

**Article: “Roadblocks on the Road to Treatment: Lessons from Barbados and Brazil”**

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# Roadblocks on the Road to Treatment: Lessons from Barbados and Brazil

Jamila Headley and Patricia Siplon

On a beautiful tropical day, two women living thousands of miles apart enter public clinics. One walks past the neatly parked cars in the parking lot, to the front door of the newly built, well-equipped Ladymeade Reference Unit, which stands across from the largest public medical facility on the island of Barbados. Everything about this experience is neat and well-ordered, from the facilities the woman is entering, to the pill boxes bearing brand-name labels that she receives at the in-house pharmacy, to the referral system that sent her here after she delivered a baby across the street. The second woman's experience appears a bit less ordered. The clinic she enters, which sits on the outskirts of one of Brazil's slum-ridden cities, is shabby, with peeling paint and a utilitarian concrete structure. Inside, there are no shiny, manufacturer-sponsored posters to match the pills being dispensed, because these pills do not bear familiar brand-name labels. Though the pictures may appear quite different, they bear a crucial similarity—both women are living with HIV, and both are fortunate to live in countries that have committed themselves to providing universal treatment access for their HIV-positive citizens.

The scourge of HIV/AIDS has affected every country across the globe, though nations have been overwhelmingly slow and incomplete in their responses. At the same time, great strides have been made in the development of treatments. It is now possible to use a combination of antiretroviral medications (ARVs) to render what was once an inevitably fatal disease into a manageable, chronic condition. However, only a few countries have made the com-

mitment to provide these medications to all their people who need them. Within that very short list are two countries that represent extremes in size, power, history and heterogeneity. Brazil: diverse, large in geography and population, with a legacy of turbulent transitions and up-and-coming as a regional power, and Barbados: a tiny island nation, with a small acreage and citizenry, fairly homogenous population, and long-standing history of peaceful and democratic governance.

The governments of both countries have made a commitment to their people to provide them with the therapies that, in most low- to middle-income countries, are only available to the few who can afford to pay for them. It is no accident that these countries have two additional commonalities that have had major consequences for people living with HIV. Facilitating both countries' commitments has been sufficient political will as well as recognition of health care as a human right. What most clearly differentiates the effectiveness of their approaches has been the relative engagement of civil society, and especially of people living with HIV/AIDS (PLWHAs) themselves, in enforcing this commitment.

## Comparable Commitments

It is political will in high places that has enabled Brazil and Barbados to provide antiretroviral therapy for all citizens. In September 2000 at a Sub-Regional Conference on HIV/AIDS, Barbadian Prime Minister Owen Arthur announced that he would move the National HIV/AIDS program under his portfolio<sup>1</sup> and committed to the provision of universal treatment.<sup>2</sup> A key influential figure in this turn of events was the Barbadian Minister of Health, Phillip Goddard, who was one of a small group of health professionals and politicians concerned about the rising incidence of HIV/AIDS and the potentially devastating effects it could have on Barbados' small population and fragile, tourism-based economy. The Prime Minister's commitment then became a reality after the World Bank agreed to provide a loan to finance antiretroviral therapy in 2001. In January 2002, Barbados rolled out its universal free treatment program.<sup>3</sup> However, compared with Brazil,

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Barbados was arriving late in the game. The Brazilian government had passed legislation guaranteeing universal free access of ARVs in 1996, supported by then-president Jose Sarney, and the government had made free AZT (the first AIDS ARV) available even earlier.

Critically, both Brazil and Barbados recognize health care as a human right. In both cases this acknowledgment served as a philosophical foundation for universal treatment access, although stemming from different roots and reflecting the countries' divergent paths to democracy. A former British colony, Barbados' journey to independence was remarkably peaceful. There was no violent uprising and no bloody struggle for power in the 1966 transition.<sup>4</sup> Rather, Barbados adopted a multi-party system with a parliamentary form of government shaped much like the colonial-era British model. The new government explicitly opted to retain key features of pre-colonial policy that it saw as serving the interests of its citizenry, including government-provided health care.<sup>5</sup> Thus, since even before independence, Barbados has had a system of free public health care throughout the island.

