

**AIDS and the State:  
The Politics of Government Responses to the Epidemic in Brazil and South Africa**

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**Summary:** Political scientists have paid little attention to the politics of epidemics. This article begins to fill this gap by taking up the question of why some states have responded to the HIV/AIDS epidemic more aggressively than others, conceptualizing AIDS responses as a form of state-building. We attempt to answer the general question by comparing two countries, Brazil and South Africa, in which we might have expected similar state responses but in which we in fact observe substantially different policy trajectories. Our method of structured comparison tests for covariance between policy outcomes and political causes, and it identifies intermediate and logically plausible steps between cause and effect. We present evidence that Brazil's response was more aggressive than South Africa's with respect to bureaucratic development, and was much more aggressive with respect to both the prevention of HIV and the treatment of persons with HIV and/or AIDS. We argue that two factors explain the divergent responses: institutions established more space for policy entrepreneurship in Brazil, and the scope of the national political community, especially as it facilitated a racial interpretation of the virus, hindered the state response more in South Africa. We examine and reject several rival hypotheses that might explain the largely divergent response in the two countries: the nature and timing of the democratic transition, who was infected and when, the relative strength of civil society, the quality of leadership, general state capacity, and international linkages.

Version 1.0: Comments welcome. Please contact the author for an updated draft.

For presentation at the Annual Meetings of the American Political Science Association, Chicago, IL September 2-5, 2004.

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### Acknowledgments:

Evan Lieberman gratefully acknowledges financial support for his research from: The Robert Wood Johnson Foundation, the Center for Interdisciplinary Research on HIV/AIDS (Yale University), Princeton University, and the Princeton Institute for International and Regional Studies; and fine research assistance from Christina Shim and Nalini Gupta.

We also thank the dozens of South Africans and Brazilians who shared valuable information and their professional insights in interviews conducted with the authors.

The views expressed in this paper do not necessarily reflect those of the World Bank or its Executive Directors.

## I) Introduction

A key implication of Charles Tilly's important thesis that wars are central determinants of state-building processes<sup>1</sup> is that national crises and exigencies provide unique opportunities for governments to command new authority over societies. When convinced that substantial threats exist, individual and collective actors within society are more likely to demand and/or to accept new state powers. If this is true, national health epidemics ought to provide opportunities, analogous to wars, for states and societies to constitute new relations that defend against potentially lethal threats. While study of the state and of development policy are central concerns of political science, political scientists have paid little attention to health policy, let alone to the politics of epidemics.<sup>2</sup>

This article begins to fill this gap by taking up the question of why some states have responded to the HIV/AIDS epidemic more aggressively than others, conceptualizing AIDS responses as a form of state-building. In modern times, no health epidemic has implied the scope of global threat and lethal consequences as has the HIV/AIDS epidemic during the past two decades. Exact statistics on HIV/AIDS are even less reliable than battle statistics, but best estimates suggest that approximately 38 million people were infected with HIV in 2003, and more than 20 million have already died from AIDS-related illnesses<sup>3</sup> – more than the aggregate battle deaths of the twentieth century.<sup>4</sup> And while research is ongoing about the secondary effects of this virus, it seems clear that in many developing countries, AIDS is having a devastating impact on households, and in turn, on society at large, by orphaning children, hollowing out a productive labor force and civil service.

In facing this shared threat, states have developed new capacities to prevent further destruction to human life through the transmission of this virus. But there has been striking variance in their responses. Some states have attempted to transform habits in intimate domains and to influence social relations in various ways so as to minimize the risk of new infections. In many countries, states have also tried to protect the lives of those already infected, by affording them life-extending drugs, and/or legislating anti-discrimination protections. On the other hand, many states have done little along these

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<sup>1</sup> Tilly, Charles. 1975. Reflections on the History of European State Making. In *The Formation of national States in Western Europe*, edited by C. Tilly and G. Ardant. Princeton, N.J.: Princeton University Press; Tilly, Charles. 1992. *Coercion, Capital, and European States, AD 990-1992*. Malden, MA: Blackwell Publishers.

<sup>2</sup> Of course, notable exceptions exist, but a scanning of the contents of the leading political science journals identified no published articles on AIDS outside the United States, and only a handful of articles on AIDS in the U.S. More generally, a scan of American political science faculty rosters indicates the dearth of disciplinary research on health, particularly in comparative perspective. Among the most thoughtful social science comparative analyses published to date have been in interdisciplinary/area studies journals: Lanegran and Hyden (1993) and Boone, Catherine, and Jake Batsell. 2001. Politics and AIDS in Africa: Research Agendas in Political Science and International Relations. *Africa Today* 48. We take up several of the hypotheses raised by the latter in this paper.

<sup>3</sup> UNAIDS 2004, *Report on the Global Epidemic*.

<sup>4</sup> Behrman, Greg. 2004. *The invisible people : how the U.S. has slept through the global AIDS pandemic, the greatest humanitarian catastrophe of our time*. New York: Free Press, xi.

lines, or have been exceptionally slow in their response. Given the scope of the problem, and the fact that the rate of new infections continues to increase in many countries, the policy relevance of the question is all-too-evident. Understanding the divergent policy responses to this common threat may also shed light on more general patterns of policy responses, helping us to understand how various political, social, and economic factors structure national policy.

Our goal is to provide general theoretical answers to what we see as a broader question concerning the origins of state authority, while paying careful attention to the particularities of this unique social, cultural, and medical problem. That is to say that we attempt to draw from various theoretical frameworks which claim to provide conceptual and explanatory insights about the formation of modern states and specific state capacities, particularly in late developing countries. A host of particular, and idiosyncratic factors have had important influences in given times and places, but we aim to isolate those factors that can give us more general insights into the pressures that either enable or constrain government action.

Although we do not conceptualize the state as a monolithic, unitary actor, we are interested in the totality of “state action,” and as such, we attempt to aggregate varied sets of policies and actions into comprehensible portraits of government responses, distinguishable from the actions of non-government and sub-national government actors. We use the national state as our unit of analysis, examine the entire history of the epidemic, and allow for varied and waving responses as a possible outcome. Our assessment of the national responses is in terms of patterned action, not merely a single event or rhetorical statement. This approach provides us greater insight into the systematic determinants of policy portfolios and strategies, and less into the determinants of any particular policy, whose causes are also likely to be the product of a host of more proximate and idiosyncratic causes.

Following a long tradition of theorizing about the state, we attempt to open the black box of understanding why certain types of policies get formulated, or why states and societies constitute differing types of relationships across time and space.<sup>5</sup> The global HIV/AIDS epidemic provides something of a natural experiment amenable to social science research in that so many states have faced a similar, and relatively novel problem at approximately the same moment in time; the differing characteristics of national polities provide opportunities to explore the effect of such factors on policy-making. There are some important ways in which HIV/AIDS is similar to other problems addressed by social policy: scarce public resources must be used to address a problem for which there is incomplete information about causes and consequences, and for which there is disagreement about prioritization relative to other problems. On the other hand, there are ways in which the problem of HIV/AIDS is unique, if not completely *sui generis*: transmitted mostly through sexual contact, initially regarded as a largely homosexual disease, and in many places transmitted through the sharing of needles used while

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<sup>5</sup> There is too extensive a literature to cite here, but an excellent, synthetic volume discussing literature on the state is Migdal, Joel S. 2001. *State in Society: Studying How States and Societies Transform and Constitute One Another*. New York: Cambridge University Press.

injecting drugs, HIV/AIDS is a highly “stigmatized” social problem, in that it tends to hit hardest the most marginalized groups within society. On the other hand, it is the very social construction of what is a “normal” problem that is central to the resolution of any policy dilemma, and scholars of policy-making would be ill-advised to relegate HIV/AIDS outside the boundaries of general policy analysis.

To date, the body of literature on the comparative politics of AIDS policy is extremely limited, but our work attempts to build on existing contributions, including the strengths and weaknesses of completed research. As far as we know, three other types of empirical analyses have been carried out in order to gain some insights into the types of questions we ask here, and while each has generated some useful analyses and observations, we believe that each is also lacking and demands an alternative approach. First, there have been numerous single country studies.<sup>6</sup> While illuminating because of their attention to specific policy histories, they lack the important theoretical payoffs of comparative analysis, and it is difficult to rule out any present or absent factors as having been necessary, sufficient, or somehow influential on the outcome, particularly in the absence of a broader theoretical and empirical literature. A second form of analysis has been the edited volume, but as is often characteristic of such studies, the lack of a shared conceptual and explanatory framework winds up providing little analytic value beyond the case study method.<sup>7</sup> Finally, preliminary cross-national statistical analysis<sup>8</sup> provided opportunities for testing some hypotheses concerning the determinants of government responses, but valid and reliable data are limited, and hence additional analysis is needed. As Boone and Batsell (2001:12) note, many of the existing concepts and measures often used by political scientists simply do not capture the political dynamics that may be

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<sup>6</sup> On Brazil, see Chris Beyrer, Varun Gauri, and Denise Vaillancourt, “Brazil’s Response to AIDS: Policy and Politics, 1982-2002” (manuscript); Daniel, Herbert, and Richard G. Parker. 1993. *Sexuality, politics, and AIDS in Brazil : in another world?, Social aspects of AIDS*. London Washington, D.C.: Falmer Press (a member of the Taylor & Franmcis Group); Parker, Richard G. 1994. *A AIDS no Brasil, 1982-1992, Coleção História social da AIDS ; no. 2*. Rio de Janeiro, RJ: ABIA : IMS-UERJ : Relume Dumará.; José Serra, “The Political Economy of the Brazilian Struggle Against AIDS,” Institute for Advanced Study Friends Forum, Paper Number 17, April 2004; Cristiana Bastos, *Global Responses to AIDS: Science in an Emergency*, Indian University Press, 1999. On South Africa, see Grundligh, Louis. 2001. Government Responses to HIV/AIDS in South Africa as Reported in the Media, 1983-1994. *South African Historical Journal* 45:124-153; Ngwenya, Charles. 1998. Legal Responses to AIDS: South Africa. In *Legal Responses to AIDS in Comparative Perspective*, edited by S. Frankowski. The Hague, The Netherlands: Kluwer Law International; Schneider, Helen. 2002. On the fault-line: the politics of AIDS policy in contemporary South Africa. *African Studies* 61 (1):145-167; Whiteside, Alan, and Clem Sunter. 2000. *AIDS: The Challenge for South Africa*. 1st ed. Cape Town: Human & Rousseau : Tafelberg; Nattrass, Nicoli. 2004. *The moral economy of AIDS in South Africa, Cambridge Africa collection*. Cambridge, U.K. ; New York: Cambridge University Press.

<sup>7</sup> Some examples include, Bayer, Ronald, and David L. Kirp. 1992. *AIDS in the Industrialized Democracies: Passions, Politics, and Policies*. New Brunswick, N.J.: Rutgers University Press; Feldman, Douglas A., Society for Applied Anthropology. Meeting, and American Anthropological Association meeting. 1994. *Global AIDS Policy*. Westport, Conn.: Bergin & Garvey; Frankowski, Stanislaw, ed. 1998. *Legal Responses to AIDS in Comparative Perspective*. The Hague, The Netherlands: Kluwer Law International.

<sup>8</sup> Lieberman, Evan. 2004. “The Politics Determinants of HIV/AIDS Prevention Regimes: Preliminary Results from Cross-National Statistical Analysis.” (manuscript) Princeton, NJ.

driving government responses, implying that future research using such methods will require significant additional data collection.

### **Method and scope**

Our approach is a paired comparative-historical analysis in which we proceed inductively, while guided by theory. Specifically, we attempt to answer our general question by comparing the responses of two countries, Brazil and South Africa – countries for which there would have been good reason to *expect* very similar responses, and in which we observe quite different outcomes. Thus, we select cases based on wide variations on the dependent variable: Brazil’s response has been very aggressive, and South Africa’s has been rather mixed, with elements of stubbornly lethargic policy and implementation, despite having one of the highest estimates of point prevalence in the world,<sup>9</sup> and the dubious distinction as the country with the largest number of people with AIDS in the world. The primary goal of the paper is to account for these differences.

There are several reasons why, *prima facie*, a comparison between them should be illuminating.<sup>10</sup> To begin with, both have had major AIDS epidemics. It is true that South Africa’s epidemic, measured by HIV prevalence, is today orders of magnitude larger than Brazil’s; but, as we argue in more detail in the “epidemiology” section below, important aspects of the epidemic followed a similar trajectory in both countries – starting among largely white, urban, gay men and visibly affecting commercial sex workers, the poor, and heterosexuals more generally only 7-10 years later. By the late 1980s, experts in both countries warned that the epidemic would eventually reach catastrophic proportions. In making this comparison, we control for “level of development.” Both countries are middle-income countries: per capita income in 2002, in international dollars adjusted for purchasing power parity, was \$9,810 in South Africa and \$7,450 in Brazil. Both also have a high degree of income inequality: South Africa had a gini index of 59 in 1995, and Brazil’s gini was 58 in 2001.<sup>11</sup> Indeed, there is little doubt that “level of development” – broadly defined to mean the overall level of wealth, prosperity, and well-being of humans within a society – influence both the nature of the epidemic as well as the ability of a national government to respond to the HIV/AIDS crisis through transformative capacities. For example, the advanced industrialized nations have managed to control the spread of the epidemic, and virtually all HIV-positive individuals have access to life-prolonging HAART. At the very least, because governments in rich countries have greater access to financial and other resources, and tend to have more authoritative and stronger states, responses to threatening epidemics such as HIV/AIDS tend to elicit

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<sup>9</sup> UNAIDS 2004.

<sup>10</sup> Indeed, there is now a substantial body of literature comparing politics and policy-making in these two countries including Seidman, Gay. 1994. *Manufacturing Militance: Workers' Movements in Brazil and South Africa 1970-85*. Berkeley, California: University of California Press; Friedman, Steven, and Riaan de Villiers, eds. 1996. *Comparing Brazil and South Africa: Two Transitional States in Political and Economic Perspective*. Johannesburg: Center for Policy Studies. Marx, Anthony. 1998. *Making Race and Nation*. Cambridge: Cambridge University Press.; Lieberman, Evan S. 2003. *Race and Regionalism in the Politics of Taxation in Brazil and South Africa, Cambridge studies in comparative politics*. Cambridge, UK ; New York: Cambridge University Press.

<sup>11</sup> World Bank, World Development Indicators, 2004.

quicker and more expansive responses. In addition, a higher level of organization of interests creates strong political pressures in such countries. Previous work demonstrates that in cross-national statistical analyses, GDP per capita is correlated with higher levels of per capita government spending on HIV/AIDS, even when controlling for estimated levels of HIV Prevalence.<sup>12</sup> And yet, level of development, as measured by GDP per capita, level of urbanization, or levels of Human Development only accounts for part of the variance in government responses across countries. Given the extreme similarities between Brazil and South Africa in terms of level of development, as measured in these various ways, it is only possible to conclude that other factors have been at work.

While we recognize that it is not possible to infer conclusions about the determinants of AIDS policy responses across all countries and all time periods from a two-country study, we strongly believe that this type of analysis is sorely needed at this still-early stage of the research cycle. A structured comparison allows us to develop useful analytic constructs and measures, while being sensitive to the limitations of any simple indicator within the context of the particular cases. It allows us to subject the conventional wisdom of case studies, which are often informed by the rhetoric of policy actors themselves, to a more rigorous comparative analysis concerning the necessity and/or sufficiency of hypothesized causal factors. Our analysis examines the ongoing process of making and implementing policy, identifying patterns of similarity and difference both across the two countries, and within each country, over-time. In addition to testing for covariances between hypothesized causes and effects, we also rely heavily on causal process observations<sup>13</sup> to assess the importance of hypothesized explanatory factors. That is, we attempt to identify intermediate and logically plausible steps between cause and effect, which helps us to rule out spurious findings. By studying the cases closely, we draw on counter-factual reasoning<sup>14</sup> in the context of the two historical records. The observational base for empirical analysis is wide-ranging: We rely upon government documents, newspaper articles, secondary accounts, websites of various actors and international organizations, and semi-structured interviews carried out by the authors with approximately 90 individuals from the two countries, carried out in Brazil (May 2003), South Africa (June/July 2003), and in Bangkok, Thailand, during the 15<sup>th</sup> International AIDS conference (July 11-16, 2004).

Ultimately, we find that two factors were most important in explaining the *divergent* responses of the governments in the context of otherwise “similar” countries:

- The first factor describes the opportunities for developing policy: Different types of **political institutions** provided much greater space for successful policy entrepreneurship in Brazil than in South Africa. Unlike standard “high-priority” government policies, such as economic policy and defense policy, an issue like HIV/AIDS is much easier for

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<sup>12</sup> Lieberman 2004.

<sup>13</sup> Brady, Henry E., David Collier, and Jason Seawright. 2004 (forthcoming). Refocusing the Discussion of Methodology. In *Rethinking Social Inquiry: Diverse Tools, Shared Standards*, edited by H. E. Brady and D. Collier. Berkeley, CA: Rowman & Littlefield and Berkeley Public Policy Press, 9.

<sup>14</sup> Fearon, James D. 1991. Counterfactuals and Hypothesis Testing in Political Science. *World Politics* 43:169-95.

national leaders to avoid, and to postpone, for many reasons, including the fact that it disproportionately affects marginalized segments of society, and it is a silent epidemic, in which illness and death arrive several years after infection. National government action requires convincing decision makers that something needs to be done, that action is likely to be effective, and that inaction will be politically damaging. We argue that such pressure is much more likely to be forthcoming in a de-centralized institutional environment, in which policy entrepreneurs can make rapid policy progress at a sub-national level, creating models and political pressure with upward cascading effects. On this score, we demonstrate that political power is far more diffuse and decentralized in Brazil, particularly when compared with South Africa, and this difference goes a long way in explaining the former's more rapid and extensive national government response.

