Learning from the Past: Statebuilding and the Politics of AIDS Policy Reform in Brazil

by Eduardo J. Gómez

When compared to the other large, highly decentralized federations in the developing world, such as Russia, India, China, and South Africa, there is no question that Brazil has emerged as the best example of how a nation should go about responding to the AIDS crisis. The government's commitment to constructing autonomous federal health agencies, working closely with civil society and subnational health institutions to implement AIDS prevention and treatment programs, has led to a persistent decline in the number of HIV cases and deaths attributed to AIDS. Given the government's recent fiscal and political problems, the obvious questions to ask are why and how the government has been able to achieve this and why it is so committed to creating effective institutions and policies for AIDS and responding to its citizens.

In this paper, I address those questions by submitting an alternative interdisciplinary approach to explaining the politics of government response to AIDS. In contrast to the recent literature, I emphasize a combination of historical institutionalism, cultural analysis, and state bureaucratic capacity to explain the emergence of political elites who are committed to continuously building strong federal health institutions in response to epidemics while working closely with civil society to devise and implement policy. Through this approach, it is argued that Brazil responded very aggressively to the AIDS epidemic because of a series of antecedent, historical institutional developments, which engendered, by the early 1980s, a federal elite commitment to building an autonomous, highly centralized health bureaucracy controlling the spread of disease while working closely with civil society. Additionally, the absence of an early institutionalization of Christian moral values contributed to the emergence of a responsive federal elite, facilitating and encouraging collective action among homosexuals at the outset of the epidemic. Hence, a *persistent* federal government commitment to statebuilding in response to epidemics, coupled with the state's willingness to respond to civil society, has led to the implementation of successful AIDS prevention and treatment programs.

The first confirmed case of HIV/AIDS occurred in Brazil in 1980. Initially, as

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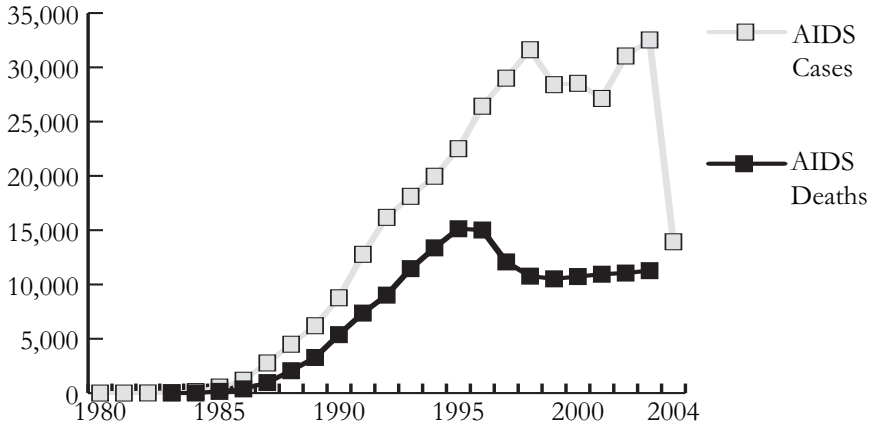
in the United States, the virus spread quickly. By 1985, the total number of confirmed cases had increased to 554, with a death toll of 154. As Graph 1 illustrates, AIDS levels increased dramatically through 1996. After that, the increase has been less rapid, and according to UNAIDS, the HIV/AIDS epidemic is stabilizing in Brazil. By 2001, an estimated 610,000 Brazilians—about 0.7 percent of the population—was living with full-blown AIDS, and in subsequent years, the number of new AIDS cases has dropped, from 32,526 in 2003 to only 13,933 in 2004.

The distribution of AIDS among the Brazilian population is striking as well. In 1996, 32.7 percent of AIDS cases were among homosexual males, 21.4 percent were attributed to intravenous drug users (IDUs), and within the heterosexual population, 18.2 percent. By 1998, however, the trend had changed considerably, with most of the confirmed cases found in the heterosexual population, at 47.8 percent, while cases among homosexuals dropped to 22.4 percent and among IDUs to 13.3 percent. By 2001, heterosexuals accounted for 59.4 percent of AIDS cases, while cases attributed to homosexuals and IDUs were 18.5 percent and 8.0 percent, respectively. [1]

Graph 1: Brazil - Number of AIDS Cases and Deaths, 1980-2004



Source: Ministry of Health, Brazil

This paper analyzes Brazil's success in containing its AIDS infection, which can be attributed to increased access to antiviral medication, combined with very progressive anti-AIDS prevention and treatment programs. In the next section, I discuss some of the recent approaches to explaining the politics of AIDS policy reform in the developing world, highlighting that most, if not all, of the recent work done on this topic is very static in nature, failing to address the linkage between historical institutions, culture, and the contemporary politics of AIDS. This is

followed by an empirical analysis supporting a more inclusive approach and concludes with a discussion of the Brazilian government's continued commitment to human security from AIDS.

Reconsidering the Politics of Government Response to HIV/AIDS

Of recent interest to political scientists has been comparing the politics of government response to health epidemics across countries. In the area of HIV/AIDS policy, while much has been written on the politics of government response in the United States,[2] less has been done comparing government response in middle- and low-income countries. Nevertheless, those studies that do exist tend to focus on the following independent variables: politicians' electoral incentives, the design of political institutions, such as federalism, and the role of civil society. I will briefly run through these approaches, highlighting their strengths and weaknesses, and conclude by proposing a more interdisciplinary approach that combines historical institutionalism, cultural (moral) analysis, and state (bureaucratic) capacity as an alternative approach to explaining the politics of government response to AIDS.