Brazil's experience of health care as a human right, conversely, is tied to its turbulent past, and especially with its return to democracy. The democratization process of the late 1980s and early 1990s saw a flowering of civil society groups, whose first hallmark was the passage of the 1988 constitution. Among these groups were ones involved with a sanitary reform movement composed not only of health care workers and academics, but also of trade unions, emerging political parties, and churches. This movement was particularly strong in São Paulo (which, not coincidentally, would emerge as the national leader in AIDS policy), where it was tied to the rise of successful opposition parties. It was this sanitary reform movement that insisted that a key feature of the new relationship between a responsive state and its citizenry must be a state obligation for the health of its people.

## Significant Differences

Despite these interconnected similarities of political will and acceptance of health as a human right, the AIDS treatment programs of Barbados and Brazil are far from mirror images. Three differences are particularly salient: cost of antiretroviral therapy, level of centralization and success of treatment uptake, and the level of coordination between treatment and prevention/harm-reduction. The extent of involvement of civil society in each country is critical to these differences.

### *Cost of antiretroviral therapy*

Accessing drugs was a crucial challenge to both Brazil and Barbados in the wake of their epidemics. By the time antiretroviral therapy came onto the scene in 1996, Brazil already had over 250,000 cases of HIV/AIDS<sup>6</sup> to grapple

with, and the World Bank had predicted that this number would inflate to 1.2 million by 2000.<sup>7</sup> That same year Brazil had passed a law mandating universal access to treatment. As a new member of the World Trade Organization (WTO), Brazil was also required to comply with the Trade Related Aspects of International Property (TRIPS) agreement. A key element of TRIPS is the agreement to respect intellectual property patents, including those of drugs, except under very strictly defined circumstances. The Brazilian law that was passed agreed to uphold all patents awarded after May 14, 1997. Although this law would have severe repercussions for the affordability of some medications, it did allow Brazil to legally ignore the patents of many of the first-generation antiretrovirals and even one of the later protease inhibitors (indinavir).<sup>8</sup>

These medications have formed the basis for a critical element to Brazil's success in providing universal treatment: the local manufacture of drugs. In 1998, reeling under the costs of brand-name drugs, the government began to turn to its own public pharmaceutical laboratories to analyze and copy the drugs.<sup>9</sup> Purchasing bulk raw materials from India and Korea, these labs were able to produce the generic equivalents at drastically lower prices. As for those drugs that fall under TRIPS, they must still be bought at negotiated prices from the major international pharmaceutical companies. On three occasions the Brazilian government has been able to bring multinational pharmaceutical industry to the table for price reduction negotiations. On all three occasions, Brazil has threatened to issue a compulsory license, which would essentially cede the patent to a national company, allowing it to manufacture the drug and pay royalties to the original patent holder. In all three cases, in the midst of loud opposition from activists (both locally and globally) the license was not issued, and the companies, knowing that Brazil's manufacturing capabilities and political will are real, have dropped their prices significantly on drugs that Brazil imports.

In Barbados, realizing treatment access proved to be much more difficult. Unlike Brazil, with its pharmaceutical industry, large market size, and strong governmental support for treatment, Barbados is in a weak negotiating position. Even the prospect of importing generic versions of the drugs remains dubious as national health programs such as the Barbados Drug Program, which provides essential drugs to Barbadians at very low costs, remain dependent on yearly negotiations with pharmaceutical conglomerates.<sup>10</sup> As a result, in the absence of a civil society calling for sustainability in HIV/AIDS programming, Barbados has unilaterally conducted negotiations with the industry, obtaining only moderately reduced pricing for the ARV drugs needed.

Even in the face of recent and significant reductions in the price of ARVs through various initiatives such as that of the Clinton Foundation, which has brokered very low

ARV prices for developing countries across the globe, Barbados has found itself locked into exorbitant drug prices. High pricing of these drugs has made it impossible for the government to finance the program using solely national resources. Barbados has been forced to seek alternative sources of funding; it received the first World Bank loan approved for the provision of antiretroviral therapy in 2001.<sup>11</sup> Unlike Brazil's, Barbados' treatment program remains in limbo, with its major source of funding—the World Bank loan—estimated to reach exhaustion in 2007.<sup>12</sup>

### ***Level of centralization and success in treatment uptake***

To stem the spread of HIV/AIDS in any country, programs should reach all of the infected and provide them with appropriate care. This requires balance between centralized and decentralized forms of management.