- The second factor describes the socio-political constraints on policy: Different **prevailing notions of political community** were a much greater impediment on policy formulation and implementation in South Africa than in Brazil. While both countries are racially heterogeneous and socio-economic inequalities are strongly associated with skin color, different political histories produced very different state policies and societal norms regarding the permeability and socio-political relevance of the color line. In turn, this has served to influence the racialization of the virus in public and private discourse, and the interpretation of the general threat of contagion. Even while South African prevalence rates soared past Brazil's peak, various actors within South Africa's divided society continued to argue that the epidemic was "contained" to certain groups, weakening the level of resolve from the central government and sowing confusion within society about the need for private and public action. High levels of intra-group tension, corresponding with low levels of sexual contact across the color bar (historically prohibited by law) provided fodder for myth making and confusion about how to interpret domestic and international trends in the epidemic. Such perceptions, evident within the general public, as well as among policy-making elites, have dampened the potential for consensus and action on AIDS in South Africa. By contrast, in Brazil, there has been an almost complete absence of racial discourse around HIV/AIDS – which while not surprising given a different legacy of racial politics, is nonetheless still significant given the strong correlation between race, class, and place of residence in that country. Even when the epidemic was largely identified within a particular geographic location, and largely among homosexual men, it could plausibly be perceived as a *national* health threat.

While other plausible arguments have been made about the determinants of responses in each country, our comparative-historical analysis leaves us less convinced that epidemiological factors (who was infected and when), the relative strength of civil society, the quality of leadership, general state capacity, or international linkages were nearly as determinative of the significant differences we document in the respective national responses.

In addition to these findings, discovered in our search for explanations for the determinants of *varied* policy responses, we also found significant evidence for a *similar* policy response. While we had initially thought that similar political regime types (recent

democratization) would serve as a control factor in our analysis, the varied timing of the respective political transitions provided opportunities to explore the impact of this factor on state responses. Specifically, the promulgation of new, extremely liberal constitutions in the wake of repudiating authoritarianism in both countries provided important foundations for enacting protective, human rights-oriented legislation. Importantly, we find that policy achievements in terms of rights do not presage analogous achievements in terms of the mobilization of resources and effort more generally.

The remainder of the paper is structured as follows: We provide a theoretical framework for understanding the components of government AIDS responses as a form of state capacity-building, and then we detail important contrasts and some similarities in the nature of the Brazilian and South African responses. Next, we identify a set of possible explanations for these differences and detail evidence that suggest the link (or lack of link) between such factors and the observed outcomes. Finally, we conclude by suggesting the theoretical and policy relevance of our findings, and suggest avenues for further research. We opt against a simply chronological exposition of events in order to parse out the analytics – a style which we realize makes for somewhat more cumbersome (and in this version, lengthy) narrative, but lends itself to the type of causal assessment that is our central concern.

## **II) Contrasting government responses**

Government policies to curb the HIV/AIDS epidemic can be understood as attempts to establish new patterns of behavior, and new habits, both among citizens and in their relationships to government. Much of AIDS policy involves getting individuals to do things that they might not ordinarily do, or would prefer to not do (wear condoms, abstain from sexual relations, use clean needles, get tested for HIV), other things being equal. AIDS policy in that respect resembles other policy areas, as when the state demands that citizens make tax payments or join the military, and it tends to be comprised of both inducements (convincing people that such actions and habits are in their own interest) and constraints (sanctions for not conforming). On the other hand, as distinct from raising revenues and building a military force, government leaders are less likely to see HIV/AIDS policy as directly serving their own, short-term interests. Rather, most HIV/AIDS policy benefits those infected or most at-risk in the near-term, and government leaders and society-at-large will benefit over the longer term. As we will find in the next section, such time horizons and perceived interests influence the nature of the politics of HIV/AIDS policy.

Before turning to explanation, however, we must begin by describing patterns of similarity and difference, and HIV/AIDS policies must be understood in context. For example, epidemiological patterns, and the particular habits associated with the prevailing modes of disease transmission vary across place and time, and we take up these potential confounds later in the paper. In order to make valid cross-national comparisons, we consider three broad areas of action that can help to distinguish aggressiveness of government responses. While there is clearly some overlap across these

areas, and presumed inter-relationship in terms of their effect on societies, we consider each distinctly to ensure that we have fully captured the various dimensions of each state's actions:

- The construction of bureaucratic capacity. The degree to which autonomous authority is established by the state for combating AIDS has varied tremendously across countries, reflecting entirely different levels of priority assigned by those in positions of power. Like other types of state capacities, a government's AIDS response capacity involves a mix of implementation, monitoring, and analysis functions.

- The broadcasting of prevention strategies.<sup>15</sup> In order to curb the spread of new infections, governments have, to varying degrees, tried to convince citizens to get their blood tested, and to alter their sexual practices – including the use of condoms, the numbers and types of partners they have, and the age of sexual debut; how and where they deliver babies; and how they use injecting drugs. In certain cases, they have tried to restrict the movement of HIV-positive individuals to prevent them from infecting others, and even to restrict the movement of those groups thought to be at high risk for infection.

- The provision of treatment and support to people who are HIV-positive. In order to extend and to improve the quality of life of infected individuals, governments have – again to varying degrees – tried to get such individuals to increase and transform their interactions with health care providers by testing their blood to learn of their sero-status, and using medications to treat their opportunistic infections, or to address the influence of the virus with anti retro-viral (ARV) drug therapies. Moreover, some governments have tried to reverse the tendency to stigmatize HIV-positive individuals, and to discriminate against them in various public and private arenas, such as in schools and the workplace. On the other hand, some governments have themselves been party to the very type of discrimination against people with HIV or who may be at high-risk for contracting the virus that has led to negative attitudes against such individuals and groups.

In this section, we detail patterns of government policy in South Africa and Brazil, with an eye to characterizing the relative timing and scope of their respective responses in terms of these three dimensions (summarized in Table 1). Notwithstanding wrinkles, nuances, and surprises in a few particular policy dimensions, we found stark contrasts in the overall government responses. In South Africa, the overall response was substantially more delayed. Policies have been derailed and have wavered, with the result that the South African state has been largely unable to develop a transformative project that reduces the risks of transmitting HIV and dying from AIDS-related illnesses to the extent feasible given the available state of medical knowledge. In Brazil, the response came earlier and was more robust. The construction of state capacity, as well as particular prevention and treatment programs, arrived sooner than they did in South Africa, and the scope of efforts to transform the patterns of behavior has been wider in Brazil than in South Africa.

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<sup>15</sup> Here we elaborate on Herbst's notion of the "broadcasting" of state power. Herbst, Jeffrey Ira. 2000. *States and Power in Africa: Comparative Lessons in Authority and Control*. Princeton, N.J.: Princeton University Press.

## **AIDS Bureaucracies**

Neither Brazil's nor South Africa's trajectory of state capacity building has been entirely consistent or linear, but it is clear that in Brazil the state made a commitment to establish policy space for the AIDS response sooner, and that the bureaucracy was endowed with wider and stronger authority, than in South Africa. Whether one looks at the timing of institutionalization, the level and growth of expenditures, or efforts to partner with civil society, Brazil has been more aggressive. The establishment of monitoring and analysis capacity, on the other hand, has been similar in the two countries.

Brazil established an **AIDS bureaucracy** in 1985, when a National AIDS Program (NAP) was created within the Ministry of Health.<sup>16</sup> The National AIDS Program would change its name eight times between 1987 and 1996, but there would be significant continuity in its policies and even its personnel.<sup>17</sup> In 1988 the inter-ministerial National Commission to Control AIDS was established. The Commission reported to the Ministry of Health but included representatives from Ministries of Education, Labor, and Justice, the principal association of lawyers in Brazil, various universities, and four NGOs. The Brazilian government negotiated the first in a series of three loans with the World Bank in 1993. That targeted funding for AIDS gave the NAP substantial autonomy within the Ministry, including the ability to hire its own staff on a contractual basis with more flexibility than civil service rules generally allowed. Since 1993 the NAP has been responsible for and has formulated AIDS policies regarding prevention and treatment on behalf of the government. A government audit showed that 476 staff and consultants were under contract with the NAP in 2002.<sup>18</sup>

By contrast, there is still no truly autonomous AIDS policy-making unit in South Africa, and it was not until 1998 – ten years later than in Brazil – when an inter-ministerial unit was established.<sup>19</sup> In general, the history of bureaucratic development has been marked by a series of starts and stalls, and a general failure to establish a clearly authoritative institution. The South African government established a relatively minor AIDS Unit and National Advisory Group in 1988, comprised of just a handful of staff members within the department of health,<sup>20</sup> which advised the government on AIDS policies and carried out some minimal prevention policies. After 1994, a national HIV/AIDS and STD Directorate was established, which by 1998 was staffed with 18 full-time staff members and 7 short-term consultants.<sup>21</sup> In 2000, the South African National AIDS Council (SANAC) was established, chaired by the Deputy President, formally constituted as the

<sup>16</sup> Portaria 236 of May 2, 1985, cited in Paulo Roberto Teixeira, "Políticas Públicas em AIDS," in Richard Parker, editor, Jorge Zahar, editor, *Políticas, Instituições e AIDS: Enfrentando a Epidemia no Brasil*, ABIA / Jorge Zahar Editor: Rio de Janeiro, 1997.

<sup>17</sup> There have been five different coordinators of the AIDS program from 1985 to 2004; in contrast, there have been fourteen different Ministers of Health. Jane Galvão, *AIDS no Brasil: A agenda de construção de uma epidemia*, ABIA / Editora 34: São Paulo, 2000, pp. 118-119; and the Ministry of Health website: <http://dtr2001.saude.gov.br/bvs/popup/estrutura/ministros/galeria.html>

<sup>18</sup> Controladoria-Geral da União, *Segundo Projeto de Controle da AIDS e Doenças Sexualmente Transmissíveis: Relatório de Auditoria*, 2001.

<sup>19</sup> Schneider, Helen. 1998. The AIDS Policy Process in South Africa. Geneva: The Policy Project, 3.

<sup>20</sup> Personal communication with Helen Schneider email June 23, 2004.

<sup>21</sup> Schneider, Helen. 1998. The AIDS Policy Process in South Africa. Geneva: The Policy Project, 3.

“highest body that advises government on all matters relating to HIV/AIDS,”<sup>22</sup> but interviews with various non-state actors and expert observers make clear that this body is not widely recognized as the authoritative source of decision-making on AIDS policy. As of 2004, the national government employed only about 100 individuals with direct responsibility for HIV/AIDS – far less than the Brazilian state, even though there are (an estimated) six times more people infected with HIV in South Africa.<sup>23</sup> Throughout the history of the AIDS epidemic, there has not been a clear center of power for the direction of AIDS policy, as the various AIDS policy-making structures have been granted limited autonomy, and have often been contradicted by various national executives.

Similarly, AIDS budgets show different **patterns of expenditure** and prioritization in the two countries: although the South African AIDS budget has been significantly increased in the past two years, reflecting increasing attention to the HIV/AIDS problem, the Brazilian state dedicated more resources to HIV/AIDS sooner. Highly reliable time-varying data on government-related AIDS expenditures are hard to come by,<sup>24</sup> but using data on “programmatic expenditures” (which in Brazil includes prevention, treatment, transfers to states and municipalities, administration, and media, but excludes civil service salaries and ARVs), Brazil’s federal programmatic spending on AIDS averaged US\$ 56.5 million from 1993-2002 and exceeded US\$ 30 million, in constant 2002 dollars, in every year since 1993. (See Figure 1). In those years for which comparable data are available, non-treatment expenditures in South Africa were lower than in Brazil for every year and did not reach US\$30 million until 2001.<sup>25</sup> (Again, see figure 1). In 2002, the last year for which final figures were available, total AIDS-related government expenditures were US\$274 million in Brazil; in the budget year 2002/03, expenditures were US\$116 million in South Africa.<sup>26</sup> The large majority of expenditures in both countries are now for the purchase and production of ARVs; those are discussed below in the section on treatment. Indeed, the South African government’s expenditures may skyrocket due to the costs of treating so many individuals, and while this will reflect some aggressiveness, the longitudinal view of the government’s approach demonstrates that more *timely* expenditure could have averted such extensive needs later on.

Even as a matter of simply including HIV/AIDS as a named priority in the national budget, the Brazilian response was quicker: Brazil’s national budget included a reference to AIDS control as early as 1988, when it was included in the program to control sexually transmitted diseases<sup>27</sup>; but it was not until the 1997 budget speech in South Africa that AIDS was even mentioned in the formal presentation of that country’s budget. The South African Minister of Finance was silent on HIV/AIDS in 1998, and it was not until 2000

<sup>22</sup> South African Government HIV/AIDS Strategic Plan 2000-5: 12.

<sup>23</sup> Interview with South African government official, 2004.

<sup>24</sup> Countries include different items in the category of AIDS-related spending, figures incorporate different levels of government expenditures in national totals, and governments pay different prices for similar levels of inputs, notably for anti-retroviral and other drugs.

<sup>25</sup> Hickey Budget Brief 127: p.4.

<sup>26</sup> Brazil AIDS expenditure data were obtained from the Assessoria de Planejamento e Avaliação, Programa Nacional de DST e AIDS, in the Ministry of Health. South African budget data are from Hickey, p. 2.

<sup>27</sup> República Federativa do Brasil, Presidência da República, Secretaria de Planejamento e Coordenação, Secretaria de Orçamento e Finanças, Orçamento da União, Projeto da Lei, Vol. 1, 1988

that the expenditure estimates of the budget would reveal specific line items dedicated to expenditure on HIV/AIDS.

Figure 1 here

**Partnerships between the state and non-government organizations**, which can take the form of the provision of financial resources, consultative frameworks, and symbolic encouragement of a particular mission, are an important component of many state strategies for influencing patterns of behavior associated with disease transmission and AIDS-related suffering, morbidity, and mortality. While state-society relationships can be conflictual, particularly when societal actors make demands on the state for providing policies and resources, state actors often find it advantageous to empower non-state organizations to help achieve their objectives both in the area of HIV/AIDS as well as in many other policy areas. Brazilian NGO's have been able to forge much deeper and "embedded" partnerships<sup>28</sup> with government than has been possible in South Africa.

Relations between South African NGOs and the national government have developed in a much more conflictual, as opposed to cooperative, manner, even if punctuated by a "honeymoon" period during the early 1990s. Nonetheless, even when relations between these spheres were more harmonious, the focus was on meetings and strategic planning, rather than active collaboration to transform patterns of behavior. An October 1992 national AIDS conference led to the development of an umbrella government-civil society organization, the National AIDS Convention of South Africa (NACOSA).<sup>29</sup> Though at the time it was considered an important milestone and the start of a deliberate and coordinated response,<sup>30</sup> it resulted in very little implementation. In 1997, government and NGO actors again attempted to coordinate a national vision in another major conference.<sup>31</sup> But as it became clear that the national government assigned low priority to the implementation of transformative policies, the distance between state and societal actors would grow, with previous collaborations giving way to outright hostility, protests, international condemnations, and lawsuits. In 2000, when the South African National AIDS Council (SANAC) was formed under the leadership of the Deputy President, Jacob Zuma, "High-profile (NGO) organizations like the AIDS Law Project and the Treatment Action Campaign were not represented,"<sup>32</sup> suggesting the government's increasing desire to pursue an approach autonomous from the most recognizable non-government AIDS organizations. In 2004, when the South African HIV/AIDS budget had grown quite large, the amount of money earmarked for transfer to NGOs was only R54MM rand – approximately \$8 million.

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<sup>28</sup> Peter Evans describes the positive effect of such a cooperative relationship between the state and private business actors in the case of Korea in Evans, Peter. 1995. *Embedded Autonomy: States and Industrial Transformation*. Princeton: Princeton University Press.

<sup>29</sup> Van der Vliet, Virginia. 2001. AIDS: Losing "The New Struggle?" *Daedalus* 130 (1), 160.

<sup>30</sup> Schneider, Helen and Joanne Stein. 2001. Implementing AIDS Policy in Post-Apartheid South Africa. *Social Science and Medicine* 52:723-731; Schneider 1998: 5.

<sup>31</sup> Schneider and Stein 2001:727.

<sup>32</sup> Van der Vliet 2001: 170.

The Brazilian record has been notably different. Brazilian government collaboration began with the participation of civil society organizations, particularly Somos and Outra Coisa, in the state of São Paulo's AIDS outreach and prevention programs for gay men in 1983. By 1986, several NGOs were involved in the federal government's policy working groups. In 1988, four NGOs (Associação Brasileira Interdisciplinar de AIDS, Grupo Gay da Bahia, Associação Brasileira de Entidades de Planejamento Familiar, and Centro Corsini de Investigação Imunológica) were given a formal role in the inter-ministerial National AIDS Control Commission.<sup>33</sup> In these years, while NGOs were collaborating with the National AIDS Program, including distributing prevention materials to vulnerable populations, many NGOs were also protesting the government's delay in regulating the national blood supply and its failure to provide information and resources for AIDS control. Conflict with the government intensified during the Collor administration, when the government adopted an AIDS prevention strategy based on mass media that NGOs perceived as stigmatizing those infected.<sup>34</sup> After the return of the previous director of the National AIDS Control Program in 1992 and the beginning of the first World Bank loan in 1993, the government began to transfer resources to NGOs for HIV/AIDS prevention, outreach, treatment, and support projects. Between 1993 and 2003, US\$25.5 million was transferred to NGOs for activities related to HIV/AIDS outreach and support. Over US\$10 million is budgeted to be transferred to NGOs in 2004, and the government now plans to allocate 15% of the HIV/AIDS programmatic budget to NGOs.<sup>35</sup> In official government documents, and in various interviews and presentations at the XVth International AIDS conference in Bangkok, the Brazilian government has touted its cooperative relationship with the NGO sphere as a uniquely productive component of its successful AIDS strategy.

