis, Fundacion Descida, FEIM, Fundacion R.E.D., Intilla, Asociacion Civil, CEDOSEX, SIGLA and FAPANS – submitted a joint *amparo* action against the National Ministry of Health and Social Welfare for the failure to supply medicines to people living with HIV/AIDS, in accordance with Law 23798. 72 hours after serving it, the *amparo* action was sustained by the judge, obliging the Ministry to provide this medication, while the case was being investigated.

During 1996 and 1997, these NGOs received numerous complains from people living with HIV/AIDS, some of whom had cover with workers' healthcare schemes which failed to provide them with medication. Others, without such coverage, were trying unsuccessfully to get medicines through the Ministry of Health.

These people began *amparo* proceedings against their healthcare schemes and also against the Ministry. Not all people living with AIDS were able to file these *amparo* actions, which meant making public their serologic state, a situation which implied for many of them serious social, work, economic and family consequences, and the payment of costs to lawyers. The joint *amparo* action of the NGOs was therefore important.

In February 1998 the Administrative Court confirmed that "The Ministry of Health has not met its obligation, as a national authority, with respect to AIDS, help and treatment of AIDS sufferers, including related pathologies, putting at great risk not only affected patients, but the whole community, violating the provisions of the law". The judge ordered the Ministry "to comply with its obligation to assist, treat and especially provide medicines – continuously in the proper way and at the right time – to those HIV/AIDS sufferers who are registered in hospitals and clinics in the country".

The Ministry of Health appealed against the sentence, casting doubt on the legitimacy of the NGOs to represent people living with HIV/AIDS. The judge confirmed "I have no doubt about these entities being competent to present this case because they develop activities which benefit the whole community, such as education and spreading information, particularly with respect to certain parts of the population affected by the consequences of the virus". Moreover, the Ministry was ordered to pay the legal costs.

This court sentence constitutes an important precedent not only in Argentina but also in the region, committing the national authorities to provide healthcare to HIV/AIDS sufferers. In 1998, as a direct consequence of this legal process and the lobbying by the NGOs of the national congress, the national AIDS program budget increased to $70 million (in 1997 it was $19 million), and the supply of medicines was largely regularized.

In February 1999, the National General Attorney reaffirmed before the National Supreme Court the sentences, pronounced at first and second levels, which obliged the Ministry of

Health to provide complete cover for medicines, diagnosis and treatment for all people living with HIV/AIDS in Argentina. In his writ, the General Attorney referred to "the legitimacy of the plaintiff to carry out this *amparo* action in defense of its interests and those of whom they represent". He affirmed "I believe I had to clarify that, since the statutes of the NGOs (plaintiffs in this action) provide for the fight against AIDS, consequently they are legitimately allowed to file an *amparo* action against the inaction of the state for presumed failure to comply with law number 23798 (AIDS law) and its regulating decree". This is what I think every time they try to base the legitimization of their action, not only in the vague interest of observing the law and the constitution but also in their capacity as holders of the right of collective incidence to protect health, which is made up of prevention, assistance and re-habilitation of those patients suffering from the Acquired Immune Deficiency Syndrome and its related pathologies. Moreover, they have the right to take legal action in order to perform one of their duties, in this case combating AIDS". The General Attorney concluded "the state is obliged to supply the reactive and medicines necessary for the diagnosis and treatment of this illness. In addition, section 8 of the AIDS law expressly recognizes the right vested in carriers, infected or already ill, to receive proper attention".

Since the beginning of the 1990s people living with HIV/AIDS have started taken some coordinated action promoting a greater public awareness of the issue and working for the defense of human rights of those affected. In 1998 the First National Meeting took place and established The Argentine Network of people living with HIV/AIDS. All of this represents a strong social organization for HIV/AIDS and achievements which are not seen in other cases of protection of the right to healthcare.

"The Argentine HIV/AIDS Situation"

The first people infected with AIDS in Argentina were registered in 1982, since when the number of sick people has increased significantly, reaching very high levels of incidence and prevalence in certain areas of the country in 1998. In addition, one can see in recent years that the epidemic has a marked tendency to affect the most vulnerable and unprotected parts of the population, such as women, young people and people with few economic resources.

According to the National Program against the Human Retrovirus and AIDS, (PNLRHS) the number of AIDS sufferers in Argentina on 30 November 1998 was 13,789 people, of which 10,887 were men and 2,790 were women [22]. Taking into account the delay in notifying newly infected people, the PNLRHS estimated that on 30 November 1998 the real number of infected people was 16,025. However, in our opinion and that of many NGOs working on HIV/AIDS, the number of infected people is considerably greater, owing to the delay in notification which is longer than that recognized by the ministry, and to this one must add "under-registration", whose impact is unknown nor recognized officially.

[22] Bulletin on AIDS in Argentina. National Program against the Human Retrovirus, AIDS and STD, Ministry of Health and Social Welfare. Year V, Nro. 15. December 1998.

According to official information 36.2% of the country's infected people were diagnosed in the last two and a half years. If one add to those the sufferers diagnosed in 1995 more than 50% of sufferers have been diagnosed in the last 4 years. In 1998 every province in the country reported cases of AIDS. The greatest concentration was registered in the province of Buenos Aires (42%) fundamentally in Greater Buenos Aires, followed by the city of Buenos Aires (34%), the province of Santa Fe (7%) with the greatest concentration in the city of Rosario and lastly the province of Cordoba (4.5 %). 88% of AIDS sufferers live in highly populated urban areas, where 64% of the total population live. This shows that HIV/AIDS is predominant in urban areas, not only because they usually live there, but also because they migrate to cities where they can maintain anonymity about their serological status and obtain better access to healthcare in terms of quantity and quality.