The Brazilian story begins quite early in the global history of the epidemic. By 1983, under pressure from local health professionals and at the height of Brazil's struggle for democratization, the state of São Paulo launched Brazil's first HIV/AIDS program.<sup>13</sup> As more cases began to appear across the country, this remarkably comprehensive and progressive program was quickly replicated by Brazil's larger states, despite the lack of early mobilization around HIV/AIDS by the Brazilian government at the national level. By 1985, when the federal government led the first national initiatives around the epidemic, comprehensive HIV/AIDS programs (including treatment for opportunistic infections) were already in place in 13 of Brazil's 27 states.<sup>14</sup> In 1989, the state of São Paulo again led the way in beginning the free distribution of AZT to PLWHAs in two of its major cities<sup>15</sup> and by 1990, again under increasing pressure from the federal states, the Ministry of Health made its first attempt at the universal distribution of all forms of treatment available at that time. However, due to the structure of the government's health care system, the universality of this program was severely impaired.

A fairly centralized public health system, in which free medications were traditionally distributed only to citizens enrolled in local public health centers, proved problematic in the management of HIV/AIDS treatment. Many of these centers found themselves unable to cope with public demand. Predominantly among the poor, who found it more profitable to trade their spots in the queues at local distribution centers for money, many PLWHAs continued to go untreated.<sup>16</sup> However, the decentralized nature in which the response to AIDS had developed in Brazil, fuelled by the gay rights movement and sanitation reform movement, had resulted in high levels of civil solidarity around the issue and stimulated the creation of various NGOs committed to fighting HIV/AIDS. These service organizations (such as Groups for AIDS Prevention in São Paulo and the Brazilian Interdisciplinary AIDS Asso-

ciation) played key roles, not only in promoting prevention and awareness of HIV, but also in the provision of treatment through free privately-owned clinics and the development of home care programs.<sup>17</sup>

By 1996, with the discovery of combination drug therapy, Brazil's National AIDS Program had evolved to strike a balance between the centralization and coordination needed to combat HIV/AIDS on the national level and the decentralization required at the state and grassroots levels to insure the true universality of treatment access. A coordinated response encompassing the Ministry of Health, the state health departments, and the NGO community now formed Brazil's national response to HIV/AIDS, and gained Brazil worldwide acknowledgement for the comprehensive and progressive nature of its response to the epidemic. More importantly, the treatment program has reduced mortality rates due to HIV/AIDS by more than half.<sup>18</sup> Moreover, with only 650,000 people living with HIV/AIDS and a prevalence rate of 0.7 percent,<sup>19</sup> Brazil has fallen significantly short of the 1.2 million cases of HIV/AIDS that the World Bank had predicted that it would grapple with by 2000.

Barbados' journey has been very different. An island of only 166 square miles, Barbados could not benefit from the scaling-up of decentralized state-level initiatives, as in Brazil. As a result, there was no diffusion of legislation, programs, or treatment from one area of the island to the national level. In fact, unlike Brazil, whose first response to the epidemic surfaced only one year after the first case had been detected in the state of São Paulo, it wasn't until 1987, three years after Barbados' first detected case, that the Barbadian Ministry of Health set up the National Advisory Committee on HIV/AIDS. This response was fuelled primarily by health professionals and remained far from a central priority of the government for more than a decade.<sup>20</sup> This highly centralized response to the epidemic had several crucial consequences. It dampened the formation of AIDS NGOs, allowed discrimination and stigma to fester in Barbadian society and thereby diminished the visibility of PLWHAs. By 1996, only pregnant mothers were being provided with treatment to reduce mother-to-child transmission and the incidence of HIV/AIDS in Barbados was estimated at over 1.5 percent.<sup>21</sup>