The establishment of **monitoring and evaluation capacity**, especially a system for epidemiological surveillance, is another way in which the state builds capacity to identify behaviors that spread the disease and the social conditions that promote them and plans for treatment interventions. Neither the Brazilian nor the South African state has been particularly aggressive in this area, but for different reasons. Although South Africa established the requisite infrastructure for a series of epidemiologically comparable sentinel surveillance surveys among pregnant women starting in 1990, the South African state did not collect early data on high risk groups, such as truckers, miners, and transient workers, which would have been useful for developing an effective response and for mobilizing the public by making evident how large the epidemic could become. Brazil did collect data on high risk groups as early as 1988, but until recently for the "general population" Brazil has relied on AIDS case reporting instead of a nationally representative sample of HIV prevalence, which has meant that evaluation of government programs has been limited in scope.<sup>36</sup>

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<sup>33</sup> Teixeira 1997

<sup>34</sup> Teixeira 1997, Galvao 2000

<sup>35</sup> World Bank 2004; Programa Brasileiro de DST/AIDS, *Resposta: A experiência do Programa Brasileiro de AIDS*, 2004.

<sup>36</sup> For estimates of HIV prevalence in various risk groups in Brazil in 1988-92, see Euclides Ayres Castilho and Pedro Cheuquer, "Epidemiologia do HIV/AIDS no Brasil," in Richard Parker, editor, *Políticas, Instituições e AIDS: Enfrentando a Epidemia no Brasil*, Rio de Janeiro: Jorge Zahar Editor, 1997. In 1996, Brazil began to monitor HIV prevalence rates among military conscripts. A large population based

## **Prevention activities**

The main modes of viral transmission were understood very early in the history of the epidemic, and national governments have been obvious candidates for broadcasting prevention messages. Both the timing and clarity of such messages have been critical: A strong prevention effort put in place early in the epidemic has a larger effect on incidence and prevalence than the same effort exerted at a later stage, after HIV has already spread widely in the population. During the early period – when the epidemic is still concentrated, usually defined as a point prevalence under 1% - the key task for state actors is to identify the prevailing modes of disease transmission and implement effective prevention programs so that the virus itself and the means through which it replicates remain limited. In that regard, most major prevention policies and programs generally occurred a decade or so sooner in Brazil than in South Africa. It is impossible to know whether, or how much, these prevention activities contributed to the lower trajectory of HIV prevalence in Brazil than in South Africa.<sup>37</sup> For our purposes, however, it is clear that the state identified the principal modes of transmission and put in place programs and activities to prevent them sooner in Brazil than in South Africa.

In a variety of ways, the Brazilian state has been aggressive in the area of prevention. Before 1990, it identified the major risk groups that would drive the epidemic, including gay men, sex workers, and injecting drug users, and initiated programs to reach them. Outreach to gay men in Brazil began at the national level with the establishment of the national AIDS program in 1985. Before a substantial budget for HIV/AIDS became available, the national program was working with gay rights NGOs and civil society organizations to reduce the incidence of sexual behavior associated with transmission. In 1989 in Brazil the national AIDS program launched a prevention campaign, *Previna*, targeted at high risk populations that included male and female commercial sex workers. Several NGOs organizing and speaking on behalf of sex workers were established in Brazil in the late 1980s and early 1990, and they began to work cooperatively with the national AIDS commission on prevention activities in 1992.<sup>38</sup> Between 1998 and 2002, 547 HIV prevention projects reached an estimated 900,000 sex workers in the country. Two municipalities in the state of São Paulo attempted to establish ‘harm reduction’ programs among injecting drug users that included needle exchange, but they were shut down by the police. But such initiatives sowed the seeds for larger action: At the federal level the Ministry of Health endorsed harm reduction as national policy in 1996. By 2003 there were 267 different harm reduction programs in Brazil that reached an estimated 145,000 IDUs. In 1994, shortly after a study in the United States in 1994 demonstrated that a course of AZT could reduce the transmission of HIV from pregnant women to

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survey of sexual behaviors was conducted in 1999 by the Centro Brasileiro de Análise e Planejamento (CEBRAP), and in 2002 Fundação Oswaldo Cruz (Fiocruz) led a survey of HIV prevalence rates among randomly selected pregnant women. In South Africa, in 1993 the Minister of Health began to request anonymous HIV/AIDS data to be submitted annually and on a voluntary basis. See Ngwena 1998: 119. The first nationwide household study of HIV prevalence was not conducted until 2002 – by a joint effort of the Nelson Mandela Foundation and the Human Sciences Research Council, a government organization.

<sup>37</sup> Ultimately, there may be underlying social and cultural reasons why even sound and aggressive government action may not successfully transform society. Our focus, however, is on government policy, not societal change.

<sup>38</sup> See Jane Galvão, 2000.

children by as much as two-thirds, Brazil began to provide AZT to pregnant women. Brazil continues to provide the 076 AZT regimen to all identified HIV-positive pregnant women even though more inexpensive and easier to administer “short course” regimens are available.

Brazil also implemented prevention programs targeted at the so-called “general population” early on, including outreach, condom promotion, and testing for HIV status. In Brazil the state launched a nationwide initiative on AIDS in the workplace in 1988, a collaboration with the archdiocese of São Paulo in 1987, a school health program in 1997, and mass media campaigns and the distribution of informational materials throughout the year and especially during Carnival in the late 1980s. Encouragement of condom use began in earnest in 1993. Before 1993 (male) condom sales were relatively flat at 10 million units per year; after that year they increased sharply each year, reaching 697 million units in 2003 (270 million of those were procured by the state). In August 2004, the government announced plans to distribute as many as 3 billion free condoms each year.<sup>39</sup> MSM condom use among casual partners was over 80% by 1990. The proportion of sexually active military conscripts who used a condom in their last sexual encounter was 68%, and between 1986 and 2003 condom use in the first sexual encounter increased from 4% to 55%. With respect to testing, an estimated 40% of patients with HIV in the Brazil know that they are HIV-positive, and in 1999 an estimated 30% of the population aged 15-49 had been tested. Time series are not available on testing, but cross-sectional data show that testing rates are higher in Brazil than in most developing nations.<sup>40</sup> While condom use has also been on the rise in South Africa, rates are much lower – with 28.6 % of women aged 15-49 reporting use of a condom during their last sexual intercourse.<sup>41</sup>

The South African government also has a long history of rolling out HIV/AIDS prevention programs, but these have been more muted, and have often been poorly planned and implemented. For example, efforts to respond to the key drivers of the epidemic – sexual transmission among migrant workers, such as miners and truckers, and commercial and transactional sex among young women – were late, so much so that by the time that major prevention efforts were launched the epidemic had passed from ‘concentrated’ to ‘generalized.’ Moreover, prevention efforts directed by the South African government, both during apartheid rule, and in the years after the 1994 election, have been variously characterized as mis-placed and mis-guided, disconnected from the

<sup>39</sup> Reuters, “Brazil: 3 Billion Free Condoms,” [www.nytimes.com](http://www.nytimes.com), August 12, 2004.

<sup>40</sup> The history of prevention efforts are taken from Parker 1990; Teixeira 1997; ILO, *HIV/AIDS no Mundo do Trabalho: As Ações e Legislação Brasileira*, Brasília 2002. Data on condom sales and condom use is drawn from World Bank Operations Evaluation Department, *Brazil: First and Second AIDS and STD Control Projects: Project Performance Assessment*, April 2004. Data on testing are taken from Ministério da Saúde, *Resposta: A experiência do Programa Brasileiro de AIDS*, 2004; from CP Archibald et al, “Undiagnosed HIV Infections: the rate-limiting step for the 3 x 5 initiative,” presentation at the XV International AIDS Conference, Bangkok, July 14, 2004; and from World Bank, *Brazil: AIDS and STD Control III Project*, Project Appraisal Document, June 4, 2003, Report 5759-BR.

<sup>41</sup> Shisana, Olive, Leickness Chisamu Simbayi, and Human Sciences Research Council. 2002. *Nelson Mandela/HSRC study of HIV/AIDS : South African national HIV prevalence, behavioural risks and mass media : household survey 2002*. Cape Town: Human Sciences Research Council.

social realities in which people live. Perhaps most notable was what came to be known as the 1996 “Sarafina II Scandal” – the production of an AIDS education musical based on the film *Sarafina*, which was criticized for providing no clear or useful message while over- and mis-spending government resources.<sup>42</sup> This followed a long history of ridiculed education initiatives launched by the prior (white) government, which were criticized for prudishness, and racism.<sup>43</sup> While the absence of targeted interventions – for example, towards commercial sex workers or injecting drug users as in evidence in the Brazilian case -- might be explained by the perceived deviance of the infected group, the South African government also famously resisted the use of ARV monotherapy for the prevention of mother-to-child transmission (PMTCT).<sup>44</sup> The South African government resisted providing anti-retrovirals for pregnant women until 2001, when the courts, ruling in a case brought by the Treatment Action Campaign, compelled the state to do so. Initially, these were provided only by public hospitals, but by 2003, the South African government provided anti-retrovirals to all pregnant women who required the medication through much wider distribution channels.

A notable exception to the general inaction on the part of the South African government to AIDS prevention involved blood safety, where South Africa was actually more aggressive than Brazil. The blood supply was deemed safe and secure in South Africa in 1985,<sup>45</sup> and in Brazil no earlier than 1988.<sup>46</sup> Even after the promulgation of the Brazilian constitution, a clandestine black market in blood existed in many states, and Congress did not pass legislation to implement the constitutional provision until 1998.<sup>47</sup> This difference implies that the South African government was capable of carrying out *some* necessary policies, but not the ones that required an active engagement with society or that involved massive transformations of attitudes and habits.

### ***Treatment and the Rights of HIV Positive Individuals***

Before the advent of Highly Active Anti-Retroviral Therapy (HAART) in the mid 1990s, effective treatment for AIDS consisted largely of treatment for the opportunistic infections associated with AIDS morbidity and mortality. Afterwards, therapies were available that could significantly prolong the lives of AIDS patients. The cost of HAART and the investment in laboratory capacity and training, however, was and remains prohibitive for many developing countries. Brazil has been noteworthy among developing countries for the scale of its commitment to AIDS treatment. The South African state, on the other hand, has been slower to enact treatment programs, slower even than some of its poorer African neighbors, and has resisted efforts of activists and NGOs to scale up treatment more quickly. Brazil also enacted non-discrimination protections for PLHAs relatively quickly, whereas South Africa was more delayed and

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<sup>42</sup> Schneider 2002: 147.

<sup>43</sup> Grundligh, Louis. 2001. Government Responses to HIV/AIDS in South Africa as Reported in the Media, 1983-1994. *South African Historical Journal* 45, 137-44.

<sup>44</sup> Nattrass 2004;

<sup>45</sup> South African National Blood Service, <http://www.sanbs.org.za/Congress/riskmgement.html>, accessed August 20, 2004.

<sup>46</sup> Lei 7649, January 25, 1988, cited in Teixeira, 1997.

<sup>47</sup> See Parker, 1990; and *A Folha de São Paulo*, December 11, 1998.

even, for a period, enacted measures to report names of HIV-positive individuals to health authorities and deport HIV-positive migrant workers.

Brazil's public health system began to provide free AZT to all patients with clinical AIDS in 1991. The national secretariat for health care began to reimburse treatments for AIDS patients provided by private philanthropic hospitals in 1992. Between 1993 and 1996 Brazil created 190 new treatment facilities for AIDS patients and 31 publicly financed home care services. In 1996 Congress passed a law requiring the public system to provide all medically necessary pharmaceuticals for AIDS patients, and Brazil began to provide HAART for patients with clinical AIDS late that year. To support the HAART program, Brazil upgraded over sixty laboratories nationwide to monitor the viral loads of patients on HAART or to conduct T CD4+ lymphocyte testing. In 2003, there were 140,000 individuals on HAART in Brazil.<sup>48</sup>

Just as the South African government resisted providing ARV's for PMTCT, it has also long resisted the public provision of such drugs for treatment up until very recently. Government leaders, especially the state president, had repeatedly complained of the expense and potential toxicity of the drug regimen. Eventually, the government decided to pursue a course to provide the ARV's publicly. On November 19, 2003, the government released a major report detailing how these medicines would be distributed, promising extremely large budget outlays and the treatment of hundreds of thousands of people in the years to come. As of 2003, approximately 21,000 South Africans were on a HAART regimen, of which only 1,500 were being funded by the government.<sup>49</sup> While the South African government may, within a few years, effectively implement a treatment program that far outstrips what is provided by the Brazilian government, or any developing country for that matter, the exceptionally late timing of this program has implied staggering death tolls with reports of gravesites being re-used in high prevalence areas because there is simply no space available for AIDS-related fatalities.<sup>50</sup> Activist groups have lamented the slow pace of the ARV roll-out.

Establishing legal protections, especially legislation guaranteeing non-discrimination in the civil sphere, has been an important way in which states have acted to support HIV positive individuals. In the United States, for instance, people living with HIV/AIDS gained enormous protections when their status was included under the Americans with Disabilities Act.<sup>51</sup> In keeping with the general trend towards a more aggressive transformative project in Brazil, a law similar to the American one was passed by Congress in 1988, guaranteeing workers the same rights afforded to those with other incapacitating illnesses. In addition, in Brazil, Congress voted in 1988 to reject a law that would have limited the entry of HIV-positive individuals into the country; a regulation in

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<sup>48</sup> World Bank Operations Evaluation Department, 2004.

<sup>49</sup> Garbus, Lisa. 2003. South Africa: Country AIDS Policy Analysis Project. San Francisco, CA: AIDS Policy Research Center, University of California San Francisco, 78.

<sup>50</sup> Wines, Michael. 2004. "As AIDS Continues to Ravage, South Africa 'Recycles' Graves." *New York Times*, July 29, 2004.

<sup>51</sup> Americans with Disabilities Act, Public Law 336 of the 101<sup>st</sup> Congress, July 26, 1990. The Department of Justice's Regulations for Title II (printed in the Federal Register July 26, 1991) included HIV in the list of diseases and conditions covered by the protections in the Act.

1992 prohibited the use of serological tests prior to admission into civil service and during periodical health testing of civil servants.<sup>52</sup> In 1996, an executive decree<sup>53</sup> established the National Program on Human Rights under the Ministry of Justice. An Annex to the latter decree enumerated the administration's short- and medium- term goals, and of the thirteen short-term goals under the heading of equal protection under the law, four were related to HIV/AIDS.

By contrast, in South Africa, a law regarding employment equity protection was not passed until seven years after the Brazilian law, in 1995.<sup>54</sup> In fact, the state initially reacted to the HIV/AIDS threat not by protecting the rights of HIV positive individuals but with coercive measures. In 1987, the government announced that it would deport all HIV-positive migrant workers, and it added HIV/AIDS to the list of "notifiable" diseases, which would require medical practitioners to report HIV positive individual names to the public health authorities.<sup>55</sup> Although both of these acts were eventually repealed, they demonstrated the government's initial intent to act in a more repressive manner, using control and force, rather than engaging in a strategy that supported the rights of the infected.

### III) Explanations

What accounts for these patterns of national AIDS policy? As we pointed out in the previous section, aggressive HIV/AIDS policy is only likely to directly benefit a minority of the population in the near-term, and is not likely to serve the direct interests of government leaders. On the other hand, given the severe, life-threatening nature of the epidemic, a set of political actors are likely to mobilize wherever the virus is prevalent, and to push for aggressive policies. Our theoretically-driven, inductive approach leads us to several conclusions: In both countries, major regime changes provided a backdrop for the mobilization of important collective actors within civil society and important opportunities for major policy reform. In the face of these similar types of political transitions, which largely overlapped with the outbreak of the global AIDS pandemic, two central factors appear to have been critical in leading to divergent processes of AIDS policy-making: First, institutional differences in the consolidation of political power and authority – specifically, higher levels of fragmentation and decentralization in Brazil provided a more fertile environment for policy entrepreneurship. Second, varied degrees of politicized racial conflict – a much deeper and more conspicuous form of racial conflict in South Africa created enormous social and political tensions around the questions of who was vulnerable to, and who was to blame for, the outbreak of this deadly viral epidemic. Even with death tolls mounting, it has been hard to gain elite or popular consensus that HIV/AIDS is truly a national emergency. As summarized in Table 2, we find little or no support for arguments that pre-existing state capacities,

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<sup>52</sup> Maria Cristina Imenta and Veriano Terto Jr., 'As Ações Brasileiras de Combate ao IV/AIDS e o Mundo do Trabalho,' and João Hilário Valente, "A Legislação sobre HIV/AIDS no Mundo de Trabalho," in *ILO, HIV/AIDS no Mundo do Trabalho: As Ações e a Legislação Brasileira*, Brasília: 2002.

<sup>53</sup> Decret No. 1904, May 13, 1996.

<sup>54</sup> Garbus 2002 [2003]: 75.

<sup>55</sup> Ngwena 1998: 119.

international influences, and/or political leadership explain the cross-national differences in government response.