Recent studies on the politics of AIDS in the developing world have focused on the issue of politicians' incentives for reform. The argument is that in order to better understand how and why leaders respond to epidemics we need to first consider the electoral, cost/benefit rationales for policy intervention. Some scholars, such as Alan Whiteside, have argued that politicians intervene with aggressive prevention and treatment programs in order to enhance their chances of winning elections.[3] AIDS policy is thus considered as a key electoral strategy. Nevertheless, others find that electoral accountability often instigates fear in proposing bold AIDS prevention (and other) programs, as they challenge individual liberties by proposing radical changes to behavioral lifestyles; consequently, policy is never implemented.[4] Thus the point emphasized by these scholars is that electoral incentives shape the response of government leaders and that, as Anthony Downs once put it, "policy" is often crafted for winning elections, rather than trying to win elections in order to implement policy.[5]

The problem with these studies, however, is that they neglect the fact that government leaders are influenced by other variables, such as historical legacies, compassion, and legitimacy. We are simply led to assume that AIDS policy is treated as any other kind of policy, shaped and molded to suit politicians' electoral needs. Nevertheless, as seen with the case of Brazil below, and cases in Africa, such as that of Senegal and Uganda, politicians often strive to implement AIDS policies prior to and *after* elections, even when such policies are unpopular with electoral constituents. Indeed, as James Putzel argues,[6] the gravity of the AIDS epidemic often moves AIDS beyond the electoral realm, forcing leaders to respond in order to maintain their political legitimacy before and after elections. Putzel thus concludes that there

is nothing inherently political about AIDS policy.

An alternative approach that places greater stock in political institutions but has yet to fully emerge in the AIDS policy literature is the impact of federalism and decentralization on the policy reform process. A good example of this approach is Varun Gauri and Evan Lieberman's recent paper entitled "AIDS and the State: The Politics of Government Responses to the Epidemic in Brazil and South Africa."[7] In this paper, the authors posit that federalism and decentralization generate sufficient incentives for an early response to AIDS. Critical here is the importance of federalism and the decentralization of health policy as catalysts for early subnational policy innovations. Comparing Brazil to South Africa, Gauri and Lieberman notice that Brazil's decentralization of authority allowed for a high degree of government response at the *state level,* which in turn eventually incited federal politicians to follow suit. Early subnational reforms in Brazil, especially in São Paulo, were made possible because of the rich history of health policy autonomy and independence from the center, which in turn generated incentives to respond early to the AIDS epidemic. While providing an excellent account of how federalism may facilitate AIDS policy reforms, the problem is that this approach assumes that within highly decentralized federations, early subnational reforms instigate enough bottom-up pressure for national leaders to mimic local and regional reforms.

But focusing exclusively on the role of federalism overlooks the deep historical and cultural factors that motivate subnational and eventually federal politicians to respond to AIDS initially, and thus ignores the historical legacies that would have inevitably led to an aggressive state response. As already noted above and discussed in greater detail below, Brazil has a long tradition of federal executive and bureaucratic commitment to responding to health epidemics, motivated since colonialism by elite beliefs that state modernization must go hand in hand with curbing the growth of epidemics. Over the years, this concern motivated subsequent elites, even under the military, to pass down these traditions of aggressive state intervention.[8] Therefore, one can easily argue, as done in this paper, that the government's recent response to AIDS would have occurred regardless of the decentralization of federal institutions.

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Yet another problem that emerges in the Gauri and Lieberman piece is that it lacks an explanation for *why* federal- and state-level elites were so quick to respond to a highly controversial moral issue, that is, a *sexually* transmitted disease, especially within such a religious environment. Other nations, such as Russia and the United States, have seen these types of moral constraints delay government response to both syphilis and AIDS. But why were Brazil's political elites so open and willing to work with this sensitive issue? Based on the analysis of Gauri and Lieberman alone,

we cannot tell.

Finally, a significant amount of research has emphasized the role of civil society in generating sufficient pressures for government response. This general argument is that a proactive civil society, including associations and nongovernmental organizations (NGOs), can have a positive effect on AIDS policy implementation by working to constantly pressure the government for reforms. When effective, Samantha Willian and Alan Whiteside have argued that a proactive civil society can act as a safeguard from experiencing a full-blown AIDS epidemic, where the virus spreads uncontrollably, as seen in several African states.[9] Willian and Whiteside posit that because a well-organized civil society incessantly coordinates to pressure the government for policy reform, society will never have to worry about a full-blown epidemic, but rather a challenging disease.

The presence of a well-organized civil society represents a necessary but insufficient condition for prompting government response to a health crisis.

Barnett and Whiteside took this debate further by making distinctions between different types of civil societies and their capacity to avoid an epidemic.[10] The most successful were societies with high levels of social cohesion and income; the second most successful were societies with high levels of social cohesion but low income, experiencing a very slow-moving epidemic, with infection checked by social controls; third were societies with low levels of social cohesion and low incomes, experiencing epidemics that develop slowly but accelerate quickly; and the least successful were highly divided societies with low levels of social cohesion and high income.[11] In this literature, moreover, scholars argue that NGOs play a vital role in funneling the interests of civil society. For as Boone and Batsell argue, NGOs help society by becoming *partners with the state,* where they step in to provide much needed, recently privatized healthcare services.[12] The pervading assumption in this literature, however, is that a proactive, cohesive civil society, especially, though not necessarily, within democracies will always exert enough bottom-up pressure to force elites into aggressively responding to the AIDS epidemic.

The problem with this literature emerges when we conduct a simple test of necessary and sufficient conditions: Is a proactive civil society a necessary and sufficient condition for government response? Or is it, rather, a necessary but insufficient condition? As I argue in this paper, and as illustrated in the Brazilian case, the presence of a well-organized civil society represents a necessary but insufficient condition. For equally necessary is the presence of a responsive elite, leaders, and senior health officials who are constantly willing to listen and respond to the needs of civil society. Thus, much of this literature tends to focus on the bottom-up process of reform without realizing that civil societal success hinges on the willingness of federal elites to be equally receptive to their needs. Therefore the issue is both a top-down *and* bottom-up, two-way *reciprocal* relationship, not a one way,

bottom-up relationship, as this pluralist literature tends to emphasize.