In 2002, in fulfillment of the Prime Minister's commitment to ensure universal treatment access, the provision of treatment for all began, with services for all adult PLWHAs available at one clinic—the Ladymeade Reference Unit—and for children at the Queen Elizabeth Hospital (Barbados' major public hospital). As in Brazil, the highly centralized nature of this program compromised the goal of universal access. Discouraged by perceived stigma from members of Barbadian society, the isolated location in which the clinic had been placed, and the label of "HIV-positive = unclean" with which all who frequented Ladymeade were branded, the numbers of

PLWHAs who came forward for treatment continued to represent only a small fraction of infections in Barbados.<sup>22</sup> Though the government has made ARVs available to its public, the universality of its program remains in question. Despite estimates of a 1.5 percent HIV prevalence rate, only 800 PLWHAs currently receive treatment or counseling at Ladymeade.<sup>23</sup> In fact, it is estimated that the government could be under-treating by over 1,000 persons.<sup>24</sup> Also, the lack of civil society organizations involved with AIDS issues has left no counteracting force to promote the level of decentralization necessary for effective universal treatment access. The result has been severe inefficiencies in the way that treatment is administered to, and received by, the affected community.

### *Level of coordination between treatment and prevention/harm-reduction programs*

Coordination between treatment and prevention programs is especially critical to the success and sustainability of a treatment program. Without curbing the number of new infections, resources directed towards universal treatment access are put under enormous strain. Furthermore, harm-reduction and prevention programs often play a crucial role in detecting cases of HIV.

In the case of Brazil, the provision of treatment was supported by a high level of civil society participation—a strong sense of solidarity among Brazilian PLWHAs, and an expanded AIDS NGO community working on a range of related issues. Thus, from the onset of the epidemic, although the government lagged in coordinating a national response, NGOs stood ready with the expertise and human resources to implement effective prevention and harm-reduction programs. This crucial role of the NGO community resulted in measures supported or implemented by the Brazilian government that were quite radical by even Western standards. For example, in 1998, the state of São Paulo passed pioneering legislation that officially authorized needle-exchange.<sup>25</sup> Soon similar laws were passed in states across Brazil, until amendments were made to Brazilian drug laws allowing needle-exchange to take place nationally.<sup>26</sup>

However, even though Brazil has already seen the positive results of pursuing treatment in conjunction with vigorous prevention and harm-reduction measures, national efforts still leave much to be desired. It is evident that treatment, rather than prevention and harm-reduction, has been the Brazilian government's main goal and that primary responsibility for prevention has been left to the NGO community.<sup>27</sup> Increasing collaboration between the primary providers of treatment (the government) and of prevention (the NGO community) is becoming an increasingly critical issue in the success of Brazil's HIV/AIDS program.

In Barbados, where an AIDS NGO community is virtually nonexistent, the full weight of the response to HIV/

AIDS—treatment, prevention and harm-reduction—has been left to the discretion and will of the government. Although Barbados has a much shorter history of making HIV/AIDS a national priority, it has nonetheless partially realized the priceless benefits of coordinating treatment and prevention. In 1996, under the advisory of the Queen Elizabeth's Hospital's AIDS Management Team, Barbados began providing AZT to HIV-positive mothers in an effort to prevent mother-to-child transmission.<sup>28</sup> By the time ART was made available in 2002, 76 percent of HIV-positive pregnant women were entering the mother-to-child transmission prevention program and following a referral system, which facilitated continued treatment and counseling at Ladymeade Reference Unit.<sup>29</sup> Not only has it successfully reduced the rate of mother-to-child transmission of HIV, but this program has played a key role in increasing the number of known HIV cases and expanding the reach of the treatment distribution.

Sadly, the story of coordination between treatment and prevention has been restricted to the mother-to-child program. Aggressive prevention efforts have not been pursued among high-risk groups (such as the homosexual and bisexual communities, sex workers, and prisoners) and prevention has been limited to billboards, public service announcements, and sporadic condom distribution.<sup>30</sup> Discussions of harm-reduction—among prostitutes, in the prison, or among intravenous drug users—have repeatedly hit a wall of resistance, especially from Barbados' still highly conservative churches, bringing the success of curbing the spread of HIV and the discovery and treatment of current cases, into jeopardy. This failure will have severe consequences, as low levels of treatment uptake by the PLWHA community and a relatively large number of estimated undetected cases have already begun to show. Like that of Brazil, the case of Barbados reinforces the importance of a comprehensive and collaborative response to HIV/AIDS.