### ***Democracy, democratic transition, and civil society***

Analysis of the AIDS epidemic provides an important opportunity to test the plausibility of Amartya Sen's thesis that governments will respond better to major life-threatening problems in the context of a democratic regime than in an authoritarian regime.<sup>56</sup> From a purely cross-section perspective, our current analysis does not provide particularly strong leverage for testing this hypothesis because we lack variation in regime type, but we can certainly conclude that neither democracy nor authoritarianism are sufficient characteristics for an aggressive response to HIV/AIDS. Since few macro-level social science theories could be stated in such strict, deterministic terms, we do not want to over-emphasize such findings. Nonetheless, given Sen's thesis it would seem reasonable to expect regime *change* to have some noticeable influence on government responses.<sup>57</sup> Both Brazil and South Africa underwent democratic transitions as part of the "third wave" of democratization,<sup>58</sup> and patterns of political change were underway in the late 1970s, just before the outbreak of the global AIDS pandemic. In each country, the politics of HIV/AIDS policy has generally been understood by local political actors and analysts to be a direct product of such transitions. On the other hand, despite the similarity of the regime transitions<sup>59</sup> as should by now be evident, the government responses to HIV/AIDS have been very different. While this observation is in line with Lieberman's (2003) findings of no statistical relationship between regime type and AIDS expenditures, it is at odds with the analysis presented by Boone and Batsell (2000).

In the face of such unsettled terrain in consideration of the Sen hypothesis, we decided to probe further into the hypotheses that political regime type and the growth of civil society under democracy might have direct effects on the policy outcomes. We explore nuances in the timing and quality of the democratic transitions in order to identify more subtle links, and this allows us to develop more nuanced propositions about the impact of democracy on public policy and the state's transformative capacity. We find that while democratic constitutions appear to have been critical pre-requisites for developing a strong rights-orientation to a government's policy profile, other facets of democracy, including more open and transparent discussion of policies, electoral politics, and the freedom for civil society actors to organize and influence government do not, on their own, determine the quality of a response to the epidemic. While the very nature of democracy implies that there will be some uncertainty to the outcomes of policy decisions, the very nature of the hypothesis suggests that vibrant democratic institutions

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<sup>56</sup> Sen, Amartya. 1999. *Development as freedom*. 1st. ed. New York: Knopf.

<sup>57</sup> Of course, regime changes are typically associated with a host of other changes, making it difficult to infer exactly the causal mechanisms at play (or not at play). However, clearly specified theory should help us to look for testable implications of observable causal processes.

<sup>58</sup> Huntington (1991). In the case of Brazil, the first widely open elections for governors and members of Congress took place in 1982, and the first direct presidential election took place in 1990. In South Africa, the first national and provincial election that afforded universal adult suffrage took place in 1994, and local elections were held in 1995.

<sup>59</sup> Seidman 1994; Friedman and de Villiers 1996; Marx 1998.

ought to be conducive or even sufficient for convincing government representatives that a deadly epidemic ought to be addressed.

Electoral and legislative politics – hallmarks of a democracy – seem to have played little role in AIDS policy-making, and when they have played a role, the effect of open debate and competition has still been indeterminate. In Brazil, for most of the history of the epidemic, AIDS has played little direct (i.e., apparent) role in the election campaigns. For instance, a review of on-line articles in a leading newspaper in the country, *A Folha de São Paulo*, found that neither former president Fernando Henrique Cardoso nor his major opponents were quoted making a reference to AIDS in the nine months preceding the 1994 and 1998 elections.<sup>60</sup> One exception involves the candidacy of José Serra, who served as Health Minister in the latter part of Cardoso's presidency, ran unsuccessfully for president in 2002, and used his position at the helm of the country's successful AIDS program as a principal "banner" for his campaign.<sup>61</sup> Indirect electoral politics might also have played a role in President Cardoso's decision to approve the law authorizing all necessary ARV drugs for AIDS patients in 1998 – his Ministers of Finance and Planning recommended that he veto the law because of its high cost and suggested instead that the distribution of publicly financed AIDS drugs be targeted on those with limited means, but Cardoso was in the midst of negotiations with Congress on the terms of a constitutional amendment permitting presidential re-election, and his reluctance to antagonize the influential senator and former president José Sarney, a key sponsor of the AIDS drugs legislation, might have played a role in his decision not to veto the law.<sup>62</sup> However, both Cardoso's decision not to veto the law and Serra's candidacy occurred well after the Brazilian AIDS program had been consolidated and can hardly be an explanation of Brazil's policy history.

Meanwhile, in South Africa, there was almost no discussion of HIV/AIDS policy in the first two national election campaigns (1994 and 1999), and only some party-based challenge to HIV/AIDS policy during the 2004 election.<sup>63</sup> The historic 1994 election – generally regarded as the birth date of South African democracy – was hardly a boon for discussion of national AIDS policy. In fact, perhaps just the opposite is true: In 1995, the year following the first election, parliamentary discussion of AIDS reached an historic

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<sup>60</sup> Cardoso did refer to AIDS activities in passing in an article January 28, 1998, in describing the new decentralization of primary health care to municipalities. The first lady Ruth Cardoso was a leading spokesperson on HIV/AIDS issues – she was invited to serve as an AIDS ambassador for UNAIDS (though she declined), and she gave the opening speech at the 1998 International AIDS Conference in Geneva. (*A Folha*, June 28, 1998 and June 30, 1998).

<sup>61</sup> *A Folha*, October 4, 2002.

<sup>62</sup> *A Folha*, October 29, 1996.

<sup>63</sup> Indeed, the Inkatha Freedom Party includes HIV/AIDS as part of its party manifesto. The Democratic Alliance (formerly Democratic Party) identifies HIV/AIDS as the fourth "key area" for policy action after crime, unemployment, and the economy. In December 2003, Cape Town Anglican Archbishop Njongonkulu Ndungane tried to make the link between democracy and AIDS policy reform, calling on South Africans to make HIV and Aids an issue during the 2004 general election. (Aziz Hartley, "Make AIDS issue at the polls, urges Ndungane," Cape Times online, December 2, 2003, accessed December 18, 2003 [www.iol.co.za](http://www.iol.co.za)). However, there is little evidence that his call was heeded.

low for the history of parliamentary discussion of HIV/AIDS, which began in 1988.<sup>64</sup> The only evidence we could find that could plausibly link government action on HIV/AIDS to electoral politics was the Fall 2003 announcement about the proposed ARV-based treatment program – an announcement which came approximately six months before the Spring 2004 election. Given the extent of international and increasing domestic pressure from various civil society organizations, the ANC leadership may have perceived some slight vulnerability to this issue and chose to head it off by announcing such a plan of action. Nonetheless, despite the severity of the AIDS problem by 2004, no political party managed to make the government’s failings a significant campaign issue. Indeed, for most South Africans, AIDS has not been seen as a central policy problem: only 13 percent of surveyed citizens identified AIDS as a priority problem that the government should address.<sup>65</sup>

Of course, Sen’s argument involves a much more expansive notion of democracy than merely electoral competition,<sup>66</sup> and thus it is useful to consider other aspects and mechanisms of the democratic impact. For example, we can ask what role does the constitutional protection of civil liberties, and fair, non-arbitrary judicial enforcement of such liberties play in shaping government action on HIV/AIDS? We find that when we incorporate such expansive notions<sup>67</sup> of democracy, that the protection of “human rights” for HIV-positive individuals was clearly enhanced by the nature of democratic transitions in both countries. The timing of rights legislation in both countries post-dated the installation of new, democratic constitutions. Specifically, in the South African case, far more coercive measures, which *restricted* the rights of many HIV-positive individuals and “high risk” groups were enacted *prior* to the democratic transition, and as we describe above, protective legislation was drafted after 1994. In both countries, it is clear that the broader principles enshrined in the respective constitutions written as part of the democratic transitions – arguably two of the most liberal constitutions in the world – similarly influenced how HIV-positive individuals would be treated under the law. From a counter-factual perspective, it is simply not possible to imagine similar protections having been afforded or enforced in either country prior to the writing of these constitutions under democratic rule.

Also related to the concept of democracy is the existence of a more “open” society in which private, voluntary organizations, autonomous from the state – civil society – can organize and influence state policies. Around the world, such organizations have been actively involved in influencing AIDS policy at the local, national, and international levels. Many of these organizations, such as ACT-UP, and *Médecins Sans Frontiers*

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<sup>64</sup> As measured by the number of index entries referring to HIV/AIDS in the Hansard parliamentary debate records: 1985: 0; 1986-7: 0; 1988: 13; 1989: 8; 1990: 11; 1991: 26; 1992: 21; 1993:9; 1994: 6; 1995: 3. Unfortunately, indexes were not available after 1995.

<sup>65</sup> Whiteside, Mattes, Whilan 2002: 25-6.

<sup>66</sup> Unfortunately, the more wide ranging our definition, the more difficult it becomes to distinguish democracies from non-democracies, which is why most social scientists opt for more restrictive definitions. For example, both Brazil and South Africa possessed relatively vibrant and vigorous news organizations even during the waning years of authoritarian rule.

<sup>67</sup> For a more expansive definition of democracy, see Diamond, Larry Jay. 1999. *Developing democracy : toward consolidation*. Baltimore: Johns Hopkins University Press.

(Doctors Without Borders), are truly international organizations that have worked in dozens of countries, diffusing important policy ideas and repertoires of action, including slogans, symbols, and strategies. Beyond policy advocacy, in many countries where HIV/AIDS is a problem, such organizations play an important role in service delivery. Given the assumption that such organizations have been central to bringing the problem of HIV/AIDS to the attention of so many people around the world, we decided to explore the question of whether or not any *differences* in the quality of civil society within a particular country might help us to account for our outcome. While we do not rule out the conclusion that a strong civil society may be necessary, or *almost always* necessary,<sup>68</sup> for advancing an aggressive AIDS policy agenda, the comparative analysis demonstrates that *even a truly vibrant network of non-government AIDS organizations is not sufficient to elicit an aggressive government response.*

If viewed in isolation, the Brazilian case would provide support for the positive role of civil society in shaping an aggressive HIV/AIDS policy regime. Brazilian civil society was organized and active in the movement to restore democracy and to expand health care access, and it continued to play a significant role in motivating the state to respond aggressively to AIDS. The movement to restore democracy to Brazil and to hold the military regime accountable for human rights abuses spun off a movement to provide health care to underserved groups and regions (*movimiento sanitarista*), based in some of the largest cities, including São Paulo.<sup>69</sup> The movement partly achieved its objectives only after the return of civilian democratic government. The 1988 Constitution called health care a “right of all and the duty of the state” and guaranteed universal and equal access to health care, interpreted to mean that the government would make health care available free of charge. The legacy of the struggle against the military regime and its human rights abuses informed and motivated activism towards AIDS policies. The extent of social mobilization around AIDS was unprecedented in health care, and was responsible for the visibility, political strength, and stability that the national program would achieve. NGOs in Brazil had formal positions in the Ministry working groups in 1986. Four seats on the first inter-ministerial AIDS council in 1988 were given to NGOs. Influential former exiles and opponents of the military regime contracted AIDS themselves and played significant roles in the mobilization of Brazilian society to fight AIDS in 1987-88, and in the effort to assure the safety of the blood supply, which Brazil did not achieve until 1988. NGOs were also vocal in their opposition to AIDS policies under Collor and influential in the return of the previous leader of the national AIDS program after Collor was impeached.<sup>70</sup> Civil society organizations demonstrated and lobbied successfully so that condoms were included (along with beans, pasta, and rice) in the “basket of necessities” that large Brazilian corporations provided their workers, and in the simultaneous decision in 1998 to exempt condoms from taxes, so that the price of

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<sup>68</sup> Here, we follow Ragin’s (2000) “fuzzy set” approach to necessary and sufficient conditions, in which a single case cannot be the source of rejecting a hypothesis about necessity and/or sufficiency. We know that Cuba has responded aggressively to the AIDS epidemic and lacks a strong civil society, so it is certainly necessary to loosen any claims to strict necessity or sufficiency.

<sup>69</sup> Kurt Weyland, “Social Movements and the State: The Politics of Health Reform in Brazil,” *World Development* 23 (10), October 1995: 1699-1712.

<sup>70</sup> See Teixeira 1997, Galvão 2000.

the condom would fall an estimated 30%.<sup>71</sup> Brazilian civil society and AIDS NGOs played a role in lobbying Congress and the President's office to overcome resistance within the Ministry to the World Bank loans for AIDS, and launched simultaneous street demonstrations in sixteen states in 1999 to secure additional funding for AIDS treatment despite the recent devaluation and financial crisis. Although several government programs had suffered budget cuts in 1998, and although in the original proposal from the Ministry of Finance the largest cut was to fall on health care, the AIDS budget was not cut and in fact listed in the "essential" programs to be protected. The final proposal from the Ministry of Finance for 1999 increased the budget for AIDS drugs to R\$314 (US\$176 million, using average exchange rates for 1999) the Ministry managed to reallocate resources internally so that the ARV budget was R\$500 million (US\$ 80 million), and then in September (partly in response to the street protests) an additional R\$157 million (US\$88 million) was appropriated for ARVs (whose domestic prices had risen as a result of the devaluation).<sup>72</sup> The number of Brazilian AIDS NGOs multiplied after the World Bank loan earmarked a stream of money to civil society for outreach, support, and prevention efforts; and their numbers in turn increased the visibility and political strength of the AIDS community in Brazil.<sup>73</sup>

Notwithstanding these important achievements, what theoretical significance can we attribute to an active civil society in a model of the determinants of government AIDS policy? The South African evidence goes a long way towards nullifying the conclusions that might be inferred based on a reading of the Brazilian case on its own. In South Africa, civil society was similarly strong, and played a significant role in the establishment of democracy and the end of apartheid,<sup>74</sup> but as discussed earlier, the trajectory of the government's response to the epidemic has been very different. Even prior to the end of apartheid, the NGO sector developed in response to the lack of state response to the epidemic. As Mary Crewe observed in 1992, "much of the successful work in AIDS prevention is being taken on by NGOs and other important groups such as unions and the ANC."<sup>75</sup> While there are no precise figures on the numbers of AIDS-related NGOs and organizations, various medical groups, grassroots political organizations, and community-based service delivery organizations have operated individually and collectively since the mid-1980s in South Africa, many of these in concert with anti-apartheid organizations or in communities with poor service delivery due to the machinations of the apartheid state. As of 2000, there were over 600 NGOs working in the HIV/AIDS field, and by 2004,<sup>76</sup> the AIDS consortium website claimed

<sup>71</sup> *A Folha de São Paulo*, July 6, 1998.

<sup>72</sup> *A Folha de São Paulo*, September 18, 1998, September 23, 1998, September 2, 1999, September 9, 1999; interviews with Brazilian policy makers.

<sup>73</sup> The number of registered NGOs working on HIV/AIDS increased from 120 to 480 between 1993 and 1997; see Galvão 2000. A review conducted for the World Bank in 2003 found 798 different NGOs working on HIV/AIDS in Brazil.

<sup>74</sup> According to Howard's (2003) calculations of the strength of civil society using 1997-8 World Values Survey data, the two countries had similarly strong civil societies, but South Africa scored higher than Brazil. Seidman (1994) traces the development of similar grassroots union movements in the democratization process in the two countries.

<sup>75</sup> Crewe 1992: 71. During this period, the ANC was still a liberation organization, not even constituted as a formal political party, let alone as the governing party it would become.

<sup>76</sup> Van der Vliet 2001: 170.

over 1000 organizational members. In fact, there is perhaps no single individual who has drawn more attention on the global HIV/AIDS “stage” in recent years than South Africa’s Zachie Achmat, the gay, HIV-positive, AIDS-activist, who refused to take ARV’s until they were made publicly available. Achmat founded the popular Treatment Action Campaign (TAC), which has mobilized a series of campaigns, including court litigation, public relations campaigns, and civil disobedience against the South African government, including a February 2003 march of approximately 10,000 people on Parliament demanding a treatment plan. While Achmat’s and TAC’s actions, along with the strong AIDS civil society, can be credited with some of the more recent policy developments in South Africa, including plans for public provision of ARV drugs for PMTCT and for HAART, we are struck by the relative *insensitivity* of government decision-makers to the strong and vibrant South African civil society that has mobilized on this issue. Perhaps the South African government’s response would have been even more lackluster in the absence of such civil society activity, but we cannot conclude that a strong and active civil society is close to sufficient for a strong government response given that the relative size and mobilization of civil society actors has been at least as large as in Brazil.

While diachronic analyses highlighted the positive relationship between liberal constitutions and rights-oriented HIV/AIDS policies, more generally, our comparative analysis suggests that the quality of a political regime or the strength of civil society have a largely indeterminate influence on government action. Additional specification is required to predict the nature of government responses.

### ***Institutions***

Differences in national political institutions provide significant explanatory power in our attempt to account for the varying Brazilian and South African policy responses. Indeed, social scientists from a range of theoretical and methodological perspectives<sup>77</sup> have found that formal and informal rules of political decision-making, autonomous from pre-existing endowments or preferences, can influence the nature of policy outcomes in predictable ways. Interests may be aggregated in very different ways given the institutional structures of a polity, and those interests may themselves be shaped by the dominant institutions at work. Scholars have explained patterns of cross-national variation in policy areas as diverse as railroad policy, tax policy, conscription policy, health insurance policy, and social security policy through analysis of institutional variation across both time and space.

To say that institutions matter, however, does not provide sufficient analytical guidance, because it’s not clear which institutions should matter most in which domain. Writing about the development of AIDS policy up until about 1991, several scholars hypothesized that the institution of federalism influenced the history of AIDS policy in the United

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<sup>77</sup> See, for example, Steinmo, Sven, Kathleen Thelen, and Frank Longstreth, eds. 1995. *Structuring Politics: Historical Institutionalism in Comparative Analysis*. New York: Cambridge University Press; and Bates, Robert H., Avner Greif, Margaret Levi, Jean-Laurent Rosenthal, and Barry R. Weingast. 1998. *Analytic Narratives*. Princeton, NJ: Princeton University Press.