An important change in the Argentine epidemic occurred in recent years which was the incidence according to gender. At the start of the epidemic, sufferers were fundamentally male. The first female sufferer was diagnosed in 1987. In 1988 the male/female ratio was 14:1, this fell by 1990 to 6,7:1 and since 1993 it has remained under 4 males to each female, with an increasing but slight tendency to fall further. In 1997 it stood at 3:1.

The average age of people infected was falling in the course of the epidemic, currently standing at 31 years of age for males and 24 years of age for females. One can see that females become infected earlier than males and that 48% of the females infected are between 15 and 29 years of age, while 40 % of males correspond to that age group. Inversely, in the 30 to 44 year age group men represent 45 % while women fall to 30%.

Also the patterns of transmission have changed following the spread of the epidemic among heterosexuals and intravenous drug users. This increase turned women, young and poor people into the most vulnerable group. The increase in HIV/AIDS incidence in women also raised the risk of mother/child transmission, which in Argentina corresponds to 7.2% of all the cases, one of the highest in the region. Currently, the most important form of transmission in Argentina, for men as well as women, is via sexual contact (47% in both sexes), followed by blood mainly by intravenous drug users. The latter trend is more prevalent among males (46%), and lower in females (33%). The evolution of the different forms of transmission of those older than 13 years of age in Argentina shows that homo-bisexuality increased up to 1994. Afterwards the figure stabilized and in 1997 there was a slight decrease. The forms of transmission via heterosexual sex and intravenous drug use have increased equally since 1990. Until 1995, intravenous drug use as a means of transmitting the disease was higher in incidence than heterosexual sex. Since 1996 the latter has predominated; the number of sufferers who said they became infected via heterosexual sex was 89 times higher than in 1987 and is still rising.

In Argentina, the mortality statistics for AIDS can be obtained from two sources: vital statistics from the National Health Statistics Program through death certificates obtained in the civil registries; and the National Program against the Human Retrovirus, AIDS and STD which receives specific information on death caused by AIDS through the provincial programs. The "under-registration" and the lack of notification of deaths to the PNLRHS is very significant and becomes more so with time. The average rate of "under-registration" is between 50 and 70%. It is necessary to verify these figures with the National Program of

Statistics which, in general, has a lower "under-registration" rate of deaths, but which for HIV/AIDS it is unsure of because of problems due to death certifications and/or the non-specification of cause. According to information published by the Ministry of Health the rate of mortality in 1990 was 52.3% of registered sufferers, with a downward tendency towards 1993, which was 23.8% and in 1995 there was another small peak at 27.9%. It has been falling since 1995 and in 1997 was 14.5 % [23]. According to PNLRHS the drop in deaths between 1995 and 1997 is due to the larger number of people who underwent combined therapies and to the prevention of other illnesses, due to the improvement in registration through monitoring. We do not share this sole explanation, firstly because there is still considerable "under-registration" where more die than the official figures state; and secondly because treatments at this time were still not available to all of the ill and infected.

According to the Ministry of Health Bulletin, there is a tendency in the city of Buenos Aires since 1987 that shows an increase in the mortality rate in young people groups: from 20-29 years of age and from 30-39 years of age. In the province of Buenos Aires the increase in the mortality rate in young population started in 1989 but showing a smaller difference with other age groups than the one in the city of Buenos Aires. In the province of Cordoba, this mortality rate has increased since 1991 but figures are lower since all age groups are affected by mortality uniformly.

If one considers the gender variable, the greatest impact upon the mortality rate is among 20-39 year old males, in the city of Buenos Aires the rate of mortality for this age group is 250% above the total. Among females, the mortality rate registered a sustained increase, even though there latterly appeared, especially among the youngest, according to the evolution of incidence.

Argentina is the fifth ranking country in the American continent in terms of the number of AIDS sufferers, behind the United States, Brazil, Mexico and Canada. However, if we take into account the rate of incidence, Argentina with 61.2 per million rate is fourth after the U.S (234.1), Honduras (201.3) and Brazil (103.7)[24]

It should be noted that the total number of people living with HIV in Argentina is unknown. Law No 23798 (National AIDS Law) in its section 10 establishes the obligation to notify the authorities about AIDS sufferers and their death but it does not provide for the notification of those infected with HIV. The PNLRHS receives notifications from the provincial programs. This notification is carried out by filling a special form in the hospital where the person has been treated. The details requested in the form are age, sex, residence, form of transmission and education. The process of filling the form and sending it to its corresponding jurisdiction and then to the National Register is slow. There is a significant delay which worsened due to the increase of sufferers.

Just in 1996, the diagnosis date of the illness was included in the notification form[25]. The lack of data which would allow to calculate the delay between the diagnosis date and the

[23] Bulletin on AIDS in Argentina. PNLRHS, Year V, Nro. 14. July 1998.
[24] Aids Monitoring in the America continent, quarterly report updated March 1998. WHO
[25] Interview with Dr. Claudio Blosch, epidemiological at PNLRHS

notification date is one of the factors that prevents this system to improve in order to obtain an accurate magnitude of the epidemic. According to the National Program, the data recollection has improved since 1996, pointing out that 75% of sufferers notify the authorities about their illness within a year after the diagnosis and 95% within two years after the diagnosis. However, this information does not match with the results of the investigation of the Epidemiological Situation of AIDS in Latin America and the Caribbean coordinated by Izazola Licea [26]. According to him, "the probability of being notified within six months of a new AIDS case is of 46% and 64% within 12 months". Moreover, this publication states that the notifications are often incomplete and for example, 86% of them do not specify the diagnosis date. Compared with other countries such as Chile, Mexico and Brazil, Argentina most lacks this information.

There exists also a significant "under-registration" of new AIDS cases due to the lack of either diagnosis or notification. Since 1988 the estimates for AIDS sufferers was higher than those which have been reported. In 1997 this gap reached the top. Failure to obtain more real and reliable records prevents us to know the real magnitude of the epidemic and hinders the possibility of measure the evolution and obtain estimates of treatment needs for the near future.