### **Why the Path Matters**

The widely divergent experiences of what appears to be the same political decision—universal treatment access—are rooted in major differences between the two nations. One aspect is particularly critical: the extent to which this decision was driven by civil society activism, and particularly activism of PLWHAs and affected communities. In their comparative analysis of the Brazilian and South African responses to their respective AIDS epidemics, Gauri and Lieberman consider the impact of civil society, but ultimately suggest that two other factors—institutions and the norms of political communities—are responsible for the divergences they found.<sup>31</sup> Here we suggest the ways in which civil society involvement may be the decisive factor in determining AIDS treatment policy direction and success.

### ***Community involvement and Brazilian success***

The Brazilian case exemplifies remarkable integration between government officials, particularly from the Ministry of Health, and activists from gay rights organizations, AIDS service/activist groups, and women's organizations, among others. The response to AIDS began at the local level, most notably in São Paulo—the center of an emerging gay liberation movement and the site of most of the early reported AIDS cases. There, gay activists began meeting with the State Secretariat of Health as early as 1983, which formed a working group on AIDS in mid-1983 within the Division of Hansen's Disease and Sanitary Dermatology.<sup>32</sup> This working group would become the foundation for the State AIDS Program, which would in turn serve as a model for other states.

Of course, like the original program in São Paulo, these state based-programs and the national program which followed did not arise in a vacuum. They were established in response to a flourishing civil society movement with many organizational members and thus, continue to stand accountable to the Brazilian people. Three of the most well-known of these are the locally based chapters of Support Group for AIDS Prevention (GAPA) (beginning with GAPA-São Paulo), the Brazilian Interdisciplinary AIDS Association (ABIA) founded in Rio de Janeiro in 1986, and the Grupo Pela VIDDA-Rio de Janeiro, which began as a project within ABIA and now maintains chapters in a number of cities throughout Brazil. Two of the most influential early leaders of these organizations, and of the AIDS movement generally, were the “two Herberts”—Herbert de Souza (more popularly known as Betinho) and Herbert Daniel. Both men had been progressive political exiles and then were active in the redemocratization efforts in the 1980s upon their respective returns. Betinho, a hemophiliac whose two brothers were also HIV positive, is credited with providing the impetus for ABIA, while Daniel became the founder and first president of Grupo Pela VIDDA-Rio de Janeiro, the first explicit organization of PLWHAs in the country.

Though the most influential, these organizations are not isolated. Rather, they have worked in tandem with numerous other groups drawn from various sectors of civil society. Parker notes that as early as 1990, the Second National Meeting of AIDS NGOs had representation of 38 groups including religious groups and organizations representing both gay and sex-worker rights.<sup>33</sup> Also, as women became increasingly affected, organizations representing feminist, lesbian, and female-health concerns have joined the movement in growing numbers.

The interaction between civil society and government in Brazil has been exceptional, particularly in the sense that AIDS activists appear to have been able to avoid the trap of cooptation and de-radicalization. Petchesky has noted that a key difference in the Brazilian case “is the responsiveness of government officials, particularly in the

national, state and municipal health departments, to popular and NGO demands.” She further notes that this is not coincidental “since many of these officials, especially at middle-bureaucratic and municipal levels, have come out of the gay, lesbian and feminist movements”.<sup>34</sup> Although the government has been remarkably receptive to advocacy networks, activists and advocacy organizations have managed to maintain their independence—to the extent that they called for the impeachment of the Collor government on charges of corruption, in the early 1990s.