States,<sup>78</sup> Canada,<sup>79</sup> and Australia.<sup>80</sup> In each case, the author identified particular features of the federal polity that seemed to influence the relative strength of that country's political actors, and the eventual policy outcomes, but stopped short of providing a general theory of the influence of the role of federalism. In a review of theories of public health more generally, Nathanson is at odds with some of these accounts, hypothesizing that, "public health policies contributing to mortality decline are more likely to be originated and implemented by strong, highly centralized states."<sup>81</sup> While we would agree with Nathanson that a certain minimum level of centralized state capacity is necessary to role out a strong public health plan (this would be almost tautological, because conceptually one could not imagine a coordinated national policy from a failed or non-consolidated state), our analysis concludes just the opposite: over-centralization of state power may *impede* the development and implementation of such public health policies.

Institutional analysis requires a holistic view of where power lies. Indeed, both Brazil and South Africa can today be described as democratic, federal polities, but such characterization belies the important differences in the "rules of the game" for making key policy decisions. Political power in Brazil is diffuse, widely dispersed across spheres of government, locations, and political parties, and national policies consistently hinge upon the uneasy cooperation and coordination of shifting sets of political actors. Brazil is a highly decentralized and politically fragmented polity, in which spatially defined units have enjoyed a high degree of policy autonomy, and express independent political views in the national legislature.<sup>82</sup> Between 1985 and 2004, no party has ever held a majority of the seats in either house of the Congress. By contrast, in South Africa, political power has been highly concentrated within a single political party, which enjoys enormous authority across sectors and provinces. Up until 1994, South Africa was a unitary state, ruled by the National Party, which enjoyed legislative majorities for over four decades. And while the country has been shifting to a federal model since 1994, a new political party, the ANC, continues to dominate not just the national legislature (with over two-thirds of the seats in the National Assembly), but also controls the vast majority of the provincial governments (7 of 9 after the 1994 election and 8 of 9 after the 1999 election).<sup>83</sup>

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<sup>78</sup> Bayer, Ronald, and David L. Kirp. 1992. The United States: At the Center of the Storm. In *AIDS in the Industrialized Democracies: Passions, Politics, and Policies*, edited by D. L. Kirp and R. Bayer. New Brunswick, NJ: Rutgers University Press.

<sup>79</sup> Rayside, David M., and Evert A. Lindquist. 1992. Canada: Community Activism, Federalism, and the New Politics of Disease. In *AIDS in the Industrialized Democracies*, edited by D. Kirp and R. Bayer. New Brunswick, NJ: Rutgers University Press.

<sup>80</sup> Ballard, John. 1992. Australia: Participation and Innovation in a Federal System. In *AIDS in the Industrialized Democracies*, edited by D. Kirp and R. Bayer. New Brunswick, NJ: Rutgers University Press.

<sup>81</sup> Nathanson, Constance A. 1996. Disease Prevention as Social Change: Toward a Theory of Public Health. *Population and Development Review* 22 (4), 611.

<sup>82</sup> For example, see Abrucio, Fernando Luiz. 1998. *Os Barões da Federação: Os Governadores e a Redemocratização Brasileira*. São Paulo: Editora Hucitec.

<sup>83</sup> One may ask if there are prior institutional factors that explain the source of such ANC dominance, particularly in light of the fact that standard explanations of party fragmentation are contradicted by the South African case: As a highly heterogeneous (11 official languages), under a Proportional Representation system, one might have expected a much more highly fragmented set of election results. However, after

Contrary to Nathanson's prediction, we found the *de*-concentration of political power to be more of a boon to aggressive AIDS policy-making than centralization.<sup>84</sup> Because there are such strong *disincentives*<sup>85</sup> for chief executives to act on HIV/AIDS, unlike say economic policy, additional pressures and examples from sub-national governments can be extremely important in the development of national policy. While we recognized that timely, aggressive action may occasionally be forthcoming in centralized polities due to particular idiosyncratic circumstances,<sup>86</sup> on balance, it stands to reason that most chief executives would be reluctant to deploy significant resources on a problem such as HIV/AIDS in the early stages of an epidemic. For various reasons, HIV/AIDS has been associated with marginalized groups, who do not ordinarily hold significant national political power, and in a democratic polity with various competing priorities, such actors tend not to be the focus of public policy priorities.

The case of Brazil demonstrates how decentralized decision-making can create bottom-up pressures for national state action. At least eleven Brazilian states, including São Paulo, had organized state AIDS programs within their state health secretariats before the national program was established.<sup>87</sup> Where the epidemic was initially most concentrated, political organizations could mobilize local and *estado*-level policy makers to act with a speed and intensity that would have been much more difficult if they had needed to gain national-level acceptance. Early in the epidemic, within the Ministry of Health in Brasília, some officials argued that AIDS did not satisfy the epidemiological criteria of "transcendence," "magnitude," and "vulnerability" necessary to warrant a response from public institutions. As late as 1985, INAMPS (Instituto Nacional de Assistência Médica da Previdência Social – the medical care division of the social security institute) argued that AIDS was a "public health problem," not a medical concern, and therefore an issue for the state health secretariats, even though the latter had few health facilities available to them at the time.<sup>88</sup> But in São Paulo, the state government had for over two years been working with gay rights NGOs to promote prevention and behavior change. In 1986-87 the federal program did begin coordinating the response to AIDS on the part of the state health secretariats and establishing strategies and norms throughout the country. A number of important policy decisions were made at the *estado* level before they were implemented nationally: for example, São Paulo passed a law requiring serological

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decades of resistance, the ANC managed to develop an extremely strong following as the victorious "revolutionary party" in the struggle against apartheid, and began its rule under the charismatic leadership of Nelson Mandela. We treat the current party system as an exogenous variable because the factors that shaped that system are largely idiosyncratic.

<sup>84</sup> We do not believe that such a finding applies to all policy areas, however. Lieberman 2003, for example, finds just the opposite in the case of income tax policy/collections.

<sup>85</sup> One can easily imagine several disincentives: few leaders anywhere feel comfortable discussing sex or sexuality; behavior change is difficult and it may be very difficult to observe results such that there is a political payoff to the leader; and many leaders may fear that bringing attention to the problem may be an impediment to investment and growth.

<sup>86</sup> For example, the loss of the President's family member due to AIDS-related death is often cited as a key driver.

<sup>87</sup> Teixeira, 1997, p. 52.

<sup>88</sup> This paragraph, as well as the rest of this section, draws on Teixeira 1997, Galvão 1997, Galvão 2000, Parker 2000, and interviews. The quotations in this paragraph are taken from Teixeira 1997.

testing of the blood supply well before the national law, and São Paulo made plans to make HAART available to patients in that state even before the decision was made nationally. Given the influence of São Paulo, Rio de Janeiro, and the broader South/Southeast in Brazilian economy, society, and politics, their policy decisions created significant pressure for the national government to follow their lead.

In South Africa, despite variations in rates of HIV prevalence and in the capacity of local actors to mobilize, there is no analogous story of local-level influence on national policy. Decision-making and hence political power are far more centralized. After 1994, the ANC National Executive Committee (NEC) has exhibited tremendous control over a range of policy issues, including HIV/AIDS. Once such policies are put in place, ANC members of parliament (MP) have very little incentive to publicly challenge such policy ideas because they could easily be replaced by the party's leadership, given the list system under which the parliament operates. MP's are assigned and routinely re-assigned to constituencies by the party leadership, and are not truly accountable to a local constituency. In a similar manner, although some degree of policy autonomy is constitutionally reserved for provinces, in practice, most provincial leaders are selected by the ANC's NEC, and their tenure largely depends upon general levels of compliance with national directives and initiatives. Importantly, quite distinct from Brazil, the South African provinces lack revenue-raising (taxing) powers and are wholly dependent upon the resources collected by the national government. While there are constitutional guarantees for certain levels of funding, it is clear that the central government maintains various capacities to punish provinces which are viewed as being out of line. Perhaps more importantly, as the national leadership of the ANC appoints the provincial leaderships in the provinces it controls, such leaders understand their constituency for maintaining office to be the national leadership, and not the general population of the province. South Africa uses a Proportional Representation/ Party List system at both the Provincial and National levels of government. Such institutional features contribute to centralization because of the overwhelming electoral dominance of the ANC – if party support were more fragmented, the opposite would be true.

In such an environment, the capacity for policy entrepreneurs to push for decentralized responses is highly limited. For example, in 2001, despite recommendations by its health department that Nevirapine be supplied in all 112 municipal clinics, senior ANC members in the Durban Metropolitan council voted against the measure. According to one ANC member: “We can never embarrass the national government, which has adopted a wait and see approach.”<sup>89</sup> It is almost impossible to imagine a Brazilian municipal political leader making such a comment – on the contrary, sub-national governments at the *estado* and *município* level openly challenge and attempt to defy the national government. And in the South African case, the ANC government has made clear its intolerance for policy entrepreneurship. For example, in 2002, when the province of Kwazulu-Natal announced it would provide Nevirapine to HIV-positive pregnant women, this was reported as “defiance” of government policy, and the national minister of health commented that “the premier should not have acted unilaterally.” In another

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<sup>89</sup> “ANC In New HIV/ Aids Denial,” Mail & Guardian Online, December 7, 2001; via Aegis <http://www.aegis.com/news/dmg/2001/MG011205.html>.

example, the national government tried to block a \$13 million grant to that province to extend an AIDS care program affiliated with the Harvard AIDS Institute.<sup>90</sup> Because the country had lacked a Country Coordinating Mechanism, the province applied on its own to the Global Fund for HIV, TB, and Malaria, to the displeasure of the national government. According to the news report, government spokesman Joel Ntshitenzhe explained, “We need to ensure that submissions to the Global Fund are unified, so we don’t have individual municipalities and provinces out on their own.”

Within the context of South Africa’s federal system of government, there has been *some* variation in the nature and timing of provincial policy-making, but this pales in comparison with the rapid response of cities and states in Brazil. Particularly in the provinces of Kwazulu-Natal and the Western Cape, where ANC support has been weakest, there have been roll-outs of policies such as the distribution of ARV drugs for PMTCT and for treatment of HIV-positive individuals before the national government. But these initiatives have tended to come only 1 to 2 years prior to more general roll-outs, and have been carried out in the context of national government debates around new policies. As such, advance implementation in these provinces has tended to be depicted as “pilot implementation” of national policy, rather than as vanguard action on the part of truly autonomous, localized governments.

Moreover, we do not believe that provincial administration under-*capacity* is a central feature of the explanation for the SA government’s weak responses to HIV/AIDS.<sup>91</sup> It is true that many of the Provinces have historically under-spent their HIV/AIDS allocations – which many analysts have interpreted as lack of capacity, but on the other hand, most have *over-spent* their total (non AIDS-related) resources. Rather than using the budgetary data to indicate the presence or absence of *capacity*, we believe it reflects the deliberate choices of provincial leaders to steer clear of a policy domain that has not been thoroughly backed or promoted by the central state. Sub-national governments have been forced to respond more to top-down pressures, rather than bottom-up (civil society) or local expert pressures in the context of South Africa’s institutional environment.

We realize that our answer still begs the question of why the national executive, particularly in the South African case, would not have wanted to pursue an aggressive HIV/AIDS policy, even as the country’s rate of HIV prevalence has increased. To answer this, we turn to the important differences in the nature of political community across the two countries, which have shaped public opinion about the nature of the epidemic.

### ***Political Community***

In forming judgments about appropriate national policy to prevent disease, government leaders and societal actors must *interpret* a wide range of evidence – medical and otherwise – about current circumstances and various policy options. As Americans have observed in the political debates surrounding recent military interventions in Iraq, the

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<sup>90</sup> Steinglass, “In South Africa, Politics Hinder AIDS Treatment,” *Boston Globe* via Lexis-Nexis. June 11, 2002.

<sup>91</sup> As argued by Schneider 2002.

notion of “clear and present danger” is highly contested, and opinions about almost any set of “objective” circumstances are often largely structured by prior circumstances. Societies face many potential threats, and yet which ones come to be understood by decision-makers as generally threatening, and “actionable,” is determined by social and political processes.<sup>92</sup> Undoubtedly, such processes are influenced by a wide range of variables, but in our search for a variable that might convincingly account for different political dynamics around risk – presumably holding constant the “actual” risk of infection and mortality – we were struck by the important influence of national definitions of political community.<sup>93</sup> Indeed, a central question for any policy is, does it benefit “us,” – i.e., the entire national public, and at least the governing party’s core constituents? Or, is this something that is really only a benefit to “them” – i.e., to foreigners, marginalized groups, and/or political adversaries? The answers to such questions depend not merely on a set of “facts,” but on commonsense or hegemonic<sup>94</sup> notions of who constitutes “us” and “them.”

In the case of disease, policy discourse surrounding the issue of victimization is central: “Risks may be portrayed as universal (we’re *all* at risk) or particular (only *they* are at risk).”<sup>95</sup> We agree that such questions are central drivers of government response, but we believe that such questions get answered in the context of historically-endowed patterns of group solidarity and conflict. Specifically, drawing on a broader literature of the impact of ethnic conflict on policy making and development,<sup>96</sup> we argue that in more ethnically divided and polarized societies, it is less likely that political leaders, and the general public, will perceive HIV/AIDS as a universal risk. It is also more likely that “hard” medical evidence will be clouded through disparate interpretations, involving various “us/them” dynamics. Both mechanisms imply less aggressive action in the context of greater ethnic conflict. This helps to explain South Africa’s less aggressive response to HIV/AIDS.

While we previously described the institutional configurations of the respective Brazilian and South African states as diffuse and concentrated, in many ways, late 20<sup>th</sup> century norms of political community are just the opposite.<sup>97</sup> Both countries are “racially

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<sup>92</sup> Nathanson 1996.

<sup>93</sup> A central factor identified for explaining variations in national patterns of taxation in the two countries in Lieberman, Evan S. 2003. *Race and Regionalism in the Politics of Taxation in Brazil and South Africa*, *Cambridge studies in comparative politics*. Cambridge, UK ; New York: Cambridge University Press.

<sup>94</sup> Laitin, David. 1986. *Hegemony and Culture: Politics and Religious Change Among the Yoruba*. Chicago: University of Chicago Press.

<sup>95</sup> Nathanson 1996: 615.

<sup>96</sup> The contributions here are vast, ranging from the more sociological perspective of Ekeh, Peter. 1975. Colonialism and the Two Publics in Africa: A Theoretical Statement. *Comparative Studies in Society and History* 17 (1):91-112, to the economic explanations of Alesina, Alberto, William Russell Easterly, Reza Baquir, and World Bank. Development Research Group. Macroeconomics and Growth Division. 1999. *Public goods and ethnic divisions*. Washington, DC: World Bank Development Research Group Macroeconomics and Growth; Easterly, William and Ross Levine. 1997. “Africa’s Growth Tragedy: Policies and Ethnic Divisions.” *The Quarterly Journal of Economics*. 112(4):1203-1250.

<sup>97</sup> As discussed in Lieberman (2003), this is not merely a coincidence. Brazil’s pursuit of a federal model of state structure, and the South African pursuit of a unitary model during the decades surrounding the turn of

heterogeneous” in the sense that they are comprised of a wide mix of immigrant and indigenous groups, centuries of mixing, and the juxtaposition of large African-descended and European-descended populations. In both countries, skin color and income and wealth are highly correlated. Yet, the political and social construction of racial categories are rather different: the history of South Africa led to a much greater level of social and political salience for physical characteristics than was the case in Brazil. Up until 1994, institutionalized white supremacy was the law of the land in South Africa, while in Brazil, the state had long promoted “non-racialism” and racial mixing in personal relations, even while Brazilian society has continued to value whiteness with higher levels of social acceptability.<sup>98</sup> It is true that in recent years, Brazilians have begun to politicize the increasingly obvious correspondence between race and class, but racial politics are orders of magnitude less central and less conflictual for most spheres of policy and politics than in South Africa. As part of Brazil’s more tolerant social order, that society has also been more tolerant of homosexuality.<sup>99</sup>

In the wake of such differences, HIV/AIDS was interpreted very much in racial terms in South Africa, while the policy discourse in Brazil has been almost completely devoid of racial labels. In turn, these differences have contributed to a political environment in which a common threat – in fact, objectively a much smaller threat in Brazil after a certain point – was much more easily interpreted as a truly national threat in Brazil than in South Africa. Using conflicting bits of evidence, various South African political actors have portrayed HIV/AIDS as “their” problem, or “their” conspiracy. Indeed, many other observers have similarly linked various forms of race-based intolerance to the proliferation of HIV within the country, as well as to the specific question considered here, of the weak South African government response.<sup>100</sup> While these accounts provide useful process tracing evidence linking South Africa’s apartheid history to its government AIDS policies, such examinations beg the question of the particularity of the South African case, and how we might interpret these results in comparative perspective. If such hypotheses have merit, than in an otherwise similar county, but one in which racial cleavages are more permeable and seen as less fundamental, we should see less constraint on mobilizing demands for and supply of government action. In this sense, the Brazilian comparison provides illuminating, and in this case, confirmatory evidence. Our contribution is to highlight this comparison, and to better specify the relationship between political community and policy outcomes.

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the 20<sup>th</sup> century were closely related to the ways in which those countries addressed their respective racial questions.

<sup>98</sup> The literature on the “myths” of racial democracy in Brazil is now extensive. See, for example, Hanchard, Michael, ed. 1999. *Racial politics in contemporary Brazil*. Durham: Duke University Press; and Turra, Cleusa, and Gustavo Venturi, eds. 1995. *Racismo Cordial*. São Paulo: Editora Ática.