Since 1998, the PNLRHS has been carrying out epidemiological monitoring studies in the whole country in order to have a more accurate idea on the epidemic evolution. They have been collecting systematically information on the infection prevalence in certain population groups. They collected information from the following groups: pregnant women, people requesting STD services, people entering the Armed Forces, prisoners, intravenous drug users and regular lab users. Until November 1998 only 13 jurisdictions and the Armed Forces had provided data. The majority of the information submitted was obtained from blood banks and pregnant women from 5 provinces. Information obtained from people requesting STD services, prisoners and intravenous drug users groups was extremely poor and was only provided by one or two provinces.

There is also a big disparity in the number of samples included in each population group and each province. This shows the relativity and caution with which this information should be interpreted due to the fact that the samples were taken from small groups of people and from very few provinces. With these statistics, one cannot describe with certainty the epidemiological profile of AIDS as carried out by PNLRHS, which qualified it as: **Concentrated**, because the prevalence of HIV is greater than 5% of the population of risk and less than 5% of pregnant women; **urban**, because the majority of cases occur in communities with more than 50,000 inhabitants; **inclined towards the poor**, because those who become ill are people with low socio-economic and educational levels and without regular job; **marginalization**, because the people are socially excluded; and **the female dimension**, because of the large rate of growth of the illness among women.[27]

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[26] Izazola Licea, J.: Epidemioligic and economic situation of AIDS in Latin America and the Caribean.
[27] Bulletin on AIDS in Argentina. National Program against the Human Retrovirus, AIDS and STD, Ministry of Health and Social Welfare. Year V, Nro. 15. December 1998.

This description of the epidemic, in our opinion, needs more evidence based on epidemiological monitoring studies and a higher number of detailed observations covering a larger amount of the population. It is vital to reduce the time taken to send this information in order to obtain more up-to-date knowledge of the epidemic. The current method of collecting information about the prevalence among different groups of population as carried out by PNLRHS is a necessary job to keep with the understanding of the AIDS situation, but it is still highly insufficient, not only because of the scarcity of centers that carry out this work, but also because of the small number of provinces that take part, which we believe should be improved and maintained.

VI THE PROCESS OF PURCHASING AND DISTRIBUTION OF MEDICINES

a) Study methodology

In order to study the mechanism for the purchase and distribution of medicines and their provision to people living with HIV/AIDS, interviews were undertaken with different players at national and provincial levels, with public health sector professionals, NGOs representatives and groups of people living with HIV/AIDS (PLWAS). These interviews were carried out personally by the researchers or by telephone on the basis of a questionnaire containing open questions specially designed for this purpose, which is included as Annex III of this report.

Despite delays in carrying out some interviews, generally they were completed according to schedule, except for a key interview with the authorities for the purchase of medicine and its distribution, in other words, the management group of PNLRHS which comes under the National Department of Services Regulations . This interview did not take place despite a written request and one by telephone. The authorities responded in writing to the request for information but did not complete all the questions nor did they clarify certain points. This information was received during the final revision of this work and it was necessary to include it and therefore delayed finishing the work.

As regards the provincial programs, we gave priority to the province of Buenos Aires program analysis because this province has the greatest rate of incidence and prevalence of HIV/AIDS and in this province there is the largest number of sufferers registered in absolute terms.

The people that were interviewed were officials from PNLRHS, officials from the AIDS Program of Buenos Aires province, Heads of hospital services from the city of Buenos Aires and Greater Buenos Aires, recognized by their work with HIV/AIDS sufferers, representatives from NGOs working with AIDS and PLWAS from different organizations. The list of those interviewed is attached as Annex IV.

b) Beneficiaries

Nationally, PNLRHS is responsible for the provision of medicines. These are supplied free of charge to those people without healthcare schemes if they are insolvent or without means of support. Those people covered by workers´ healthcare schemes or private medical

insurance should request medicines through the administrators of their schemes according to laws 24455 and 24754.

PNLRHS also provides coverage and prescription of treatment to poor people and those without healthcare schemes. PLWAS living in the city of Buenos Aires and the south of the country have to undergo the viral charge test in the Buenos Aires Medical Faculty and those living in the northern half of the country have to undergo it in the Medical Faculty of Rosario University, according to agreements signed by the National Ministry of Health with both universities in 1998. These tests are free but there are considerable delays, therefore many people have the viral charge test privately, even in the above-mentioned faculties where, if you pay, the test is done without delay.

According to the statistics from the PNLRHS up until December 1998, they provided HIV/AIDS medicines to 10,104 people without discriminating between the infected and the sick. According to the information provided by the National Department of Services Regulations in the period July/December 1998 a total of 12,539 patients were helped. In table No 1 the total number of patients undergoing treatment is shown according to jurisdiction and health centers, such as Garraham Hospital (children), Posadas Hospital (in Greater Buenos Aires) and the Federal Prison Service. If one considers the estimated number of sufferers since 1982 and the AIDS mortality rate one can conclude that there is a considerable number of infected people undergoing treatment and that the real number of sufferers is, as we have already said, under estimated.

TABLE No 1
TOTAL NUMBER OF PATIENTS ASSISTED BY THE PROGRAM – MAIN JURISDICTIONS. July/December 1998 period

Jurisdiction	Patients
Government of the city of Buenos Aires	4728
Province of Buenos Aires	2474
Santa Fe	600
Cordoba	533
Garraham Hospital	310
Posadas Hospital	299
Federal Prison Service	209
Other jurisdictions	3386
All jurisdictions	12539

Source: PNLRHS. National Ministry of Health and Social Welfare. March 1999.