The Brazilian case also represents another strength of policy derived from the grassroots demands of the people most affected by HIV/AIDS—a comprehensive approach. Unlike health care professionals who, no matter how empathic, view the issue through their primary means of interaction with it—treatment—the PLWHA deals with all its complexities all the time. It is this person who suffers discrimination, must negotiate relationships with HIV-negative partners, and must consider the legal ramifications of any action. It is therefore not surprising that in Barbados, where the impetus for the program came from the top in the absence of an authentic PLWHA movement, other issues affecting the lives of PLWHAs have been neglected or not addressed in an integrated way. In Brazil, on the other hand, the PLWHA movement, together with allies from the gay community, women's groups, and NGOs representing other at-risk populations, demanded that HIV be addressed as a human rights issue in all its dimensions—from prevention, to discrimination, to support of sexual diversity.

The self-empowering, activist perspective, emanating first from the streets of São Paulo and building up through local, state, and then national governments, has implications not only within Brazil, but outside its borders. After making the critical decisions to push forward with proactive policy initiatives on the prevention and treatment fronts, the Brazilian government had *itself* become an activist on the world stage. By the year 2000, it had moved from being primarily a target for Brazilian activists to an energetic participant in the transnational treatment access movement. It had shown that it was possible to defy the collective wisdom of the World Bank, the multinational brand-name pharmaceutical industry, and the United States. For various reasons, all these entities had been opposed to Brazil's decision to pay for a universal treatment access program and to produce the medications in it. Although the World Bank would eventually come around to the Brazilian idea that treatment could be cost-effective (as the World Bank-sponsored Barbados program attests), the American pharmaceutical industry would continue to fear Brazil's patent-breaking potential. Yet, just like the non-state activist groups with which it allied, Brazil has been able to take its case to the global court of public opinion and mount convincing arguments that it

is operating from the morally superior (as well as more cost-effective) position.

### *The limits of professional advocacy and political vision in Barbados*

The Barbadian context is inherently different from that in Brazil in certain non-negotiable ways. Its much smaller size, greater dependence on the United States, and reliance on a tourism-based economy that might react negatively to either noisy political demonstrations or open discussions of the island's high-risk populations, are realities of which political leaders and health care professionals are well aware. These realities may also help explain limited internal organizing among at-risk populations and a strictly top-down push for treatment.<sup>35</sup>

Barbados' treatment program was, in some sense, a natural evolution focused on addressing the medical needs of its constituents. The initial AIDS clinic was located at the Queen Elizabeth Hospital respiratory unit, where the country's first AIDS patient was treated.<sup>36</sup> Before 1996, the hospital dealt only with opportunistic infections, adding treatment to prevent mother to child transmission that year and the national program to provide ARVs in 2002. In contrast to the Brazilian model, there has been no push from civil society and, consequently, no attempts by government to address stigma by empowering marginalized groups. No legislation has been passed to protect the rights of PLWHAs and there has been no push for prevention policies among marginalized populations. As a result, stigma continues to fuel HIV transmission. For example, when the Attorney General suggested that the government consider condom distribution in prisons, there was a resounding call, echoed throughout the island and in the press, for her resignation.<sup>37</sup>

Under these conditions, Barbados' treatment program cannot be optimized. The nation's PLWHA community finds itself in a Catch-22. They have the ability to access medications, but not the guarantee that taking them in public will not cost them their jobs. HIV-positive mothers who are treated in the mother-to-child prevention program sometimes fail to continue their own treatment across the street at Ladymeade because they know that walking through the doors is itself a public announcement of one's HIV status.

Just as the grassroots activist approach has had positive repercussions outside Brazil's borders, so has Barbados' lack of a movement meant missed opportunities within the region. Because it is relatively prosperous, Barbados plays a crucial leadership role in the Caribbean region. The encouragement of a genuine movement of people infected/affected by HIV/AIDS in Barbados would provide a useful template for other Caribbean countries where stigma is even stronger and treatment is still unavailable. Barbados could also play an important role in a pan-

Caribbean movement targeting pharmaceutical companies and the trade policies that support them. Although Barbados is too small to stand alone, it could be a powerful catalyst in uniting the region to address HIV/AIDS.