<sup>99</sup> In a 1995-7 World Values Survey, 49 percent of South Africans mentioned that they would not like to have a homosexual as a neighbor, while only 26 percent of Brazilians mentioned this group.

<sup>100</sup> Indeed, this would be viewed as almost conventional wisdom among most South African observers, but specific arguments linking the severity of the AIDS crisis in South Africa to apartheid can be found in Crewe, Mary. 1992. *AIDS in South Africa: The Myth and the Reality*. London, England: Penguin Books; Van der Vliet 2001; Grundligh, Louis. 2001. Government Responses to HIV/AIDS in South Africa as Reported in the Media, 1983-1994. *South African Historical Journal* 45:124-153.

In particular, we find that in comparing the politics of AIDS policies in the two countries, a clear and consistent difference that emerges is a political discourse around *who* is afflicted with AIDS, and who is to blame. Specifically, such questions have remained central to the struggle over AIDS policy in South Africa, and they have been much less important in Brazil. Although some South African analysts point to the racial demographics of the disease as a key determinant of the outcome, the reality is much less important than the interpretation and transmission of such “facts.” Most importantly, almost no surveys of HIV prevalence are conducted or reported *without* racial statistics. Like virtually every social or economic issue, the state continues to categorize according to race group. By contrast, in Brazil, there is not a single mention of the racial composition of the virus in any government report.<sup>101</sup> Despite racial differences in Brazil, and an increasingly open discussion about general socio-economic inequalities along skin color lines in recent years, particularly as researchers demonstrate the association between race and economic opportunity/position in that society, strong historical legacies continue to prevent race from becoming a “politicizable” dimension of the political conflict over policy. Frankly, it has been unthinkable in the Brazilian context to discuss AIDS as a “white” or “black” disease, while in South Africa, such perspectives are entirely standard.

In the case of South Africa, there is a clear and consistent history of the racialization of the disease, as well as a linking of the disease to “deviant” homosexual lifestyles, which in turn, has helped to de-rail the government’s response.<sup>102</sup> In 1988, the government propagated separately targeted AIDS programs for white and black audiences.<sup>103</sup> Such moves reinforced pre-existing racial myths in the country as being directly relevant for HIV/AIDS. In turn, racial politics would continue to play an important role in the controversy around AIDS throughout the course of the epidemic.

There is substantial evidence of racial interpretations of the risk associated with HIV within society. For example, in 1988, white inhabitants of a small white resort town argued against the desegregation of South African beaches, citing the risk of AIDS as a reason for barring a visiting black Canadian professor. A town spokesman told a South African newspaper that while the beach is officially open to all races, blacks would need to use nearby bathroom facilities. “We are not prepared to share our toilets with blacks,” he told the anti-government Sunday Times. “What if they have AIDS?”<sup>104</sup>

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<sup>101</sup> Until very recently, the Brazilian Ministry of Health did not collect any statistics on HIV or AIDS cases by race. Interviews with Ministry of Health officials at the XV International AIDS Conference, Bangkok, July 15, 2004.

<sup>102</sup> In their various accounts, Grundlingh, Van der Vliet, Schneider, and Crewe have identified racial intolerance and homophobia as central to the South African experience. Our contribution is to situate these experiences in comparative perspective, by demonstrating that even in societies with a great deal of heterogeneity in terms of racial identities, and sexual orientation, that such intolerance need not be a central dimension of the policy debate.

<sup>103</sup> Van der Vliet 2001: 155.

<sup>104</sup> U.P.I. , January 10, 1988, “ AIDS cited as reason to bar blacks from South African resort ,” BRENDAN BOYLE via Lexis/Nexis Academic Search.

Race-based fear has not been limited only to the white population, however. For example, as Phillips identifies, in 1991, an important black magazine, *Drum*, reprinted (without comment) an article from an African American journal entitled, 'Is AIDS a conspiracy against Blacks?' implying that it was deliberately introduced by the government in the last days of apartheid to try and check the advance of African liberation." Particularly among blacks, AIDS was nicknamed "Afrikaner Invention to Deprive us of Sex."<sup>105</sup>

Such views have remained important within public discourse about the virus. For example, according to Dr. Hoosen Coovadia, a member of the president's AIDS panel and chair of the United Nations 2000 AIDS conference in Durban. "Blacks, coloreds, and Indians were told that we were inferior races, that we couldn't control our sexual impulses . . . that we were animals with primitive urges... This made people look for alternative explanations for AIDS, apart from the accepted global reasoning."<sup>106</sup> Importantly, the conflict over HIV/AIDS in South Africa cannot be understood simply in terms of racial epidemiology because actors from various persuasions have wanted to believe that AIDS was some "other" groups problem. As SA Institute for Medical Research (SAIRM) AIDS center educator Nicolaus Knigge explained in a news report, "SA's sexual taboos posed a challenge to the AIDS educators, and the country's racial attitudes inevitably surfaced. Whites often believed it was a black or gay disease while many blacks believed it was a white disease or a plot to control the black population."<sup>107</sup>

In the wake of such fears and mis-perceptions it becomes more understandable, if still lamentable, that public sentiment in favor of more aggressive HIV/AIDS policy would be weakened and fragmented. In the context of a highly divided society, it has become quite easy to "blame" the other group for HIV/AIDS, rather than to demand public policies that would benefit "all of us." From this vantage-point, even since the South African government came to be run largely by blacks, there has been sufficient suspicion about the nature of the disease (real or imagined; viral or social; indigenous or created in the West), and about who was most vulnerable, that there has been much less public support for aggressive policies than would seem to be warranted by the high rates of prevalence.

Indeed, we believe that this perspective can help to "explain" the seeming incoherence of President Mbeki's record on AIDS policy, and the lack of a greater outcry or public backlash by the majority black population. In an April 3, 2000 letter to world leaders on AIDS in Africa, printed in various publications around the world, Mbeki wrote, "whatever lessons we have to and may draw from the West about the grave issue of HIV/AIDS, a simple superimposition of Western experience on African reality would be absurd and illogical." By challenging the conventional wisdom of "the West," in its views on HIV/AIDS, he has been able to promote an alternative view (even while relying on the scientific views of a handful of Americans), and to incorporate ideas and beliefs that resonate with the black African population, including an emphasis on the notion that

<sup>105</sup> Phillips, Howard. 2001. AIDS in the Context of South Africa's Epidemic History: Some Preliminary Thoughts. *South African Historical Journal* 45, 15.

<sup>106</sup> Singer, Rena. South Africa Lifts its Barrier to AIDS Drugs," Pp. A27 in *The Boston Globe*. Pretoria. 2002."

<sup>107</sup> Tania Levy, "All Must Become Involved in Fight to Control AIDS," *Business Day*, August 27, 1990.

disease is associated with poverty, and that traditional medicines and witch doctors can play a useful role in combating the disease. Notions of risk and culpability are structured by pre-existing conflicts over the nature of political community and the moral worth of involved groups.

Even among South African activists, deep-seated divisions around racial lines have impeded political unity. Leaders from the National Association of People Living with AIDS (NAPWA) and from the Treatment Action Campaign (TAC) have been openly critical of one another, making various charges of racism. Sandile Zondani of NAPWA was reported as saying, “TAC leadership is window-dressed with a few Africans "who cannot say or do anything without first asking their national chairperson [Zackie Achmat]... TAC (should) stop using Africans for their selfish ends.”<sup>108</sup> In response to such remarks, Mark Heywood, TAC treasurer writes on the organization’s website, “it is necessary to report and condemn the racism that is being fomented and encouraged by NAPWA's leadership.”<sup>109</sup> Such rifts over matters of victimization impeded the unity and hence the political impact of civil society. Thus, as we discussed earlier, the problem is not the absence of civil society in South Africa, but its influence on policy.

While we do not want to give the impression that Brazil is a completely harmonious and infinitely tolerant society, from a comparative perspective, there are clearly important differences in the politics of political community. Anyone who has traveled to the two countries would recognize palpable differences in the degree to which people intermingle in casual contact across the color-bar in the two countries. Certainly, one can find evidence of racism and homophobia in Brazilian society, and a homophobia associated with HIV/AIDS in much of the world was also evident in many of the early reactions to AIDS in Brazil.<sup>110</sup> However, racial intermingling as well as public displays of homosexuality and cross-dressing have been longstanding components of public life in Brazil, especially at the annual Carnival celebrations in a manner that would be completely unrecognizable in the South African context. Rather, longstanding myths of social mobility across racial lines, as well as high levels of social interaction, particularly in public spaces, meant that a lethal, sexually transmitted virus, could easily be interpreted as affecting all of “us.” Brazilian AIDS NGOs in the late 1980s emphasized “solidarity” with those infected, and the Ministry’s media campaigns attempted to avoid stigmatizing portraits of AIDS victims, also opting for an approach based on solidarity.<sup>111</sup> While the rhetoric of post-apartheid reconciliation that followed the 1994 election of Nelson Mandela in South Africa may have aspired for such solidarity in the creation of a

<sup>108</sup> “AIDS Activists Take On One of Their Own,” *Mail & Guardian*, March 11, 2003, via AEGIS, <http://www.aegis.com/news/dmg/2003/MG030303.html>; accessed August 20, 2004.

<sup>109</sup> [http://www.tac.org.za/newsletter/2004/ns30\\_03\\_2004.htm](http://www.tac.org.za/newsletter/2004/ns30_03_2004.htm); accessed August 20, 2004.

<sup>110</sup> For instance, the Cardinal of Rio de Janeiro (Eugênio Sales) viewed the disease as divine retribution: “When the love of God, manifested in obedience to his teachings, is disparaged, whippings from a new threat to life awaken the recalcitrant.” Quoted in Teixeira, 1997. In 1985 the major newspaper in the Northeast, *A Tarde*, published an opinion piece in which a journalist wrote: “The bet way to get rid of the AIDS is to eradicate the carriers of the gay plague.” Quoted in Marcelo Cerqueira and Luiz Mott, “Interfaces da Violência: AIDS e Homofobia,” in Cristina Câmara et al, editors, *O Outro Como um Semelhante: Direitos Humanos e AIDS*, Ministério da Saúde, 2002.

<sup>111</sup> On the use of “solidarity,” see Galvão 2000: p. 85, and Teixeira 1997: p. 61.

“rainbow nation,” longstanding divisions were too deep, and no such idiom of true solidarity has resonated widely within the population.

### ***Rival explanations***

To sum up, we have argued that different sets of political institutions and norms of political community – both in place prior to the onset of the AIDS epidemic – account for the different types of government responses to HIV/AIDS observed in Brazil and South Africa during the late 20<sup>th</sup> and early 21<sup>st</sup> centuries. During the period under discussion, these two countries were at similar levels of economic development and undergoing similar types of political transitions, and as such, these factors were ruled out as explanations for the outcome variable, even while we concede that one or more of these factors likely influence country-level outcomes, and could help to explain broader patterns of cross-national variation. In pushing our explanation, we sought to assess the explanatory power of a few other prominent factors, but we find little reason to believe that state capacity, international influences, or the quality of leadership can successfully account for the important differences.

### **Epidemiology**

A simple explanation might explain public health policy differences as a function of disease patterns. Indeed, prior research found a statistically significant relationship between adult prevalence rates and per capita AIDS expenditures.<sup>112</sup> If that relationship held for the countries this study addresses, South Africa’s response would have been more aggressive than Brazil’s by the mid-to-late 1990s. A slightly more nuanced view, which assumes an elitist approach to policy-making in developing countries, would suggest that only when the problem affects the dominant social classes will there be a significant response. A selected reading of the evidence would support this position, and in a recent essay, the former Brazilian health minister and presidential candidate, José Serra, makes this argument:

No matter what the explanations for the differences between the South African and Brazilian situations, one factor must be underscored: in the Brazilian case, AIDS first took root among the middle and upper middle classes and generated an enormous impact among opinion-makers in the nation’s media. In South Africa, the epidemic afflicted the poor black population, a demographic segment that simply did not have the same power to interpret the meaning of the disease nor the ability to mobilize a response to it. This was true even in the post-apartheid period.<sup>113</sup>

But there are two problems with this explanation. First, in the first decade HIV/AIDS most visibly affected urban, white, educated gay men in *both* countries. A paper in 1991 found that for the years 1982-1990, 43% of reported AIDS cases in South Africa were transmitted through men having sex with men.<sup>114</sup> The corresponding figure for Brazil in

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<sup>112</sup> Lieberman 2004.

<sup>113</sup> Serra, José. 2004. *The Political Economy of the Brazilian Struggle Against AIDS*. Princeton, NJ: Institute for Advanced Study.

<sup>114</sup> Hamilton, Robin. 1991. Special Issue on HIV/AIDS. Johannesburg, South Africa: South African Institute of Race Relations.

mid 1993 was 56%.<sup>115</sup> If the aggressiveness of the national response were a direct consequence of the influence of the most affected group, one would have expected the South African government to have launched as aggressive a national response as the Brazilian government did. It is true that in the early 1990s the absolute number of cumulative cases of diagnosed AIDS was more than an order of magnitude higher in Brazil than in South Africa, but there was every reason to believe, based on reports from antenatal clinics in Johannesburg and the rate of increase in both reported AIDS cases and HIV point prevalence, that the HIV problem would become massive in South Africa.<sup>116</sup>

Second, there was also widespread concern in Brazil that the epidemic was poised to become “generalized” or “explosive.” Estimates of the number of HIV-positive individuals in Brazil in 1990 ranged from 350,000 to over a million, and there was considerable alarm at the rate at which reported AIDS cases were growing.<sup>117</sup> In particular, while the word had gotten out to the MSM communities in the Southeast, and by 1990 the share of new infections related to MSM and the rate of high risk behavior among MSM were both declining – in no small part due to the activism and outreach of gay men’s organizations – there was concern that the rest of the population had not gotten the message. A leading Brazilian AIDS clinician said in early 1993, “We are going to see something of Biblical proportions. These biblical tragedies wiped out large portions of populations.”<sup>118</sup> As in South Africa, the real fear among health experts in Brazil in the early 1990s was that the epidemic would widen to affect poor and marginal groups who would be more difficult to reach than the MSM population had been in the 1980s.

In other words, the task at hand for the Brazilian government in the late 1980s and early 1990s was not to build a program to prevent and treat HIV/AIDS among gay men, but to continue to reach and support gay men while expanding the program to other groups such as prisoners, IDUs, and sex workers – all of whom were the subject of concern as a result of surveillance studies conducted at the time – and to the population as a whole. It is therefore hard to interpret the aggressive response on the part of the Brazilian state as an effort to protect an influential group. It is probably also incorrect, or at least problematic, given existing levels of prejudice, discrimination, and violence against gays in Brazil despite the country’s deserved reputation for tolerance, to identify gay men as a particularly influential group in that country. The underlying point here, however, is that HIV/AIDS was interpreted and constructed as a national problem in Brazil and not in South Africa, even though the state of the epidemic and projections concerning its future

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<sup>115</sup> World Bank 1993.

<sup>116</sup> The number of reported AIDS cases in South Africa in 1990 was 613; in Brazil in March, 1992, it was 24,704. See Hamilton (1991) and World Bank (1993). See Grundligh, Louis, 2001, Early responses, attitudes and behaviour regarding HIV/AIDS in South Africa, 1983-1988. *Journal for Contemporary History* 26 (1):86-103, for numerous examples of early warning cries for medical professionals.

<sup>117</sup> A review of prevalence estimates is in Galvão 2000: p. 145. A New York Times article in 1993 estimated 1 million infected with HIV (“AIDs in Latin America- A Special Report,” *New York Times*, January 25, 1993). In 1991, one study projected that there would be 5.7 million cumulative HIV infections in Brazil by the year 2000 (Galvão 2000: p. 192).

<sup>118</sup> “AIDs in Latin America- A Special Report,” *New York Times*, January 25, 1993.

trajectory were similar at the time the first hard bits of epidemiological data were emerging.

### **Existing state capacities/ state strength**

Can the puzzle of cross-national differences be explained by differences in the overall capacity of the respective states? If so, which capacities? Certainly, it stands to reason that a generally more efficacious state would be more effective in dealing with any specific problem. In order to assess this hypothesis, while avoiding tautological assertions (i.e. of the form, “South Africa’s weak government response was due to the country’s weak state capacity to deal with HIV/AIDS”), it is necessary to be precise about terms and causal pathways. The notion of capacity must exist as a general phenomenon, separate from, and prior to the specific tasks associated with preventing and treating HIV/AIDS. We define capacity in terms of measurable skills, systems, knowledge, facilities, and personnel available to the state to carry out its functions. In this sense, there is no support for the idea that Brazil’s pre-existing capacities were, *ex ante*, better suited for dealing with the AIDS epidemic. Instead, we find differences in the ways in which the respective capacities were used, and transformed during periods of democratic transition, leading to different types of outcomes.

Indeed, many prominent accounts of the South African AIDS response point to the *lack* of a strong health capacity, particularly a provincial capacity, to carry out a massive AIDS program.<sup>119</sup> According to such accounts, the changing structure of the South African government following the end of apartheid created a vacuum of bureaucratic capacity, which explains the government’s deficient response. Moreover, the transition created unique problems as the health care sector was re-structured within a newly created system of “cooperative governance” across the three government sectors (local, provincial, and national governments). While plausible on its face, we ultimately find such an explanation to be insufficiently persuasive: the South African response failed not simply at the level of implementation at the point of service, but at the level of policy formation. Moreover, according to the South African constitution, several of the most important functions of government, including trade, tourism, education, and welfare, are all “concurrent functions” of the central and provincial government, and in several of these areas, the South African government has been quite successful, suggesting that on its own, a new system of intergovernmental relations has implied an overall failure of government policy. Even within the area of health, the government rolled out a policy guaranteeing free care to all pregnant women and children aged six and under.