The theoretical approach taken in this paper is thus an attempt to see how much leverage may be obtained by taking a more reciprocal approach that nevertheless places greater stock in federal elite response to AIDS. The analysis is tilted in favor of federal elites because it is they who establish federal agencies in response to epidemics and decide whether or not to maintain them over time, whereas civil society's role always depends on the elites' willingness to respond to their needs. Of course, the presence of a proactive civil society is seen as a necessary condition because without it there may not be sufficient pressures for the federal government to respond. Therefore, and in contrast to the literature noted above, I argue that better understanding the contemporary politics of AIDS policy may require a deep historical institutional and cultural analysis accounting for the *rise* of receptive political elites who progressively respond to societal needs. Indeed, recent political scientists are starting to gravitate toward this idea, arguing that authors of studies of contemporary AIDS politics have overlooked key historical lessons and legacies shaping current day legislation.[13]

The historical approach submitted in this essay focuses on the noninstitutionalization of Christian moral tenets on one hand, and the persistent tradition of federal elite commitment to building centralized health agencies while addressing societal needs on the other. Both of these historical institutional and noninstitutional movements are mutually dependent, such that the degree of moral noninstitutionalization will constantly influence federal elite commitments to building centralized, effective public health agencies.

The Victorian impulse is seen in, for instance, Russia where it has continually shaped legislation, institutions, and policy response to AIDS.

Regarding the institutionalization of morality, this paper explores and builds on James Morone's recent work on how the Christian moral impulse throughout American history shaped political elite views of sin and how, based on these beliefs, this in turn influenced the design of federal institutions and policy.[14] In brief, Morone asserts that, throughout American history, two types of moral politics transpired: dark "Victorian politics," where elites devised institutions and policies in ways that discriminated against immorality; and the "social gospel" approach that blamed the political and economic conditions of the day rather than individual behavior. According to Morone, the Victorian politics of government response to sin is the reflection of a lengthy history of the institutionalization of these discriminatory moral convictions, periodically inculcated through the constant interaction of morally inspired elites with great Christian "revivals": that is, periodic public gatherings generating moral "shocks" or "awakenings," continually reminding elites of who they are, what they believe, and from where they draw their political inspirations—and thus politics. As Michael Ross argues, these moral "tipping points"

periodically emerge throughout history, in turn, explaining how morality often influences the creation and sustainability of institutions.[15] The Victorian impulse is seen in, for instance, Russia where it has continually shaped legislation, institutions, and policy response to AIDS. Russia's Victorian impulses were shaped not only by the historical presence of a Christian morality, but also the conservative moral impulse of Soviet Communism. This outlook helps explain why few, if any, efforts have been made to implement federally sponsored anti-AIDS policy. The government has responded to certain segments of society struggling with AIDS, such as intravenous drug users, homosexuals, and prostitutes, with open discrimination and distaste, using their moral convictions as excuses to both avoid the implementation and enforcement of key anti-AIDS prevention and treatment programs while publicly chastising these so-called "sinners."

The early historical absence of Victorian morality in the Brazilian political realm led to the absence of a morally discriminatory outlook toward civil society.

In Brazil, however, the social gospel approach dominates. The early historical absence of Victorian morality in the political realm led to the absence of a morally discriminatory outlook toward civil society. Rather, political elites' perennial commitment to secularism in medical science and policy led to the emergence of a more politically responsive elite, one that sought to help so-called sinners through statebuilding and anti-AIDS legislation.

In addition to this moral outlook, perhaps equally as important for understanding the Brazilian government's response to AIDS, is a consideration of how the historical commitment to statebuilding arose and persisted. Scholars of AIDS politics have overlooked the importance of understanding the contemporary influence of historical efforts to construct highly centralized, autonomous public health agencies in response to epidemics and their *direct* association with statebuilding and modernization. As the case of Brazil illustrates, the federal government's response to the AIDS epidemic in 1985 very much reflected the government's long-held tradition of creating a centralized public health agency that could contain epidemics. The government's similar recent response to AIDS thus reflects a continued federal, political, and elite interest in controlling health epidemics from above, rather than completely decentralizing policy and implementation to subnational governments, as seen in other countries, such as the US, Russia, and India.

Understanding historical institutions and their legacies also enhances our understanding of the reasons why some democracies exhibit far more propitious social conditions for the *emergence* of a proactive civil society versus others. In Brazil, for instance, the absence of condemnatory institutions, such as military law, throughout Brazilian history, coupled with the outgoing military government's interest in gravitating toward individual rights and universal health care, facilitated

and encouraged collective action. This, combined with the absence of historical institutional condemnation of immoral behavior, motivated the homosexual and other at-risk communities to work together with NGOs and the Church for an aggressive response to the government's AIDS policies. However, it is important to note that the success of civil society was in large part determined by the presence of a receptive military and eventually democratic political elite, which was not openly discriminatory toward those affected by the disease.

The point I am trying to emphasize here is that, in contrast to the recent literature on the politics of government response to HIV/AIDS, more research must be done on the historical institutional and noninstitutional factors influencing the *rise* of a responsive political elite, one that equates statebuilding with a response to health epidemics and that is consistently responsive to the needs of civil society, on one hand, and the historical emergence of the institutional conditions leading to effective civil societal response, on the other. Therefore, the key issue raised by Cathy Boone and Jake Batsell on the *origins* of "good governance" for AIDS will be expanded here, where research should be "aimed at better understanding where state strength and effectiveness comes from… [This can] contribute to broader and more general understandings of what it takes to generate state capacity…"[16] This approach requires a deep historical, institutional, and cultural analysis, explaining the *sources* of current day state capacity and the political will for reform. Unfortunately, however, most of the current literature on the politics of government response to AIDS is, as noted above, highly static, focusing on the immediate politics of reform. Future work will thus need to look further into historical, institutional, and cultural issues in order to explain why federal elite interests and institutions are so path dependent and whether or not such patterns are also present with other types of epidemics, such as malaria and tuberculosis (TB).

There are, however, several limitations of the argument presented here, for I have omitted a discussion of the types of endogenous reproductive mechanisms that both lead to and sustain the presence of a responsive federal elite. These reproductive mechanisms may take the form of inter-elite learning, institutional traditions/norms, and/or sunk costs.[17] Discussions of endogenous reproductive mechanisms and their interaction with exogenous shocks, such as democratic breakdown and economic crisis, are required in order to test for the continual presence and efficacy of these endogenous mechanisms. Therefore future work will need to explore what, precisely, these mechanisms are, how they originate, and how they sustain themselves over time.