According to the AIDS Program in the province of Buenos Aires, 2,800 people were receiving treatment in January 1999 of which 72% were receiving protease inhibitors in combined schemes. According to information provided by the National Ministry, 2,474

people in the province received treatment for free during the July/August 1998 period. As one can see, the figures presented by national and provincial bodies are not the same which could be due to the different periods looked at by each body. Table No2 shows quantitative information about the use of protease inhibitors during the period July/December 1998.

TABLE No 2
Estimates for Consume of Protease Inhibitors
Health Secretariat. July-December 1998

Total Treatments	Months						
	July	**August**	**Sept.**	**Oct.**	**Nov.**	**Dec.**	**Average**
Indinavir	2560	2974	2415	4996	2443	3915	3234
Saquivosis	344	623	651	640	558	581	566
Ritovosil cap.	1019	932	55	653	791	147	599
Ritovosil syrup	26	51	61	132	226	422	153
Nelfonovir syrup	-	3	6	16	26	34	14
Nelfonovir cap.	54	87	152	464	407	557	287
Total	**4003**	**4670**	**3433**	**6901**	**4451**	**5656**	**4853**

Source: PNLRHS. National Ministry of Health and Social Welfare. March 1999.

There is a frequent relationship with patients suffering from lung tuberculosis (23%) assisted in the Province of Buenos Aires and with those suffering from extra-lung tuberculosis. In AIDS and Tuberculosis cases, medication for the latter is received from the National Tuberculosis Program through the Provincial Program.

c) Legal Regulations for purchase and distribution

In 1997 the Ministry of Health and Social Welfare of the Nation adopted resolution 346 whereby it modified the responsibility and mechanism for the purchase of medication for HIV/AIDS and opportunistic infections. It also established a different distribution system to provincial programs and its entities**.** This resolution set forth that the PNLRHS –National Program against the Human Retrovirus, AIDS and ETS- is in charge of determining the technical specifications of the products to be acquired and the amount and quality of such products. The National Department of Services Regulation by means of the Management sector is in charge of purchasing medicines, monitoring reception thereof, storing and control of stock, as well as distribution of medicines to provincial programs and its entities. Moreover, medicines are delivered and distributed directly to PLWAS in the Ministry.

To such effect, the PNLRHS, with the assistance of a committee of experts and internationally renowned scientists specially constituted to that effect, updates state-of-the-art treatments and Vademecum of medicines for HIV/AIDS, available in public services countrywide for the treatment of people at the Public Health Sub-sector. According to the latest update, this Vademecum not only includes the antiretrovirals, but also the antibiotic, antiretrovirals and general medicines, for the treatment and prophylaxis of opportunistic infections; not for the treatment of tuberculosis which is treated through the National

Tuberculosis Program and its respective provincial programs. The updated Vademecum is attached hereto as Annex I.

Purchase of medicines is performed by means of public biddings carried out by the National Ministry through the Management sector of the National Department of Services Regulation. The new regulation was intended to decentralize delivery and provision of medicines to persons living with HIV/AIDS. Medication is thus delivered to the Hospital or other entities so people do not need to go to the Ministry any longer to get their medication. It must be noted that, until the end of 1997, when this regulation was issued, even residents of the provinces had to come to Buenos Aires to obtain their medicines. **With the new regulation, as stated by professionals and NGOs and PLWAS representatives, total de-centralization was not achieved at the Hospital, but delivery of medicines improved in part.**

It must be noted that according to the report from the National Department of Services Regulation –Management sector-, medication was delivered to an average of 956 persons per month during the period July-December, 1998. As from September, the number of patients going to the Ministry increased to 1604 in December. In a brief statement accompanying these statistics, the Management sector ascribes this increase to problems in relation to the provision of a specific medicine (Ritonavir), since the laboratory stop that for of container**,** as well as to the fact that many patients started the treatment and were then unable to complete the documentation for the drugs to get to the hospital, and so chose to go directly to the Ministry.

TABLE 3
Patients receiving medication at the
Health Ministry from July to December, 1998

Month	**Number of Patients**
July 1998	400
August 1998	966
September 1998	1181
October 1998	1233
November 1998	1413
December 1998	1064

The report also indicates that the increase of people obtaining their drugs at the Ministry is due to lack of medicines at hospitals, deriving from delivery problems by the laboratory, as in the case of Ritovar in capsules mentioned above, and/or to the non-delivery at the right time and in the proper manner at hospitals due to delays in distribution within the jurisdiction. This last cause does not coincide with the information provided by hospital representatives, ministry authorities and PLWAS in the two jurisdictions that were interviewed. According to them medicines are not purchased in a timely manner and in

sufficient quantities, therefore, PLWAS and/or relatives obtain from hospitals the available drugs and complete the amounts required for the month at the Ministry.

The Management sector report states that lack of delivery of some medicines by some laboratories compelled patients under treatment in the city of Buenos Aires and the great Buenos Aires to obtain medicines that were not available at hospitals where they are treated from the Ministry. Under this circumstances, equally addressed in both reports, we may assume that patients from far away provinces were not able to reach the Ministry for distance or economic reasons, and also had problems with the provision of medicines. This could not be verified as we did not analyze the situation in other provinces due to limited time and funds for this study. However, we know that discontinuous provision is detrimental to the result of the treatment. We may assume that this situation affected approximately 20 to 30% of the patients during the last semester.

According to the physicians that were interviewed, in many instances, patients and relatives go from the hospital to the Ministry and they do not obtain all the medication prescribed for the month. This is due to: unavailability of medicines included in the Vademecum at hospitals or the complete dose for the month, in which case hospitals provide drugs for one or two weeks, or unavailability of one or more types of medicines because they were not purchased or delivered in time. Both the official report and the opinion of the professionals interviewed indicate that more than a year after the application of the new regulation, distribution problems continue, thus affecting people under treatment, as analyzed below.

d) Administrative process to allow access to medication

Together with the new regulation for the purchase of these drugs within the Health Ministry, resolution 346/97 established the responsibilities of beneficiaries of hospitals, provincial programs, and provincial health ministries for the treatment of HIV/AIDS. Below there is a revision of the administrative procedures to be followed by patients with HIV/AIDS to access to medication once prescribed by the doctor.