More generally, we find little reason to have predicted that the Brazilian response would have been more aggressive given general similarities and even some relative Brazilian weaknesses in state capacity beyond the investigated area of AIDS. Our paired historical comparison suggests that there are little grounds for supporting the view that cross-

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<sup>119</sup> For example, Schneider 2001.

national differences can be explained by *ex ante* differences in state capacity.<sup>120</sup> We make this argument by comparing *ex ante* state capacity in South Africa and Brazil along two dimensions: 1) general state capacity and 2) capacity in the social sectors. For the purposes of explaining social policy outcomes, it is analytically important to isolate and examine distinct aspects of state capacity because it is not uncommon for states to have developed a capacity to achieve education or health objectives without an accompanying capacity to, for instance, wage war or manage the economy.

At the level of generalized state capacity, it would be difficult to argue that Brazil's has been a more efficacious state than the South African during the last two decades of the 20<sup>th</sup> century. Using overall levels of central state taxation and direct collections of income tax as proxies for state strength,<sup>121</sup> tax revenue as a percentage of GDP was lower in Brazil than South Africa in every year for which data were available from 1980-2002. The estimated percentage of roads in the country that were paved was also substantially lower in Brazil than South Africa in every year from 1990-2001. South Africa's composite ICRG country risk rating exceeded Brazil's in seventeen of the twenty years from 1984-2003. While these are all partial and imperfect measures of generalized state capacity, the consistency of the direction of the difference presents a portrait in which general state capacity in South Africa is not obviously less than, and in many areas probably higher than, Brazil's. As a result, difference in general state capacity cannot explain the more aggressive response of the Brazilian state to HIV/AIDS.<sup>122</sup>

Turning to the social sectors, both countries are known for their historically high infant mortality rates, low literacy rates, and generally low levels of human development given their level of income. For instance, the ranking of both countries on the UNDP's Human Development Index (HDI) was below their ranking on per capita income in 2004. Both countries only recently launched reforms that made their general health care system accessible to poor and excluded groups: Brazil in 1990 with the inclusion of informal sector workers into the system that was formerly available only to those contributing payroll deductions, and South Africa in 1989/90 with the desegregation of the public system. But there remain numerous informal barriers to access, and substantial inequalities in access to care remain in both countries. On the other hand, a recent study pointed out that the two countries are similar *model* cases of non-contributory pension systems,<sup>123</sup> revealing the existence of capacity to deliver in the social sectors in both countries.

For the purposes of our analysis, it is noteworthy that levels of human development in South Africa *ex ante* – before the AIDS crisis – were similar in the countries, or better in

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<sup>120</sup> Again, we do not rule out that more extreme differences in state capacity, perhaps as proxied by GDP/capita, are almost certainly very important when understanding patterns of national responses across countries more different than Brazil and South Africa.

<sup>121</sup> Lieberman, Evan. 2001. Taxation Data as Indicators of State-Society Relations: Possibilities and Pitfalls in Cross-National Research. *Studies in Comparative International Development* 36 (4):89-115.

<sup>122</sup> All data in this paragraph were taken from the World Bank's central database: World Development Indicators and Global Development Finance, 2004.

<sup>123</sup> Barrientos, Armando et. al. 2003. Non-Contributory Pensions and Poverty Prevention: A Comparison of Brazil and South Africa. London, UK: HelpAge International.

South Africa than in Brazil. (Increasingly ravaged by the AIDS crisis, South Africa's HDI has since dropped.) South Africa's HDI score, for instance, was higher than Brazil's in 1985 and 1990. In 1990, adult literacy was 81% in South Africa and 82% in Brazil. On an expert-based assessment of "family planning program effort," South Africa scored 50% higher than in Brazil in both 1982 and 1989.<sup>124</sup> A recent, similar evaluation methodology for maternal and neonatal health services rated Brazil's program "weak" while South Africa's was "moderate."<sup>125</sup> Overall expenditures on health and education were not significantly different between the two countries in the years for which comparable data were available, and where they were different, South Africa's were higher. Public sector health expenditures as a share of GDP were around 4% in South Africa and around 3% in Brazil from 1997-2001. Public sector education expenditures as a share of GDP averaged 5.9% in South Africa from 1986-1999, and 3.6% in Brazil from 1993-2001.<sup>126</sup>

In other words, while it is true that for the response to HIV/AIDS Brazil has developed skills, systems, knowledge, facilities, and personnel more effectively than South Africa, state capacity in Brazil was not stronger across the board, stronger *ex ante*, or stronger in other social sectors in Brazil than in South Africa. Differences in state capacity cannot, then, explain the more aggressive response to HIV/AIDS in Brazil.

### International influences

International influences remain significant in the formulation of health policies, particularly in developing countries, which are subject to pressures from various international organizations and which do not have as much indigenous technical expertise as the rich countries. In the area of AIDS, we noted at the outset that there emerged a consensus opinion in the international scientific community on the viral nature of the disease, its main modes of transmission, its clinical progression, and the steps needed to contain its spread – which we call the 'Geneva consensus' – by the late 1980s. One hypothesis for explaining the variance in the response to AIDS among developing countries would be, then, that countries respond aggressively to the disease to extent that international actors have the power (particularly through trade and/or financial aid) to persuade them to conform to the 'Geneva consensus.' The argument would be analogous to the position, held by Marxists and liberals alike, that multinational corporations, the flow of international capital, the international trading system, and/or development agencies have unusual influence in the domestic policies of developing countries.<sup>127</sup> Richard Parker (1990), for instance, argues that AIDS-related policy in Brazil was a "prisoner" of the broader political process, including the "world system." He argues that international influences were particularly important with respect to the relationship of the

<sup>124</sup> John Ross and John Stover, "The Family Planning Program Effort Index: 1999 Cycle," *International Family Planning Perspectives* 27(3), September 2001.

<sup>125</sup> Rodolfo A. Bulatao and John A. Ross, "Rating maternal and neonatal health services in developing countries," *Bulletin of the World Health Organization* 80, 2002: 721-727.

<sup>126</sup> Again, expenditure data in this paragraph are taken from the World Bank's central database. Measures of HDI and literacy are taken from the UNDP: [http://hdr.undp.org/statistics/data/pdf/hdr04\\_table\\_2.pdf](http://hdr.undp.org/statistics/data/pdf/hdr04_table_2.pdf).

<sup>127</sup> For a review of arguments like these, see Robert Gilpin, *The Political Economy of International Relations*, Princeton University Press, 1987.

National AIDS Program to the Ministry of Health, and on the effort of AIDS NGOs to adopt a national network that resembled related efforts on the global level.<sup>128</sup>

It is true that international organizations were more involved in Brazil than in South Africa. Most obviously, the World Bank lent Brazil US\$325 million between 1993-2003 to respond to the HIV/AIDS epidemic. USAID spent an average of US\$2 million per year on HIV/AIDS in Brazil from 1992-2003. Other international organizations who contributed technical support to Brazil but smaller levels of financing included Germany's GTZ, the United States CDC, UNAIDS and GPA and other UN agencies, the Ford Foundation, the UK's DFID, and France's *Agence Nationale de Recherches sur le Sida*. At the same time, South Africa was an international pariah because of its apartheid government, and had little contact with international organizations until after the political transition in 1994.

It is also true that until the last few years, the price of medications to treat AIDS put them out of the reach of most developing countries. Large, multi-nationally based pharmaceutical companies produced the drugs that composed HAART and enjoyed patent protections that gave them monopoly production rights. A combination of a lack of indigenous capacity to produce the drugs and a reluctance to alienate the governments in which the MNCs were based, largely the United States and Europe, led nearly all developing countries to abide by the patent protections even though they could legally have been infringed under TRIPS agreement. The recent Doha Declaration explicitly recognized the right of countries to issue compulsory licenses for national health emergencies such as AIDS and to begin to produce the medicines for HAART domestically. Obviously, this aspect of the international environment has affected AIDS policies in developing countries.

But the argument that international influences explained the greater aggressiveness on the part of Brazil has three problems. First, to take up the argument regarding AIDS drugs, AIDS pharmaceutical policies in South Africa and Brazil have resembled each other more than they have differed. Both governments have pursued aggressive strategies against pharmaceutical MNCs: Brazil's has used the threat of compulsory licenses to negotiate lower prices on imported drugs and has faced up to a potential challenge from the United States in the WTO, and South Africa's fought a suit brought by 39 pharmaceutical manufacturers challenging the country's right to import generic drugs (the government maintained their claim, as the companies withdrew their suit). Both countries have styled themselves as emboldened leaders of the developing countries in this regard, and both have autonomous research and manufacturing capacities to produce drugs on their own. The international political economy terrain is complex and contentious for both countries. But Brazil has pursued far more aggressive AIDS treatment policies. The reason for this, we argue, is that the effects of the international environment have been mediated by different domestic political arrangements, which we described above. We do not view the MNC/pharma influence as determinative of the larger policy outcomes we study.

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<sup>128</sup> See Parker (1990).

Second, many of the key moments in the Brazilian response to the epidemic preceded the World Bank loan. Before the loan was signed in 1993, Brazil had established a national program, a Brazilian president had mentioned AIDS in a public speech, the government had begun to purchase and distribute some AIDS drugs, including AZT monotherapy free of charge, and the government continued to advance the rights of AIDS patients. As we described above, the government had issued a number of human rights protections, including a decree prohibiting the use of HIV tests in physical examinations of public sector workers.<sup>129</sup> At the state and municipal levels, at least 67 local laws and resolutions regarding HIV/AIDS had been approved by the end of 1992. These included requirements that motels and hotels provide condoms, guarantees of non-discrimination for public sector workers and students, legal recognition and incorporation of AIDS NGOs, the reservation of hospital beds for AIDS patients, incorporation of information on HIV prevention into public and private school curricula, and compulsory HIV testing of prisoners.

The World Bank loan helped the Brazilian program reconstitute itself after a period of instability, but the driving political forces in the development of Brazil's HIV/AIDS policies were domestic, not international. After the election of President Collor in 1990, the NAP was dismantled and, in a pattern consistent with Collor's effort to govern with the support of the media and public opinion and without the support of stable party alliances, the MOH set up an alternative structure for organizing the response to AIDS. Municipal AIDS Commissions would coordinate activities in the field without input from the state health secretariats, which had been leading the response since 1983. These Municipal AIDS Commissions frequently lacked the expertise to develop and manage HIV/AIDS policies. Conflict with state secretariats and confusion regarding the direction of policies occurred throughout the country. At the same time, the MOH launched a publicity campaign that emphasized the danger of AIDS to the uninfected and isolated itself from the NGOs and community groups that had been active for almost a decade. Declaring that "Brazil will not be a guinea pig" and impugning the expertise of WHO, the Minister of Health refused to participate in WHO-led HIV vaccine trials, which resulted in the virtual isolation of the Brazilian AIDS program from the international community.<sup>130</sup> At that time, the AIDS loan from the World Bank helped the NAP rebuild itself and re-gain political independence. But given the mobilization of Brazilian civil society and the state's activities in AIDS even during the Collor years, it is likely that the many of the achievements of the program in the 1990s would have occurred, some of them perhaps a bit later, even without the loan. For example, when Brazilian political leaders approved the 1996 legislation to finance HAART to all AIDS patients for free, there was an explicit decision to finance AIDS treatment entirely with domestic funds so as to make AIDS policy more sustainable.<sup>131</sup> The size of the loan, in any case, was less than a tenth of what was needed to finance Brazilian expenditures on treatment alone.

Finally, differences in foreign assistance on HIV/AIDS can be explained from the perspective of domestic policy choices. The Brazilians sought the loan from the World

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<sup>129</sup> Portaria No. 869, August 11, 1992.

<sup>130</sup> This history is described in Parker (1990) and Teixeira (1997).

<sup>131</sup> *A Folha de São Paulo*, October 16, 1996.

Bank; it was not one that the Brazilian government was “forced” or even “persuaded” to take on. At the time, the Brazilian government had decided not to borrow any longer for the social sectors because the loans were not viewed as productive, and the hyperinflation of the early 1990s was complicating the development projects that were already underway. The decision to change course and pursue a World Bank loan was a result of the policy entrepreneurship of the NAP under the new government in 1992. After 1994, the South African government steadfastly rebuffed offers of aid and assistance, particularly from the World Bank. In more recent years, the SA government has been non-cooperative and even combative with both the U.S. government and the Global AIDS fund, even as it has finally begun to accept financial aid for dealing with the epidemic. In short, both countries have been able to maintain some policy autonomy from the advanced industrialized countries in terms of how they have dealt with the epidemic, but only in Brazil has this produced policy aggressiveness.

### The role of leadership

Questions of structure versus agency; and the influence and autonomy of elites as compared with the influence of the general public are longstanding questions in political science. In recent years, observers of policy in the developing countries have tended to emphasize elite influences to a greater degree, pointing out that formal institutions tend to be less well specified and less important for decision-making processes. In settings where many chief executives are notorious for extensive graft, leading to the bankrupting of state treasuries – Zaire’s Mobutu being a stunning example of this tradition – observers tend to place the blame on the individual (and hence credit to individuals who do not behave in such a manner) rather than the environment in which they operate. Scholars have pointed to “ideological preferences of decision makers”<sup>132</sup> and “political leadership”<sup>133</sup> in the determination of economic policy choices,<sup>134</sup> particularly in African countries. Similarly, in Grindle and Thomas’ important edited volume on policy making in the developing countries, several contributors emphasize the autonomy of policy elites.<sup>135</sup> Notwithstanding, most scholars conclude, as we do, that there is a dynamic interplay between public opinion and organized interests groups on the one hand and relatively autonomous policy elites on the other, such that any useful model must consider policy as the product of influences inside and outside the state.<sup>136</sup> And yet, so many observers of the AIDS epidemic have tended to focus on the role of “leadership,” while our analysis has focused more on societal and structural factors. Ultimately, we felt

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<sup>132</sup> Van de Walle, Nicolas. 2001. *African Economies and the Politics of Permanent Crisis, 1979-1999*. Cambridge, UK: Cambridge University Press, 50.

<sup>133</sup> Gray, Clive, and Malcolm McPherson. 2001. “The Leadership Factor in African Economic Policy Reform and Growth.” *Economic Development and Cultural Change* 49 (4):707-740.

<sup>134</sup> Oddly enough, their vision of “good leadership” is largely classified by the degree to which individual leaders followed the “Washington consensus” of economic policy reform. In other words, for them, a good leader is an obedient follower!

<sup>135</sup> Grindle, Merilee Serrill, and John W. Thomas. 1991. *Public choices and policy change : the political economy of reform in developing countries*. Baltimore: Johns Hopkins University Press.

<sup>136</sup> Grindle and Thomas 1991: 33; Walt, Gillian. 1994. *Health policy : an introduction to process and power*. Johannesburg; London ; Atlantic Highlands, N.J.: Witwatersrand University Press, Zed Books.; Van de Walle 2001: 49-50)

it was important to consider the variable of leadership more thoroughly. Specifically, we ask, can the different government AIDS responses be explained by the varied leadership styles and intuitions of the respective chief executives? Our answer to that is simple: No.

Political scientists have not taken up the question of leadership with any great zeal, relegating the notion that a particular individual makes a difference – the “Great man theory” of history – to the realm of epiphenomenal “noise.” Of course, specific examples of “great men” are hard to ignore: Surely, the world would be a different place in the absence of a Mandela, Gandhi, or Churchill. Trying to assess the counter-factual, of *how* different the world, or particular societies, would have been in their absence is more difficult. Not surprisingly, during the course of regular politics, political leaders themselves ascribe enormous significance to the policy packages they would deliver and the subsequent welfare benefits for society. And yet, it is for social scientists to investigate such claims with a characteristically skeptical eye. Specifically, we must investigate the hypothesis that aggressive AIDS policy requires or is much more likely in the context of a good, strong head of state. This would be extremely difficult in the context of a “large-N” statistical study, but we believe that our comparative-historical analysis is well-suited to such an inquiry.

In the case of HIV/AIDS, it has become conventional wisdom to attribute the policy successes of countries such as Uganda and Brazil to “good leadership,” and South Africa’s stalled response to “poor leadership.” More generally, the international AIDS policy community repeatedly looks to “good leaders” to address the scourge of the pandemic. Again, we attempt to subject the argument to careful scrutiny. First, we require a reasonable definition. If leadership is defined in terms by an individual’s initiative of good policies, and/or evidence of good outcomes, then the hypothesized relationship is merely tautology: good outcomes will be produced by “good” leaders. Rather, we attempt to isolate two aspects of executive rule that could be assessed. The first is the extent to which leaders command the respect of the general public. While we do not go so far as to say that a leader must be charismatic in the Weberian sense, anyone identified as a charismatic should be recognized as displaying high leadership traits. Shy of this criteria, we would classify any extremely popular leader, who gained the widespread confidence and respect of the general population as someone who has the potential to lead a society to adopt a policy that might be somewhat unpopular or unappealing. We can also define leadership in a manner that is more proximate to the outcome under analysis: In this sense, leadership is a general style of policy management that implies timely visibility on an issue. Thus, “quiet leadership” is an oxymoron in our lexicon, and leadership is in evidence when we see initiation of discussions and action on the policy area. Moreover, it is important to point out that we assess leadership in terms of the chief executive of the country. Of course, individual bureaucratic agencies may have skilled or unskilled managers, but the most analytically relevant question concerns chief executive leadership styles.