Statebuilding and the Origins of Health Bureaucracy

There is a rich history of government response to health epidemics in Brazil. Indeed, from colonialism to the 1920s, Brazilian political elites equated statebuilding with government response and control of health epidemics.[18] Located mainly in the coastal ports, colonial and newly independent elites believed that overcoming disease was vital not only for safeguarding the burgeoning agricultural economy, but also for

spurring economic development and advancing political nationalism. Thus, since colonialism, government response to epidemics has been equated with statebuilding: building a modern state that could compete with its European counterparts.

Two years prior to political independence, the Brazilian emperor and his medical elites responded to a host of epidemics, such as yellow fever, malaria, and smallpox, by creating a strong, highly centralized bureaucracy: the Departmento Geral de Saúde Público (DGSP), which was linked with the Minister of Justice in the Interior. This institution was designed with the intent of monitoring and curbing the rise of epidemics. From 1902 through 1920, the DGSP acted as a highly centralized administration freely penetrating state boundaries to eradicate various kinds of epidemics.

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What is important to note is that throughout this period, state elites, namely the emperor and his medical staff, were highly autonomous from civil society. Because epidemics posed a tremendous threat to the economic and political modernization of Brazil, as well as its importance for contributing to a grander sense of nationalism and pride, elites did not want either the DGSP or its policies to be influenced by powerful governors or landed and agricultural elites.[19] Civil society did not play a role in federal policymaking during this time.[20] Medical professionals and some intellectuals were the only civil societal actors that could, to some extent, influence legislation through informal meetings with the president and medical bureaucrats.[21] Yet their influence was very limited, relegated only to suggestions of how to improve medical access and treatment. They were *not* physically represented in the DGSP, nor did they directly influence policy legislation.

Even with the arrival of an authoritarian government in 1930, led by Getúlio Vargas, this pattern of centralized control over health epidemics continued and even expanded. Vargas increased the amount of fiscal resources going to the Ministry of Health and bolstered its centralized managerial authority, while creating the Servicio Especial de Saude Publico in 1942 to provide health services to all workers.[22] Thus, like his predecessors, Vargas sought to maintain and strengthen the federal campaign to curb the growth of epidemics.

The federal government's commitment to centralized bureaucratic control over epidemics did not end with the downfall of Vargas in 1945. Rather, it persisted, spanning across a series of future democratic (1945–1964) and military (1964–1985) regimes.[23] This commitment dovetailed nicely with the outgoing authoritarian government's efforts to create a more universal health care system, one which did not discriminate based on race, social status, or income. These twin fronts, that is, a persistent, progressive federal elite commitment to containing health epidemics

through centralized bureaucratic institutions, coupled with a commitment to universal health care access established by the outgoing military,[24] set the stage for an aggressive government response to HIV/AIDS.

Morality and the Politics of Sex

The historic absence of dark Victorianism since the colonial period helped provide the necessary groundwork for a deeply institutionalized and socially embedded tradition of secularism toward sexual behavior in the public sphere. The Portuguese who colonized Brazil never set out to convert the natives to Catholicism, nor did they have in mind to instill Christian teachings within federal institutions. Instead, political centralization, service to the crown, and economic decentralization were the key driving forces during the colonial period.[25] Further, Portuguese Catholicism was rich in "hidden morals"—Catholic ideals that were understood to be present in the family and community, but did not surface in the political and economic sphere, according to Richard Parker, in *Bodies, Pleasures, and Passions.*[26] Portuguese-style Catholicism, moreover, was very open to sexuality, even to the point of believing in saints who gave spiritual advice about good and proper sex.[27] Because of this, sexual activity was constructed as something socially and scientifically acceptable to discuss. Further safeguarding society and politics from the possible emergence of dark Victorianism were annual festivities openly embracing sexuality. In *Sex, Drugs, and HIV/AIDS in Brazil,* James Inciardi writes that the yearly carnival festivities held in Rio helps to suppress any potential movement toward sexuality as a social—and hence, political—taboo:

> *Carnival, an annual three day pre-Lenten festival, is a ritual reversal in that every form of pleasure is possible—there are no prohibitions that temper sexual practice or desire. It is a time when Brazilians momentarily suspend their moral categories and undertake "dangerous," prohibited practices. In this way, Carnival momentarily serves to both suspend and challenge dominant social structures like religion and the genre hierarchy.*[28]

Against this backdrop, political modernizers of Brazil allowed for the concomitant transformation of economy, society, and sexuality. That is, the European movement toward the scientification of sexual activity—discussing and analyzing sex in a scientifically objective manner—was embraced by government and civil society.[29]

Thus by the twentieth century, one detects the absence of dark Victorianism in Brazilian sexual politics. The movement toward the rational scientific, as seen in Western Europe, and the social acceptability of different types of sexual activity paved the way for a different type of government response to sexually transmitted diseases (STDs). Indeed, by the early 1980s, scholars began alluding to the fact that the Brazilian government did not immediately associate HIV/AIDS with the immoral, sexual nature of homosexuals, prostitutes, and drug abusers, as had been the case both in Russia and the US. Cristiana Bastos, for example, argues that the federal government initially associated the HIV/AIDS epidemic with the affluent

lifestyles of gay men in society, that is, their socioeconomic status and lifestyle, not their sexual preferences. She argues that associating with socioeconomic lifestyles provided a good excuse for the government not to intervene initially, relying instead on the gay community's ability to pay for the anti-retroviral (ARV) treatment.[30] Underpinning the association between wealth and disease, moreover, was the prevailing ideology of denying the existence of homophobia, akin to the denial of racial discrimination.[31]

The Government's Response to HIV/AIDS

The government's initial response to AIDS throughout the 1980s was marked by a high degree of fear and uncertainty. This, in turn, led to a slight delay in government response. This type of response was not attributed to the dark side of Victorian moral politics, but rather to social fear and bewilderment.[32] It was also attributed to the view that AIDS was seen as a health problem mainly associated with the affluent gay community, who could, the government believed, finance medical treatment on their own. This perception gradually changed, however, as homosexuals from all socioeconomic levels, but especially the poor, became increasingly afflicted by the disease. The government quickly realized that it would need to provide antiviral medications for both the homosexual community and the larger population. It is rather interesting to note that São Paulo's Ministry of Health had already responded to the epidemic, signaling to the federal government that it needed to respond more aggressively.