Necessary documentation

To obtain medication free of charge through the PNLRHS, HIV/AIDS patients must submit the documentation detailed below:

1. Summary of the patient's clinical history stating diagnosis with Elisa Test and confirmation with Western Blot, CD4 dosage, and viral charge**.**
2. Medical prescription indicating drug(s) and dose(s) in detail.
3. Social survey carried out by the hospital's social service or other public authority showing that the patient does not have economic resources to afford purchase of medication.
4. Certification issued by ANSES - National Administration of Social Security -, entity in charge of coordinating all Medical Social Security systems in Argentina, stating that the patient does not have medical coverage under Social Security.

5. Certification issued by PAMI (Pensioners' Healthcare Scheme) stating that the patient does not receive disablement or incapacity pension, and is not a beneficiary of any other pension whatsoever.

Documentation indicated in items 1, 2, and 3 must be issued at hospitals or public health centers. PLWAS must obtain necessary documents by themselves or through their representatives: relatives, friends, or others. Once obtained they can either a) take them directly to the Health Ministry, Management sector, or b) submit them to the hospital where they receive treatment. In this case, the hospital sends all documentation to the PNLRHS together with a request table for purchase of medication especially prepared and completed by the hospital and another request corresponding to the Provincial Program. If documents are presented in the Management sector of the Ministry, the process is shortened and medication is received earlier. In any of the above two alternatives, it must be noted that such documentation must be renewed every three months. This means that the process of gathering the documentation and submitting it must be repeated four times a year.

We investigated how long it takes to obtain all documentation, and found that a minimum of two to four weeks is required. Considering that this must be repeated every three months, only gathering all paperwork takes from three to four months yearly.

The patient's or other person's time is not taken into account by government officials. When they establish and inform how long it takes to obtain medication, they only consider the time from the moment the request is received by the PNLRHS to the time it is sent to the hospital or other entity. The National Ministry of Health estimates that this process takes one month, as stated by the interviewed professionals. However, if we add at least 15 or 30 days to this period to complete the documentation, plus the hospital's delay to process documentation as well as the delay at the provincial level, the minimum time from prescription to reception by the patient varies from two to three months, if medicines are ordered through the hospital. If the process is started at the Management sector of the Ministry it may be reduced 15 to 30 days.

e) The Process of Purchase and Distribution

As prescribed by Ministry Resolution 346/97, the National Department of Services Regulation is responsible for the purchase and distribution of medicines through the PNLRHS's Management sector. Purchases are made through public biddings. On September 28, 1998, the Ministry approved Resolution 763 whereby request and distribution proceedings are ruled by the Management sector. On the basis of this resolution, the two alternatives described above to obtain medication are recognized: 1) through jurisdictions, via hospitals and 2) through the Management sector, at the Ministry's offices. In the latter case, the patient or a representative may start the process.

When the request is made through the jurisdiction, the process is started at the hospital or other entities which sends to the responsible jurisdictional authority a monthly table with the medication request, and where the patient's personal data and required documentation mentioned above is stated. The jurisdictional authority is the only officer authorized to

present requests to the Management sector of the Program at the National Ministry. Requests should be made within the first fifteen days of each month. It must be signed by the jurisdictional authority and accompanied by the forms from the hospital or entity. Such forms with the medication prescribed by physicians must be signed by the hospital chief of services. In the provincial programs, forms from different public entities are summarized in a monthly TABLE to be sent to the Ministry's Management sector. Moreover, the jurisdictional authority must inform about new treatments, deaths, quits derived from the patient's decision and suspensions ordered by the doctor occurring on such month.

Once requests are received, the Management sector sends them to the Storage Department and notifies the jurisdiction which is in charge of picking up the medication from said Department within 3 working days after notification. In the event the jurisdiction fails to do so, the Management sector will order the jurisdiction to get the medication within the following 3 days. If this new term is expired, the medication may be distributed to other jurisdictions or delivered directly to the Management sector.

Once medication is received by the province, the jurisdictional authority distributes it to the different hospitals where it is stored in the pharmacy. Patients must pick up their medicines against presentation of the medical order in the hospital's pharmacy and sign a table which the jurisdictional officer sends to the Management sector. Each hospital receives medicines assigned to people with the corresponding personal data, thus medicines are only delivered to the patient or his/her agent, otherwise they must be sent back to the Ministry.

In cases of direct delivery to the patient through the Management sector, the patient and/or his/her agent must get medicines in such area. **The Ministry Resolution states that this procedure and direct delivery at the Ministry shall only be made after all jurisdictions' requests are fulfilled.** We must recognize that this was not fulfilled since from October 1998, when this resolution was sanctioned, to December 1998, the number of people requesting medication directly at the Ministry increased, as stated above.

This increase was expected since delays are reduced by avoiding the bureaucratic process at the hospital and/or jurisdiction, not only in relation to the request process but also at the time of distribution. Obviously, only people living in Buenos Aires or suburbs or those who have money and time can access the Ministry. Unemployed people or people with a minimum salary, which constitute the majority among those who live with the HIV/AIDS, or living in the provinces, cannot obtain medication at the Ministry. Thus the mechanism of request and delivery at the Ministry, which implies free attention and better quality of healthcare only benefits those who live in Buenos Aires or nearby, and those who have enough economic resources and time evidencing once again the system's inequality and injustice. This is a violation of basic human rights of poor people living with HIV/AIDS in the provinces, who should be benefited by the free delivery of medicines, rather than being discriminated and excluded from the Public Health System in Argentina.