### **Conclusion**

The World Health Organization has widely distributed a list of recommendations for successfully disseminating anti-retroviral therapy in developing countries. Paramount on this list is political commitment, along with standardized approaches and increased capacity, technical support, sustainable financing, and linking treatment and prevention.<sup>38</sup> However, a look at Brazil and Barbados brings the comprehensiveness of these recommendations into question. The dialogue about how to achieve access to universal treatment seems to have neglected an important component of any such policy. A comparative analysis of Brazil and Barbados clearly illustrates that the involvement of civil society, and more specifically, of communities most affected by HIV/AIDS, is vital in ensuring the success of a comprehensive treatment program. As a result, in Barbados but not Brazil, despite political will at the highest level of government and recognition of health care as a human right, obtaining sustainable funding, standardizing approaches, ensuring maximum capacity, and coordinating treatment and prevention have been major sticking points.

Though political will and a foundation of health care as a human right has brought free antiretroviral therapy to all who need it, the wider Barbadian society has failed to take responsibility and ownership of the issue of HIV/AIDS. With no input from people infected and most affected by HIV/AIDS, the universality of Barbados' program is compromised. HIV/AIDS attacks the very foundations of our societies. We see that an effective response to this epidemic must, therefore, branch out from all levels of society, and must be characterized by the powerful combination of demand, from the people, and an unprecedented commitment to act, from the government.

Returning to the two clinics visited above—one tidy and ordered, the other, dilapidated—illustrates an important point. Appearances can be deceiving. Certainly the most important object in both cases is what lies inside: free life-saving medications provided by visionary governments. But unfortunately, what may be less clear to the casual observer is that the struggle to create those clinics matters, as well.

### **Notes**

- 1 Barbados National HIV/AIDS Commission 2003, 4.
- 2 Personal interview with Dr. Timothy Roach, Director of the Ladymeade Reference Unit, Barbados, July 16, 2004.
- 3 Ibid.

- 4 Beckles 1990.
- 5 Personal interview with Dr. Erskine Simmons, physician and political analyst, Barbados.
- 6 Berkman et al. 2005, July 17, 2005.
- 7 Rosenberg 2001.
- 8 Ibid.
- 9 Brazilian Ministry of Health 2001.
- 10 Personal interview with Dr. Mickey Waldron, July 19, 2004. Waldron was a part of the AIDS Management Team and now sits on the board of the Barbados National HIV/AIDS Commission.
- 11 Marquez 2004.
- 12 Personal interview with Dr. Mickey Waldron, July 19, 2004.
- 13 Parker 2003.
- 14 Teixeira et al. 2003.
- 15 Ibid.
- 16 Ibid.
- 17 Teixeira 2003.
- 18 Brazilian Ministry of Health 2001.
- 19 Brazil. CIA World Fact Book. 2005.
- 20 Personal interview with Dr. Mickey Waldron, July 19, 2004.
- 21 CIA World Fact Book; UNAIDS Epidemiological Fact Sheet: Barbados.
- 22 Personal interview with Dr. Timothy Roach, July 16, 2004.
- 23 Ibid.
- 24 Ibid.
- 25 Berkman et al. 2005.
- 26 Ibid.
- 27 Ibid.
- 28 Personal interview with Dr. Timothy Roach, July 16, 2004.
- 29 Personal interview with Dr. Carol Jacobs, July 20, 2004. Jacobs is the director of the Barbados National HIV/AIDS Commission and Chair of the Board of Directors of the Global Fund to Fight AIDS, Tuberculosis and Malaria.
- 30 Personal interview with Ms. Sheila Stuart, July 16, 2004. Stuart is the director of the Bureau of Gender Affairs, Barbados.
- 31 Gauri and Lieberman N.d.
- 32 Parker 2003.
- 33 Ibid, 158–159.
- 34 Petchesky 2003.
- 35 Personal interview with Ms. Hilda Thompson, July 19, 2004. Thompson was a nurse on the AIDS Management Team.
- 36 Ibid.
- 37 Personal interview with Ms. Sarah Adomakoh, July 21, 2004. Adomakoh was a HIV/AIDS researcher at the Chronic Disease Research Institute.
- 38 World Health Organization 2005.

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