In 1985, President Sarney responded by creating a National AIDS Program (NAP). This program was housed under the Ministry of Health, controlling *all* of the activities associated with HIV/AIDS prevention and treatment. Sarney delegated a high degree of autonomy to the program and appointed ministers that were viewed as purely technocratic and apolitical. Despite initial complaints of his somewhat apathetic response to the AIDS situation, when he finally decided to create the NAP, his main priority was to construct a highly centralized agency governed by nonpolitical appointees that were well-versed in epidemiology.[33] The first appointee was Lair Guerra de Macedo Rodrigues (1986–1990; 1992–1996), followed by Eduardo Cortes (1990–1992) and Pedor Chequer (1996–2000). Perhaps with the exception of Cortes, who was sorely criticized for his somewhat condemnatory public relations campaigns, all of these ministers were allowed to operate autonomously.[34] Galvão argues that these ministers often coordinated with other agencies at the federal level to ensure that their initiatives were supported by the other branches, thus avoiding any overlap or conflict of responsibilities. NAP directors have fought to maintain this sense of autonomy while trying to obtain more resources from the Ministry of Health and international donors.[35] Each subsequent presidential administration has allowed this to occur, in turn leading to a high degree of administrative—and thus program—stability.

As in the past, scholars find that the NAP continues to maintain a highly centralized form of governance, especially in its relationship with subnational health

agencies.[36] Teixeira notes, for example, that the NAP believed that all states and municipalities had to implement its policy prescriptions from Brasilia, that they were, in a sense, "calling the shots from above."[37] Teixeira also notes that, throughout the 1990s, the NAP often established municipal agencies working on monitoring HIV and implementing prevention/treatment projects, despite the expressed discontent of state and municipal health agencies.[38] The centralized managerial authority of the NAP continues to this day. Relatively stable political conditions, especially under the presidency of Fernando H. Cardoso (1994–2000), when combined with a very low turnover of political appointees, have created a highly centralized agency that continues to formulate and implement policy while imposing its will on subnational health agencies and NGOs.[39]

This does not mean that the NAP and the Ministry of Health were completely isolated, despotic agencies. Although it maintains its centralized character, the NAP has always been simultaneously committed to consulting and representing the interests of civil society through NGOs while working in cooperation with other federal agencies. Since its inception in 1985, it has committed itself to institutionalizing the interests of civil society by establishing a federal AIDS Commission *(Comissão Nacional de AIDS)* and actively recruiting and representing the opinions of various NGOs and the Church.[40] Such trends continued over time, as NAP leadership sought better ways of improving its programs.[41] At the same time, the NAP organized several federal commissions to obtain advice from other agencies, such as the Ministry of Education and Justice.[42] At no time, however, were either NGOs or other agencies influencing policy decisions.

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In sum, since the initial AIDS outbreak, Brazil's political elite, namely the president and directors of NAP, were quite responsive to the needs of civil society. As in the past, the government retained its long-held tradition of creating a centralized bureaucracy to curb the spread of a major health epidemic. What is more, it combined a high degree of bureaucratic autonomy with the establishment of a close-working coalition with civil society and other bureaucratic agencies.[43] This kind of elite response continues under the current Ignacio de Silva "Lula" administration. Lula and the NAP have retained a fervent commitment to autonomously implementing policy while continuously working with civil society. It is important to note, however, that the presence of historical institutions in Brazil, in this case, the presence of an authoritarian government, had a very different effect on the incentives and capacity of civil society to mobilize. Indeed, it was the *absence* of

aggressive state repression based on sexual orientation, coupled with the outgoing military's interest in universal health care and human rights, that fostered a more cohesive civil societal response.

Civil society played an important role in the government's response to AIDS, especially the homosexual community, which had the highest rate of HIV/AIDS prevalence during the initial outbreak. Although the government initially blamed the homosexual community for the outbreak, the government's subsequent actions illustrate rather clearly how receptive and committed it became, a response which set the tone for future policy interventions.

Equating civil and human rights with universal access to medicine led to the emergence of several old and new civic associations.

At the beginning of the epidemic, the political conditions could not have been more propitious for the homosexual community's quest for an immediate government response to AIDS. The community's innovative and effective strategy for collective action, rather than immediately harboring their association with AIDS and their rights for medicine, instead saw them gradually, strategically lobbying the government and joining already well-established human rights organizations, concomitantly pressing for universal health care access. This took place as years of military rule were coming to an end, and the future possibility of a democracy, with individual rights, was essentially guaranteed, generating very strong incentives for the homosexual community to work together and with other parts of civil society to press for a government response to the epidemic. Indeed, Bastos notes that the fight for citizenship in a country that was emerging from an authoritarian government provided a larger, better umbrella for anti-AIDS organizing than a strictly homosexual-based movement might have provided.[44] She even goes to the extent of arguing that "the fight for civil rights and AIDS grew up together. And that in some cases, the energy of AIDS activism helped strengthen the awareness of and fight for civil rights."[45] Additionally, the pairing of human rights to medicinal access emerged at this point. Fair and free access to medicine was an essential right that all Brazilians should be granted.[46] This combined nicely with an emerging new federal commitment to universal health care.

Equating civil and human rights with universal access to medicine led to the emergence of several old and new civic associations. Gay rights groups created in the 1970s reemerged to campaign against AIDS, and several new groups emerged in cities across Brazil. Support Groups of AIDS Prevention were also formed in more than a dozen major urban centers by a diverse group of social workers, health professionals, gay activists, and individuals concerned with providing social and psychological support for AIDS victims. At the same time, The Group of Life *(Grupo Pela VIDAA),* also formed in Rio, was the first publicized organization committed to fighting for the rights of gays and challenging the justice system for

equal access to medicine. VIDAA was also the first organization to address the issue of "living with AIDS." Other formal institutions emerged, such as those formed by influential intellectuals and scientists or by liberal religious leaders.[47]

The role of the church was also important during this time. The Brazilian Catholic Church has worked with the government in its campaign to increase awareness and prevention of HIV/AIDS.[48] In a country where the majority of citizens are Roman Catholic, the church has, in contrast to Vatican policy, openly promoted safe sex through the distribution of condoms and sex education programs. Furthermore, the church continues to be involved in periodic federal level commissions organized by the NAP and Ministry of Health. Its role has been vital in helping citizens in the most isolated areas of Brazil, mainly the Northeast and Eastern (Amazonian) region, where it is difficult for health administrators to reach citizens. Prostitutes, intravenous drug users, and others affected by AIDS have also worked together and through NGOs to voice their concerns, however, it is the homosexual community, which had the highest prevalence rate at the beginning of the outbreak, that has demonstrated the most organization and commitment to realizing a government response to AIDS.