Those involved with the AIDS Program in the Province of Buenos Aires inform that the procedures established by the Ministry does not permit to stock drugs, only the medication ordered by each patient under treatment is delivered on a monthly basis. Provincial officers state that, even though during the last year provision of medication is being complied with

at the right time and in the proper manner, some drugs, such as 3TC and Daraprin were not in stock, or sometimes, as it happened at the beginning of 1999 only half doses of some medications were delivered.

This lack of stock in the AIDS Provincial Program and lack of medication at the Ministry which hinders provision to the provinces, derives in difficulties and delays in treatments, particularly in the case of pregnant women and patients with intolerance to treatment, whose medication must be changed and thus a new treatment started. In this situation the Province of Buenos Aires prepares its own stock by buying a certain amount of medicines calculated on the basis of 2% of the prevalence of people with AIDS in the province. This purchase is made every three months through public biddings. However, the Province had to resort to direct purchase on some occasions, when it did not receive the medication requested from the National Program and did not have enough stock.

In relation to the prophylaxis program for pregnant women, the province of Buenos Aires has its own AZT stock which was bought directly. The calculation for this purchase was made on the basis of the 2% of seroprevalence in pregnant women shown by epidemiological studies. The AZT is available in zonal hospitals, and the AIDS Provincial Program sends medication to these hospitals every six months.

Professionals interviewed at hospitals of the City of Buenos Aires and Great Buenos Aires stated that some drugs are not provided on a regular basis, and sometimes the medication delivered is not enough to meet all the demand. They also said that frequently some medicines are unavailable at the Management sector or they are not delivered in the amounts requested. This means that the patient must go to the hospital or national or provincial ministry more than once a month to obtain the complete medication for one month treatment. This prejudices continuity of treatment, and implies more money and time which sometimes results in health problems or treatment abandonment.

In general, public hospitals countrywide do not have a complete stock, and provinces do not buy medication to have their own stocks. Only AZT is purchased on a regular basis to be used in case of work accidents, as provided by regulation for the whole country in 1998.

The experience described in relation to delivery of medication to PLWAS in the Muñiz Hospital of the city of Buenos Aires, specialized in infectious diseases, from the Posadas Hospital, important entity of the Great Buenos Aires, was different. At the Muñiz Hospital, it was informed that, theoretically, all medication should be delivered at the hospital. However, in practice, patients get one or two drugs from the hospital and the rest from the Health Ministry. At the Posadas Hospital, PLWAS get medication from the hospital only. The hospital receives, in general, the medication it requests, although unavailability and delays have been informed, which negatively affect treatments. The Posadas Hospital is far from Buenos Aires, thus being difficult for PLWAS to reach the Management sector at the Ministry to obtain the medication which is not available at the hospital. It must be noted that a large number of people treated at the Posadas Hospital live in poverty , so travelling to the Ministry is even more difficult for them.

The AIDS Program of the province of Buenos Aires informed about the existence of problems in relation to transportation of drugs. Medication must be transported in trucks escorted by security personnel. Such transportation is contracted by the provincial government, which derives in delays and high costs. It must be noted that, as prescribed by resolution 763/98, each province is responsible for obtaining medication from the Ministry, located in Buenos Aires, and transporting it to the province. The provinces which are far from Buenos Aires must have more transportation problems and afford higher costs.

Interviewed hospital staff also stated that there are difficulties in the process to request medication as well as delays, as described above. In cases of change of medication due to intolerance or lack of effective results, the patient must present again all documentation already submitted since, according to resolution 763, changes of treatment are deemed as new treatments.

Bureaucracy not only produces delays, but also a psychological and physical fatigue that is harmful to people living with HIV/AIDS. Hospital and NGO's professionals also referred to problems in relation to documents required for foreigners or for those who do not have their national identity document for different reasons. Foreigners who are not legally residing in the country, in general, do not receive medication.

f) The Sufferers' Opinion

Persons living with HIV/AIDS stated that steps to get documentation, even though they are not complicated, require a long time and sometimes the assistance of relatives or friends. Since diagnosis and laboratory tests must be made in public hospitals, they suffer the delays inherent in the public sub-sector, which postpones the beginning of any treatment or its continuity as documentation must be presented every three months.

In relation to workers' healthcare schemes, some of them have serious problems to provide certain drugs, especially the most expensive ones. However, in cases where this situation has been reported in the media or legally claimed, the situation has been regularized quickly. They informed that processes are simpler than in public hospitals, since only the workers' healthcare doctor's prescription, the summary of the clinical history and routine lab analysis are required.

Representatives of some NGOs who support residences for AIDS patients with no family, pointed out some problems in the public hospital system, such as, delays in surgery appointments, patients have no choice but to go to hospital during the morning first hours to get an appointment; limited visiting hours during hospitalization; and health staff prejudices against AIDS patients, among others.

Criticism in relation to provision of medicines was focused mainly on the number of documents requested and the delays to obtain them. Habitually, due to their health conditions or because they are hospitalized, patients are not able to do all paperwork or do not have relatives or friends who can help them. This hinders access to treatment. NGO's representatives consider that obtaining the necessary drugs takes patients over two months. They recognize that delivery has improved although some medicaments are sometimes

unavailable. Treatment interruption is frequent, and this obstacles a better adherence to the treatment. The whole process leads patients to face the anguish and uncertainty of obtaining all medication every month, which affects their psychophysical situation and life quality. In the case of children, mothers with AIDS generally neglect their own treatment to give priority to their children's.

VII NATIONAL BUDGET FOR THE PURCHASE OF MEDICINES

As mentioned above, attention of persons with HIV/AIDS, as well as their diagnosis, assistance and control of the disease, is the responsibility of the Ministry of Health and Social Welfare of the Nation. The budget for this item is included in the national budget under Ministry of Health. TABLE 4 indicates the evolution of the budget for AIDS from 1994 to 1998.

TABLE 4

Budget and execution of PNLRHS in millions of pesos

	1994	**1995**	**1996**	**1997**	**1998**
Initial Credit	10.3	21.8	13.4	18.9	77.06
Current Credit	8.1	19.6	12.7	54.7	No data
Accrued	8.0	17.2	12.4	No data	No data

Source: Ministry of Health and Social Welfare of the Nation, and Budget Commission of the Honorable Chamber of Deputies of the Nation.

From the beginning of the disease, the budget assigned to HIV/AIDS does not show a great variety of classifications, only personnel, and drugs and supplies. This means that approximately 97% of the total budget is allocated to supplies, that is, to purchase of reactives for blood testing and hemoderivatives in blood banks and to carry out spontaneously requested or medically prescribed tests, and purchase medication for treatment. In summary, 80% or over of the total budget is allotted to medication.

As drugs for treatment of HIV infected people and patients with AIDS increased, such drug costs also increased, the disease spread and the budgetary problems started. In July 1996, when during the AIDS International Conference in Vancouver the first positive results of the combined therapy and specially of protease inhibitors were presented, these results were widespread in Argentina which produced important governmental problems in order to meet the demand for this tri-therapy with higher costs than other drugs.

In 1995, when the question of the national budget was discussed at the National Congress, the NGOs and persons living with HIV/AIDS requested meetings with the Health Ministry to be informed about the requested budget. Up to that moment, traditional controversies between community groups and national authorities were centered on the absence of preventive action and the lack of budget, which was being claimed by the NGO. In 1995

the NGOs and the PLWAS started to make stronger demands in relation to the insufficient national budget to treat patients with AIDS.

In 1996 a budget is approved, which, at the discretion of community groups, was insufficient to meet medication demands. However, some time later the budget was reduced twice to almost 50%. In 1996 and 1997 unavailability of drugs was even more critical. As stated above, as a direct consequence of the *amparo* initiated by eight NGOs against the Ministry, in late 1997 a budget of 77.06 millions was approved for 1998, which represented almost four times the budget for the AIDS National Program in 1997.

Even though in 1997 the approved budget was 18,900,000 pesos, the credit was increased to 54.7 millions, as a result of the pressure made by the NGOs and people living with HIV/AIDS. Consequently, new contributions for other purposes had to be reassigned to HIV/AIDS. Moreover, in 1997, worker's healthcare schemes and private healthcare schemes are obliged to provide this therapy, and thus PLWAS pressure to obtain medication is transferred to them.

VIII SOME FINAL CONCLUSIONS

As it can be noted, Argentine legislation provides for sufficient guarantees for people living with HIV/AIDS to access to attention and adequate treatment. However, those guarantees are not always fulfilled, and not all persons living with HIV/AIDS are properly aware of their rights. For such reason, disclosure of information about legal tools that ensure access to treatment and attention, is a central aspect in the work of non-governmental organizations and networks working with AIDS. Traditionally, neither public health services, nor social security providers or private medical companies inform their beneficiaries about the services they cover and how they do it. Even more limited is information about the obligations and rights set forth by the legislation or other regulations in force. Some NGOs working with HIV/AIDS are the only institutions who receive claims as well as requests for information by PLWAS, which evidence the lack of orientation about how to obtain medication.

Although the existing legislation is detailed, it contains some basic contradictions. Both the National AIDS Law and its regulatory decree establish that the test for the detection of the virus must be "voluntary" in every case; however, the same law and a later decree establish the compulsory analysis for immigrants requesting residence in Argentina and for all Armed Forces personnel, including civil staff. This permits violations of human rights that the law not only permits but favors.

The HIV/AIDS test must be voluntary by law. The "suggestion" of medical professionals to pregnant women to have the test made is controversial. In fact, the test is legal because women sign their consent. However, many of them are pressed to have the test made or simply do not receive detailed and clear explanations about the consent they sign. This happens because professionals "need" to know the patients' serologic condition to take the adequate biosecurity measures, when these measures should be taken in all cases. Another idea which is deeply rooted in the Argentine medical concept and society is the need to

avoid the infection of the fetus with the HIV, in many cases, without properly evaluating the consequences of treatment on women, and even without being interested in them. This reduces attention on women and delivery and concentrates it on the child. What is often forgotten is that the child's welfare depends of the mother's health.

The increasing influence of NGOs working on HIV/AIDS which has brought about tangible changes in public policies cannot be omitted. Many authors recognize the influence of civil society in the design and execution of public policies. According to Finding and Tamargo, formulation and implementation of public policies constitute the result of political forces interests, that is, of the political fight between different social players, which is defined in the State, which is the scenario for the negotiation of opposed interests[28]. Oszlack and O'Donnell complement this definition and analysis of public policies, since they define as field of study the social process surrounding the origin, treatment and solution of questions before which not only the State but others (classes, parts of classes, organization, groups and individuals) adopt policies, which implies bidirectional relationships of power, influence and negotiation[29].

Under this concepts, the constant lobby actions performed as from 1994 by NGOs working with HIV/AIDS with different governmental officers, plus their educational and social assistance function, specially in relation to the lower classes, their permanent participation in the media to inform about problems referred to human rights and HIV/AIDS, their street demonstrations as well as the promotion of legal ways to safeguard human rights of people living with HIV/AIDS, constitute clear examples of the NGOs' incidence on public policies in Argentina.

In practice, all support guaranteed by legislation in relation to access to HIV/AIDS treatment, is relativized since the system is complex and bureaucratic, and even though many patients receive treatment free of charge, it is not easily obtained or guaranteed on a continuous basis. This latter aspect is the most worrying because of its effect on the illness evolution. We know that HIV/AIDS treatment must be timely and continuous to be effective. Neither of these requirements seems to be fulfilled in Argentina.