The liberal nature of the Catholic Church in Brazil has contributed to the Church's success. Both the church leadership and its members are depicted as participating in a "light" form of Catholicism, which, as noted earlier, takes morality out of the public and secures it in the private sphere. Additionally, recent extensive survey research conducted by Silvia Fernandes, a sociologist with the Center for Religious Statistics and Social Studies in Rio, found that "most people aren't worried about sticking to religious doctrine if it conflicts with the way they live, and this is especially true among the poor."[49] This has, in turn, facilitated the Church and the gay community's ability to organize and work with various NGOs and the international community when pressuring the government for a more effective response to AIDS.[50]

The key thing to remember here is that it was the *absence* of a repressive military state that allowed the gay community and other civic associations, concerned with human rights and access to medicine, to gradually develop and then strategically work together in order to pressure the government for an aggressive response to AIDS. But what is *more* important to note is that it was the absence of suppressive laws, as seen in other countries, that might have instigated a polarizing response within the homosexual community and thus conflicting opinions over how to go about pressuring the government. Without such laws, the gay community was able to think strategically and to work with NGOs for an effective response to policy. Their linkage with the NGO community, when combined with a supportive Church, continues to provide perhaps the most propitious civic conditions for collective action and bottom-up pressures for AIDS policy reform.

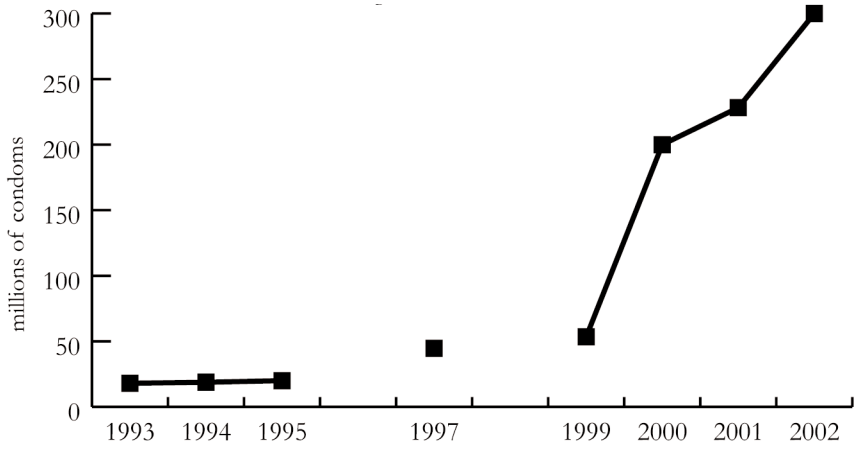
Cooperative AIDS Treatment and Prevention Programs

The dual emergence of a progressive federal elite and active civil society has, in

turn, led to the implementation of arguably the world's best anti-AIDS prevention and treatment programs. Since the early 1990s, the government has been committed to implementing various types of HIV prevention programs, ranging from free condom distribution (Graph 2) to safe sex education and federally sponsored harm reduction programs. At the same time, the government is widely known for its continued commitment to providing anti-retroviral drug medication and, moreover, continuously finding new ways to find and provide ARV medication in the cheapest, most effective way possible.

Efforts to distribute condoms started in 1993. Before then, condoms were sold at regular prices with a distribution of approximately 10 million units per year. After 1993, however, the government invested heavily in providing free condoms and working with NGOs to provide condoms at a discount. As Graph 2 illustrates, the distribution of free condoms had increased from 18.8 million in 1994 to 300 million by 2002. Recently, as part of its application for a third loan from the World Bank

Graph 2: Brazil: Federal Distribution of Condoms, 1993-2002



Source: Ministry of Health, Brazil, 2005

(AIDS III), the NAP has explicitly requested money for increasing the number of condoms distributed to 550 million a year.[51]

Sex education has also been vital. Over the years the government has sponsored several health education programs within schools while disseminating information through reports. As Table 3 illustrates, the government has sponsored several anti-AIDS educational programs that focus on the principle causes of HIV transmission, and a large percentage of the schools have adopted them. The most extensive and effective campaign has been the government's unwavering commitment to sex education. Infomercials through the radio and television are used on a daily basis.

The success of Brazil's anti-AIDS campaign is illustrated by the high degree of civic awareness regarding how HIV is contracted. As Table 3 illustrates, a survey

Table 3 – Brazil: Percentage of Population with Correct Knowledge of the Ways in which HIV is Transmitted

Indicator	N	NE	SE	S	CW	Total
% of Population with correct knowledge of how HIV is transmitted	57.6	57.5	71.8	73.5	70	67.1
% of population that believes HIV can be transmitted through insect bite	4.3	7.3	3.4	4.1	3.3	4.6
% of population that believes that HIV can be caused by using public toilets	16.4	19.9	11.5	11.5	13.3	14.2
% of population that believes that can be caused by sharing cutlery, glasses, and dishes	22.6	20.3	12.8	10.8	12.6	15.2
% of population that believes that HIV can be transmitted by sharing syringes	85.7	89.6	92.9	94.8	90.7	91.6
% of population that believes that HIV can be transmitted by having unprotected sex	97.1	96.5	95.4	95.7	96	95.9

Source: PCAP-BIR, 2005; taken from the National AIDS Program website, Ministry pf Health, Brazil, 2005

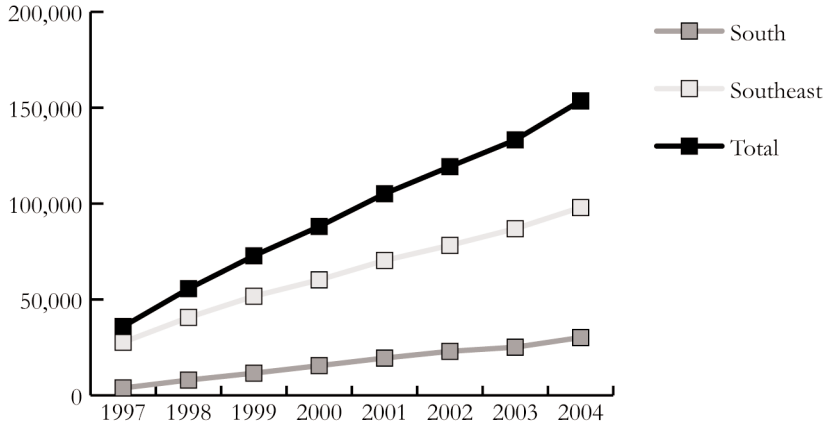
analysis in 1999 revealed that in the most afflicted regions, namely the southeastern and southern states, awareness that HIV is contracted through intravenous drug use and unprotected sex was acknowledged by over 90 percent of those surveyed. Other regions also scored very high in this category.

Lastly, the federal government has sponsored several harm reduction programs, helping curb the contraction of HIV through intravenous drug use. The major focus has been on distributing, through state and municipal health agencies and the NAP's municipal AIDS agencies, clean syringes for drug use. Recently, former minister of health José Serra, stated that this activity did not, in the government's opinion, indirectly contribute to the drug problem.[52] Rather, the goal has been to improve the physical well-being of drug addicts. This, argues Serra, will motivate addicts to get more involved in federal treatment programs, the idea being that drug addicts need to be healthy and have greater trust in government *before* working on psychological behavioral change.[53] This is not to say that the government has not sponsored programs to take care of these addictions; it has and continues to do so, but it has to make sure that addicts remain safe from HIV before enrolling them into anti-addiction programs. The results of these efforts have been quite striking. The percentage of intravenous drug users (IDUs) infected with HIV decreased from 21 percent of total HIV cases in 1994 to 11.4 percent in 2000. Within eight years, moreover, 160 projects aimed at harm reduction have covered approximately 65,000 IDUs.[54] The current government has remained committed to these programs and

sees them as vital for containing the rise of HIV.

Since the HIV/AIDS epidemic started, the government has been committed to providing antiviral medication free of charge. After several years of complaints—and lawsuits—from constituents that they were not receiving all of the medication needed, in 1996 President Cardoso implemented into law the provision of free universal access to *all* forms of anti-retroviral medication. As of 2003, Brazil provides seventeen individual types of anti-retroviral medication, including nucleoside reverse transcriptase inhibitors (NRTIs), non-nucleoside reverse transcriptase inhibitors (NNRTIs), and protease inhibitors (Pis).[55] Consequently, the number of individuals receiving ARV medication has increased substantially, from 35,892 in 1997 to 153,607 in 2003 (see Graph 4). Additionally, the federal government has been able to reduce and maintain low costs for ARV drug

Graph 4: Brazil: Number of Persons Receiving ARV Treatment in All Federal, Southeastern and Southern States, 1997-2004



Source: Ministry of Health, Brazil, 2005

production by establishing various different production plants and bargaining with international and domestic pharmaceutical companies.[56]

To ensure that citizens are receiving the medication they need, the Ministry of Health took two major initiatives. First, it established approximately 474 medical sites, mainly clinics in public hospitals, where citizens could obtain medication. This has proven vital for ensuring that those residing in the most rural areas of Brazil receive proper treatment. Next, beginning in 1997, the government implemented a software program, the Computerized System for the Control of Drug Logistics *(Sistema de Controle Logistico de Medicamentos, SICLOM),* to monitor how many antiviral medications are being used and to provide immediate availability reports to Ministry of Health headquarters in Brazil. These two initiatives illustrate the extent to which the federal government is committed to providing the local institutional and computational services needed to ensure that its citizens receive ARV medication in

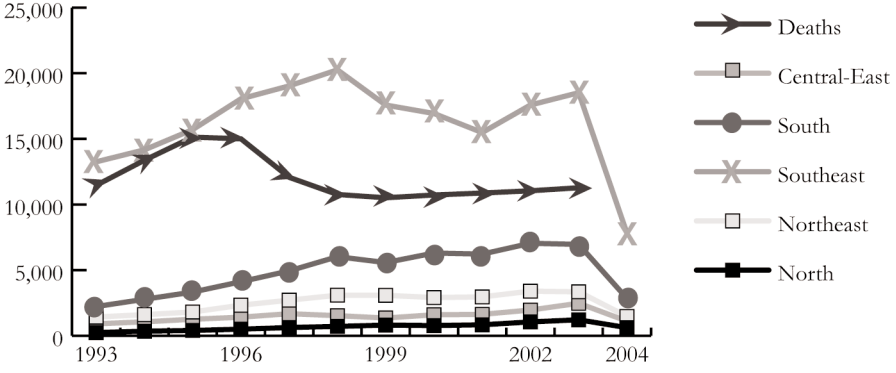
a timely, efficient manner.

Perhaps the most impressive part of the federal government's campaign to provide free, low-cost ARV services was its continued effort to pressure international and domestic pharmaceutical companies for price reductions. These negotiations mainly occurred shortly after 1995. Faced with a burgeoning AIDS crisis and fiscal crisis, President Cardoso and his Minister of Health, José Serra, forced international pharmaceutical companies to lower their prices by issuing a decree, secured through the World Trade Organization (WTO) TRIPS agreement obligations, that allowed governments to issue compulsory licenses for the production of ARV medication in cases of national emergencies (Article 78), or when abuses of economic power, such as high prices, were found to exist (Article 68).[57] This pressure worked and the companies began to lower prices. Government financing of ARV production sites began shortly thereafter, further contributing to a reduction in prices.