Under these circumstances, we wonder: the important budgetary investment made for the purchase and distribution of medication is really profitable in terms of cost-benefit, in health and life quality? Do we obtain good results or, due to logistic and bureaucratic problems, we are not providing PLWAS with the best possible service with this investment? These questions are difficult to answer, but we must make them to the whole society and the authorities responsible for health public policies in Argentina. Like in many other aspects of health services, many economic and human resources are invested, but real benefits are not evaluated or measured, in health and life terms. The cost-benefit is not measured in relation to the time it takes people to comply with paperwork requirements or to distribute medication to hospitals. The cost-benefit must be measured in terms of years

[28] Finding, L and Tamargo M. C. *Actors and Health Policy: The State versus Market Debate. Medicine and Society*: N 3, Vol. 16, Buenos Aires, 1993
[29] Oszlak O. and O'Donnell G: *State and State Policies in Latin America: towards and investigation strategy*. Ilpes, Document SP, 3, 1984.

of life earned and quality life of those years. Were there fewer PLWAS hospitalized due to opportunistic infections than in 1996? Were there fewer deceased PLWAS diagnosed in 1994/5 than in 1997/8, and who started the combined therapy earlier? Only in this way can we justify the expense. So far, the expense for treatment was increased and a bureaucratic process of purchase, acquisition and distribution of medication was created. PLWAS's human rights are not less violated or their health or quality life improved too much. For this reason, as a civil society we must continue fighting to accomplish this objective which is not only achieved with more funds and legal support.

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ANNEX I

BASIC VADEMECUM FOR TREATMENT OF HIV PATIENTS
Resolution of the National Ministry of Health and Social Welfare

Aciclovir	Amp. X 500 mg Caps. X 200 mg
Acido Folínico	Pills X 15 mg
Amicacina	Amp. X 500 y 1000 mg
Amoxilina	Pills X 500 mg Amp. X 500 y 1000 mg
Ampicilina	Amp. X 500 mg
Anfotericina B	Jar Amp. X 50 mg
Azttrominicina	Caps. X 250 mg
Cefalosporina De 3 Generación	Jar Amp. X 500 y 1000 mg
Ceftazidima	Jar Amp. X 1000 mg
Ciprofloxacina	Pills X 50 mg Amp. X 250 mg
Claritromicina	Pills X 250 mg Syrup x 25 mg/ml Amp. X 30 mg
Clindamicina	Amp. X 150 mg/ml Pills X 300 mg
Cotrimoxazol	Syrup 40-200 mg/ml
(TMP-SMX) Amp. X 80/400 mg	Pills x 80/400 mg
Dapsona	Pills X 100 mg
Didanosina	Pills x 100 mg

Doxiciclina	Tab. X 100 mg
Espiramicina	Pills X 1 g
Estreptomicina	Amp. X 1 g
Etambutol	Pills X 400 mg
Fluconazol	Pills X 100 y 200 mg
Amp. X 200 mg	
Foscarnet	Amp. X 24 mg/ml
Ganciclovir	Jar Amp. X 500 mg
G-CSF	Jar Amp. X 300 m.c.g
GM-CSF	Jar Amp. X 300 mg
Indinavir	Pills X 400 mg
Isoniacida	Pills X 300 mg
Interferón	Jar Amp. X 3 / 4.5 / 9 / 10 mill.U.
Itraconazol	Caps. X 100 mg
Ketoconazol	Pills X 200 mg
Lamivudina	Pills X 150 mg
Metil-Prednisona	Pills X 40 mg
Nelfinavir-Prednisona	Pills X 40 mg
Nevirapina	Pills X 200 mg
Nistatina	Sol. X 100.000 U ml
Penicilina Benzatinica UI	Jar Amp. X 2,4 mill. UI/1,2 mill
Pentamidina	Jar Amp. X 300 mg.
Pirimetamina	Pills X 25 mg
Primaquina	Pills X 7,5 y 15 mg
Rifampicina	Caps. X 300 mg

Ritonavir	Pills X 100 mg
Saquinavir	Pills X 200 mg
Stavudina	Pills X 30 mg y 40 mg
Vancomicina	Amp. X 500 y 1000 mg
Zalcitabina	Pills 0,373 70,75 mg
Zidovudina	Pills X 100 mg Syrup x 120 ml y 240 ml

ANNEX II

RESOLUTION 709 OF THE NATIONAL ADMINISTRATION OF HEALTH INSURANCE (1997)

MONTHLY COVERAGE OF AIDS MEDICINES

Module 1: Double antiretroviral therapy

Combinations: (AZD + DDI + AZT + DDC + AZT + 3TC-DDI + D4T + D4T + 3TC)	$ 455

Module 2: Double antiretroviral therapy with protease inhibitor

Combinations: (DDI + RITON/INDINAV - D4T + INH. Protease - - 3TC + INH. Protease)	$ 785

Module 3: Triple antiretroviral combination

Combinations: (AZT + DDI + ING. Protease - DDI + D4T + INH. Protease - AZT + 3TC + INH. Protease)	$ 1026

Module 4: Antiretrovirals therapies in pediatrics

Option 1: (DDI monotherapy + AZT monotherapy AZT + DDI)	$ 75

Option 2: (DDI + D4T)

ANNEX IV

List of people interviewed

- National Program against the Human Retrovirus, AIDS and ETS.
- Provincial Program of HIV/AIDS and ETS in the Province of Buenos Aires: Dr Remo Salve (Director)
- Head of the assistance area of the HIV/AIDS Program, Dr. Mónica Moyano.
- Hospital of Infectious Diseases Dr. Francisco Muñiz. Head of Annex XVIII, Dr. Jorge Benetucci.
- Dr. Alejandro Posadas Hospital – Hurlingham, Province of Buenos Aires – Head of the Infections Service, Dr. Héctor Laplumé.
- Ecumenical Movement for Human Rights, Pastor Lisandro Orlov.
- National Association of People living with HIV/AIDS. Ricardo Cergneux, Virginia Barnentes and Javier Hourcade.