In a recent report, former minister of health José Serra emphasized that these actions were taken in order to drive home the point that democratic citizens' health *must* supersede the monopolistic interests of large pharmaceutical companies and, moreover, that it was the duty of the federal government to undertake the most efficient means necessary to accomplish those ends.[58] The Cardoso administration was so committed to this principle that at the fourth WTO Ministerial Meeting in Doha in November 2001, Serra wrote that

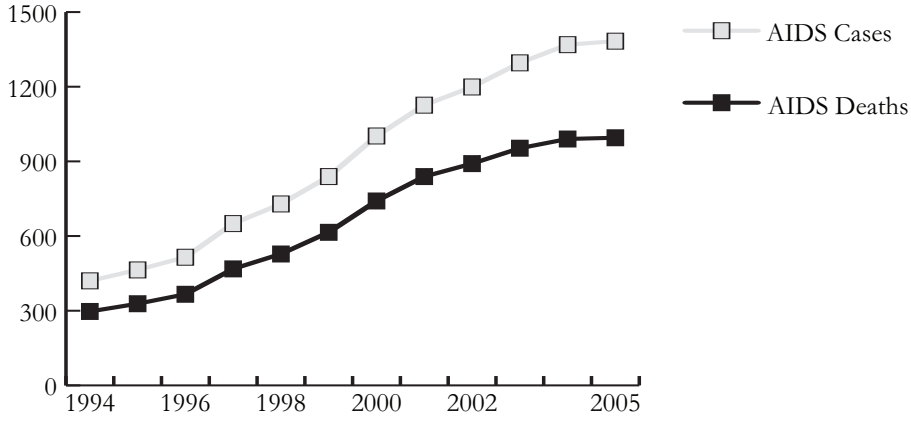
> *Brazil took the initiative of defending the idea that it is up to national governments to decide the grounds upon which they will grant compulsory licenses for life-saving medicine … [and that] the initiative was fully successful: it was adopted in paragraph 5-B of the Declaration of the TRIPS Agreement and Public Health.*[59]

Graph 4: Brazil: Cases of AIDS and AIDS Deaths 1993-2004



Source: Ministry of Health, Brazil; PCAP-BIR, 2005

Graph 5: AIDS Cases and Deaths in Russia, 1994-2005



Source: Federal Center for Scientific Research to Fight AIDS, Moscow, Russia, 2005

In sum, has the government maintained its commitment to ensuring that citizens receive AV medication in a timely manner? The short answer is yes: Lula remains fervently committed to this; he has also strived for a continued reduction in AV prices by increasing the production of medication at home while at the same time working with other countries, mainly in Africa, to achieve these objectives.

The empirical results derived from all these initiatives are astounding. As Graph 4 illustrates, the number of cases of HIV has markedly decreased and the number of deaths directly attributed to AIDS has plummeted. The wider significance of these results emerges when we compare Brazil to other large, highly decentralized federations struggling with the AIDS epidemic, such as Russia. The strong Victorian impulse in Russia, when combined with its tenuous public health infrastructure and reliance on a more decentralized form of HIV prevention and treatment policy, has contributed to a steady rise in the number of cases and deaths attributed to AIDS (see Graph 5). While Putin has recently acknowledged the fact that AIDS is an epidemic and that the government must respond, the Duma's predominantly conservative bent, when combined with the lack of internal bureaucratic incentives to reform the Ministry of Health, has made it nearly impossible to curb the spread of AIDS. What is more, Putin has been quite hostile to the presence of international NGOs seeking to provide assistance in AIDS treatment and prevention. Thus, unlike Brazil, the perpetual moral constraint, when combined with the continued presence of weak pubic health institutions (especially at the state and municipal level, with the rare exception of St. Petersburg), has contributed to the continued rise of HIV/AIDS cases in Russia.

While the Brazilian government's successful attempt to provide several prevention and treatment programs has for the most part paid off, several challenges remain. General health policy decentralization and how to manage prevention and

treatment programs in distant, rural lands, such as the Amazons will be a major challenge. For now, at least, there is no question that the government has saved its citizenry from staggering rates of HIV/AIDS infections and deaths, vital for sustaining Brazil's developmental prospects.

Conclusion

In this paper, I have taken an interdisciplinary approach to explaining why Brazil was so successful at responding to the AIDS crisis. This was done in order not only to accentuate the limitations of recent theoretical approaches to the politics of AIDS policy reform, but also to submit a different explanation for why the government has been so committed to constructing strong public health institutions while working with civil society to enact aggressive anti-AIDS policies. As in the past, federal elites have been committed to constructing and maintaining autonomous federal institutions that work closely with decentralized health agencies and civil society when implementing policy. All along this has been aided by the presence of a more secular approach to Christian morality and sexual politics. The historical institutional and cultural conditions have therefore been propitious for an aggressive response not only to AIDS but also for a host of other diseases.

What has been equally impressive is the unwavering efforts of the federal government to continually educate its citizens about HIV while securing equal access to medicine, thereby establishing a high degree of human security. Indeed, there is no question that, as in the past, the government is still committed to protecting its citizens from sexually transmitted diseases and other viruses that may reemerge as a result of the spread of HIV, such as TB. As noted earlier, mounting an aggressive prevention campaign through the media and education has been vital for protecting the citizenry from HIV. And recently, the government has instituted new prevention and educational programs targeted specifically toward young homosexual males, a demographic in which the HIV virus has quickly resurged.

In addition to responding domestically, the current Lula administration has also tried to help other nations protect its citizens from HIV. Lula has, for instance, recently worked with the Mozambiquan government to ensure that it has the resources and technical capacity needed to construct its own pharmaceutical plants and to provide aggressive prevention and treatment programs. Through these and other actions in the African region, Brazil has become one of the flagship nations for guaranteeing human security from AIDS.

Only time will tell if Brazil can maintain the institutions and resources needed to curb the spread of AIDS. History tells us that it can and will. But understanding this requires a different type of analysis, one that emphasizes the complex, inter-disciplinary intersection of historical institutionalism, culture, and bureaucratic capacity. As other nations emerge to aggressively contain AIDS and other types of viruses, especially within the so-called "fragile states," other scholars may benefit from this type of approach. This, in turn, may not only provide a fuller account for why and how governments respond to AIDS, but more importantly, it may also help

to construct a new bridge between academics and AIDS policymakers.

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