Even given these definitions, it would be extremely difficult to create a classification scheme that easily sorts out the empirical cases of leaders: e.g., Was Hitler a great leader? Was Ronald Reagan? And yet, the cases we have chosen for analysis provide examples

of such obviously divergent leadership examples that we need not engage in subtle semantical debates: In the case of South Africa, AIDS was largely neglected under the stewardship of two Nobel Peace Prize winners – Nelson Mandela and F.W. deKlerk (See Table 3). Similarly, it would be difficult to describe Thabo Mbeki the second president of post-apartheid South Africa, as being anything other than a widely respected leader, who generally commands broad respect within his own society<sup>137</sup>, let alone on the international stage, particularly as a visionary leader in advancing African integration.

Probably no world leader has been more rebuked for his statements on HIV/AIDS than Thabo Mbeki, leading many to conclude that it is due to his personal negligence that the South African response has been so wanting. Infamously, Mbeki has publicly expressed his interest in the scientific views of a small number of dissident scientists who question the link between HIV and AIDS. Between 2000 and 2001, he began to publicly question the mainstream scientific wisdom, and in a country with a staggering AIDS epidemic, he has seemed to pay little attention to the problem, rarely making the problem a significant point of discussion in more general policy addresses. Mbeki's attempt to draw on the research of "dissident" scientists brought the ire of the international community, to the extent that it became impossible for the President to avoid repeated questioning by the press. By April 2002, he said that he would pull back from the debate around these issues. Nonetheless, his health minister, Manto Tshabalala-Msimang continued to emphasize a set of heterodox policies on HIV/AIDS, such as an emphasis on diet, and the use of "olive oil" that was widely interpreted as merely a continuation of a "dissident" approach. Mbeki's and Tshabalala-Msimang's various challenges to the safety and efficacy of anti-retroviral drugs have placed them way out of the "Geneva consensus" on HIV/AIDS. This has led many to blame South Africa's blazing epidemic, and its government's failure to respond, on Mbeki's personal idiosyncracies.

While recognizing that Mbeki's words and deeds were certainly individual acts that can only be understood as having a negative influence on policy aggressiveness, we think it is problematic to argue that the South African outcome we have described is the direct product of Mbeki's own renegade action, unique to his individual persona. First off, as described above, under previous presidencies, there was a similar mode of response. Second, Mbeki's record prior to becoming president was as a champion of HIV/AIDS prevention. According to the editorial page of the *Mail and Guardian*, a progressive weekly newspaper that has been extremely critical of Mbeki as President and on his AIDS policy in particular, during his tenure as Vice President under the Mandela presidency they observed, "There is clearly a new public awareness trail that has been blazed by Deputy President Thabo Mbeki."<sup>138</sup>

Moreover, the very assumption that any given leader's whim will become policy in a doctrinaire manner must be problematized when such whims are expressed in the context

<sup>137</sup> For example, in their careful and yet critical analysis of Mbeki, Jacobs and Calland acknowledge this level of respect and popularity at home and abroad. See, Jacobs, Sean, and Richard Calland. 2002. *Thabo Mbeki's world : the politics and ideology of the South African president*. Pietermaritzburg; London ; New York: University of Natal ; Zed Books.

<sup>138</sup> "Even Thabo has to wear a condom ," *Mail and Guardian*, Electronic Edition, December 04, 1998

of democratic government. Could such shenanigans have become so influential in the Brazilian context? It seems highly unlikely because, as we discuss above, the strength of the national executive is very much a function of differing institutional environments, and in Brazil, where the presidents have never enjoyed party majorities in the legislature (let alone strong party discipline), and where policy autonomy is enjoyed by state governors, an idea viewed as out of the mainstream would be contradicted at various levels in the policy process. Frankly, a Brazilian president expressing such “dissident” views would have been publicly ridiculed and sidelined in the forging of AIDS policy. In the South African context, many observers confide that various South African leaders and technocrats disagree heartily with the President’s views, but almost no ANC leaders will publicly challenge him or the country’s slow movement on HIV/AIDS. On the contrary, many – though certainly not all – cabinet members have echoed Mbeki’s stance. For example, Defense Minister Patrick “Terror” Lekota, was reported in 2003 as saying, “All of this noise every day about HIV/AIDS and so on, that suggest that this country is about to collapse as a result of HIV/AIDS is really unfounded... There is no alarm in this country.” According to the article, “Lekota said programmes run by the government will enable it to contain the disease... The SANDF does not recruit people with what he termed ‘the condition.’ He said the defence force is not crippled by AIDS, and blamed ‘disloyal’ elements for ‘sneaking’ out stories to this effect.”<sup>139</sup>

By contrast, in Brazil, most of the presidents who were in power during the outbreak of the AIDS epidemic must be described as extremely weak and unremarkable leaders. For example José Sarney, the first democratic President of Brazil, was a lackluster governor and Senator who was accidentally installed as President in 1985 after the death of Tancredo Neves, who had been indirectly elected, but suffered fatal complications after an operation on the eve of his inauguration (Sarney had been elected Vice President). Sarney faced a panoply of financial and social problems, which he largely failed to address. Sarney was, “linked to the defeated political party and compromised by an association with an increasingly discredited military past,” and, “Unable to fulfill promises to reform the countryside, a weak president became weaker.”<sup>140</sup> President Fernando Collor de Mello was elected in 1990 in the first direct presidential election and after findings of widespread personal corruption, was impeached in 1992, ushering in President Itamar Franco, who, as an individual, has demonstrated profound disdain for the national interest, was never a hugely popular figure, and lost his bid for re-election. Of any of the Brazilian presidents who came to power during the recent democratic era, only Fernando Henrique Cardoso could possibly meet the criteria of being a “great leader,” but his inauguration into office in 1996 surely post-dates a clear trajectory of aggressive action on HIV/AIDS already in place.

In short, if the leadership hypothesis is focused on the qualities of the national chief executive, the comparative-historical analysis provides strong disconfirming evidence. AIDS policy decisions cannot be understood simply in the context of the “wisdom” and

<sup>139</sup> “Lekota: ‘No AIDS Alarm in SA’,” Mail and Guardian online, October 8, 2003. Accessed October 8, 2003, [www.mg.co.za](http://www.mg.co.za)

<sup>140</sup> Burns, E. Bradford. 1993. *A History of Brazil*. New York: Columbia University Press, 480.

“foibles” of developing country leaders, but must be recognized within the context of the broader political processes we have described above.

## IV) Conclusions

We have tried to solve a substantial policy question through the application of theory and method. Our structured comparative analysis has allowed us to explore the potential influence of a set of hypothesized factors on the development of government responses to HIV/AIDS, suggesting how and why state capacities to respond to the AIDS epidemic have developed in different ways in different times and places. Ultimately, we have identified two factors – institutions and the norms of political community – as the most determinative. We can emphasize the power of our findings by considering our two cases in counter-factual terms: If, *ceteris paribus*, Brazil had had a divided racial history or a concentrated institutional structure more like South Africa’s, we believe that national government action on HIV/AIDS would have been much less aggressive. On the other hand, if South Africa’s history of race relations had been characterized more by mixing than by separation; and/or if political power were more dispersed across geographic units or political parties, we believe that government action would likely have been much more aggressive. Given our analysis, our conclusions about the impact of democracy are less firm. There is good reason to believe that rights-oriented constitutions can give birth to new sets of rights in a form of institutional reproduction, but democracy *per se* is not sufficient for motivating aggressive policy action.

Such findings merit reflection about theory, method, and public policy. From a theoretical perspective, we find that a little explored policy area can be better understood using certain theoretical insights developed from other sets of research. From a methodological standpoint, we believe that the power of structured comparative analysis allows us to deploy a range of reliable and valid measures (which has been difficult in large-N analysis), while providing opportunities for probing theoretical propositions (which has been difficult in single case study analysis). Methodological eclecticism is critical, especially in an under-explored area of research. From a policy standpoint, we do not have any easy prescriptions that will lead to more coordinated or aggressive action on AIDS, but we do believe that our research suggests some of the opportunities and constraints on policy that have not been adequately recognized. We also find that some of the factors ordinarily taken for granted as central to an adequate government response, such as strong “leadership,” may be overblown. At the very least, our research would suggest that political rhetoric which emphasizes the connectedness of political communities and initiatives to promote decentralized policy entrepreneurship may have a positive influence on government action.

Given that we have only studied two upper-middle-income countries, both of which underwent recent democratic transitions, we realize that our theoretical findings may not travel widely and/or that other factors may also be important, or even more important, when trying to explain broader patterns of cross-national variation. Nonetheless, we suspect that our insights may have broader application for understanding HIV/AIDS

government responses in other countries, and for understanding government policy responses more generally.

Comparative social science research on government responses to HIV/AIDS remains in its infancy, and much work remains to be done. In terms of future research, additional forms of data and analysis are required to explore the veracity of the arguments we have advanced in this paper. This should include, but is not limited to, structured comparisons of other cases, additional research on the increasing roll-out of ARV programs across countries, gathering valid and reliable data for statistical analyses, and set-theoretic analyses which focus on the determinants of necessary and sufficient conditions. Moreover, some additional hypotheses need to be explored – for which we felt we had insufficient theoretical and/or empirical materials for adequate analysis. Specifically, several compelling studies of the cases we explore as well as other country cases point to other factors that political scientists have not yet adequately addressed within a comparative framework. For example, Ashforth points to the important role of witchcraft in the South African case, highlighting the very different context of personal and policy decisions when there is a lack of consensus in a germ theory of disease.<sup>141</sup> Religion and moralistic norms may also factor into the explanation. We know that in South Africa, many church leaders have had regressive influences on a full public understanding of the dynamics of HIV transmission, and that moralistic discourse, for example against homosexuality, has been used widely throughout the history of the epidemic. While such problems have not been wholly absent in Brazil, we perceive them to be much less persistent. However, we are not prepared to evaluate these fully because the state of knowledge about such factors is so limited, and the impact of religion, and views about gender and sexual relations is still quite difficult to measure across countries. Future research – both in the area of HIV/AIDS policy, and more generally – could fruitfully be pursued in these areas.

HIV/AIDS is a social as much as it is a medical problem. Social scientists should continue to conduct research on the causes and consequences of this deadly epidemic: we believe there will be important payoffs not just for our understanding of the social world, but quite potentially insights about how to usefully address this epidemic as well as future problems that the world is likely to face in a globalized environment of infectious disease.

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<sup>141</sup> Ashforth, Adam. 2002. 'An Epidemic of Witchcraft? The Implications of AIDS for the post-Apartheid State. *Journal of African Studies* 61 (1):121-152.

## **Acronyms**

- AIDS – Acquired Immunodeficiency Syndrome
- ANC – African National Congress (South Africa)
- ARV – Antiretroviral Drug
- AZT - Chemical Name: Azidothymidine/ Generic Name: Zidovudine (anti-retroviral drug)
- CD4 – a protein-based receptor for HIV found on T cells that help individuals to resist infections; HIV attacks these molecules, and when the CD4 count is low, an individual is at risk for opportunistic infections (hence, AIDS)
- HAART – Highly Active Anti-retroviral drug therapy
- HIV – Human Immunodeficiency Virus
- IDU – Intravenous Drug User
- INAMPS – Instituto Nacional de Assistência Médica da Previdência Social (medical care division of former social security institute - Brazil)
- MSM – Men who have Sex with Men
- NAPWA – National Association of People Living with AIDS (South Africa)
- NGO – Nongovernmental organization
- PLHA – People living with HIV/AIDS
- PMTCT – Prevention of Mother-to-Child Transmission
- TAC – Treatment Action Campaign (South Africa)

**Table 1: Aggressiveness of Government Responses to HIV/AIDS (1982-2004)**

<u>Policy Areas</u>	South Africa		About same	Brazil	
	Much more aggressive	More aggressive		More aggressive	Much more aggressive
<b>Bureaucratic Development</b>					
Timing and authority of national program					X
Level of historical expenditures				X	
Scope and timing of research and surveillance			X		
Scope of NGO partnerships					X
<b>Prevention</b>					
Timing of blood safety		X			
Scope of testing				X	
Scope of condom distribution and use				X	
Timing of programs to prevent mother to child transmission					X
Timing and scope of programs targeted at local risk groups (weighted three times in Overall)					X
<b>Treatment of PLHAs</b>					
Timing of monotherapy					X
Timing and scope of triple therapy					X
Scope of laboratory system					X
Timing and scope of human rights legislation					X
<b>SUM: Bureauc Development</b>				X	
<b>SUM: Prevention</b>					X
<b>SUM: Treatment of PLHAs</b>					X

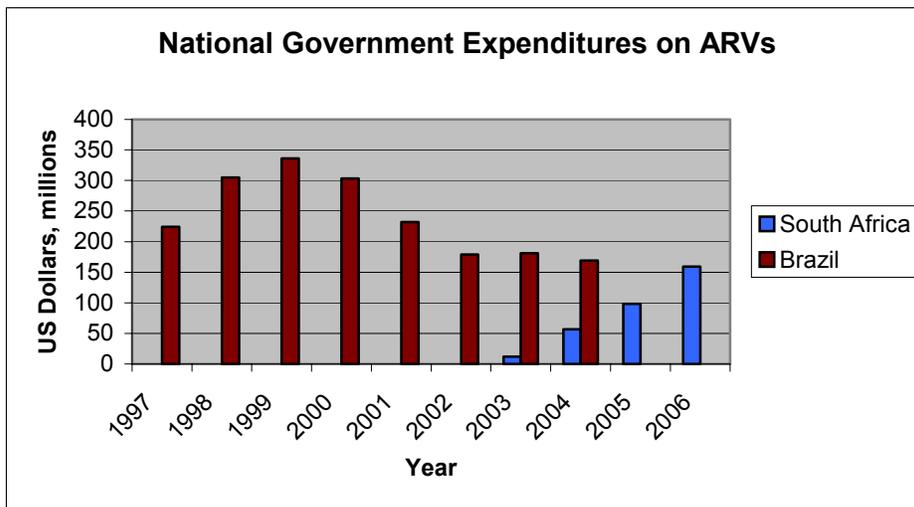
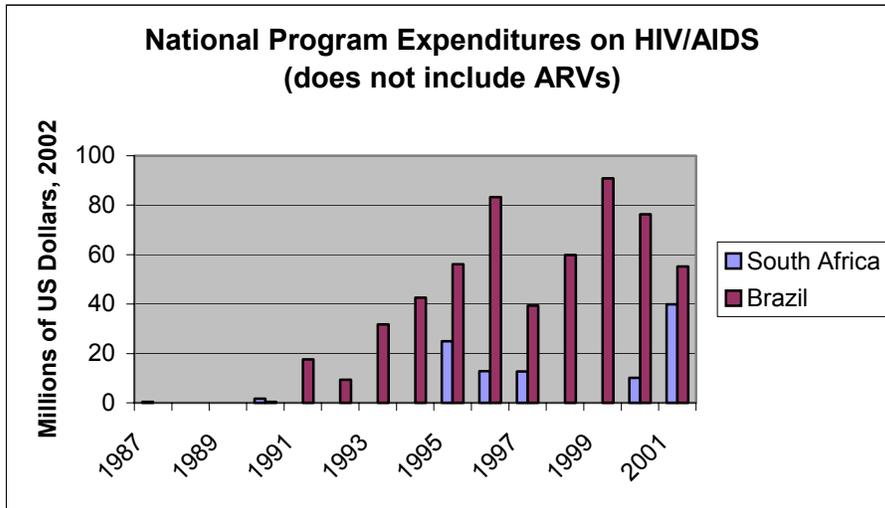
**Table 2: Theoretical Scorecard**

<b>Hypothesis</b>	<b>Evidence in favor (why one would think plausible in these cases.)</b>	<b>Evidence to reject</b>	<b>Assessment of causal weight</b>
<b>Political regime type</b>	<ul style="list-style-type: none"> <li>- Timing of regime change in each country provided some opening for new demands</li> <li>- Most human rights legislation follows the transition</li> <li>- Political actors pushing for policy are linked to the democratic movement</li> </ul>	<ul style="list-style-type: none"> <li>- Similar political regimes produce different outcomes</li> <li>- Bureaucracies develop before transitions</li> <li>- Strong civil societies in both countries</li> </ul>	Some support – but mostly on rights orientation
<b>Political institutions</b>	<ul style="list-style-type: none"> <li>- Decentralized policy autonomy generates successful experiments leading to national policy in Brazil</li> <li>- Constrained autonomy in South Africa; even with federal constitution, power is highly centralized</li> </ul>		Strong support
<b>Political community</b>	<ul style="list-style-type: none"> <li>- Multiple examples of racialized AIDS politics impeding policy action in South Africa</li> <li>- Almost no mention of race as related to AIDS in Brazil; certainly not a source of policy conflict</li> </ul>		Strong support
<b>Epidemiology</b>	<ul style="list-style-type: none"> <li>- Epidemic in Brazil begins among gay, middle-class men in Southeast</li> </ul>	<ul style="list-style-type: none"> <li>- Both countries posed to have major, widespread epidemics in 1980s</li> <li>- Also began with gay men in South Africa</li> <li>- Gay men not well organized before AIDS in Brazil</li> </ul>	Weak support
<b>International links</b>	<ul style="list-style-type: none"> <li>- World Bank loan to Brazil</li> <li>- South Africa pariah state pre-1990s</li> </ul>	<ul style="list-style-type: none"> <li>- Both countries play structurally similar role in world economy</li> <li>- South Africa rejects many AIDS-related loans, assistance programs</li> </ul>	Weak support
<b>State capacity</b>		<ul style="list-style-type: none"> <li>- Both countries undergoing massive state transformations</li> <li>- South Africa strong in other sectors which were transformed</li> <li>- South Africa possesses very similar, if not stronger state capacity than Brazil</li> </ul>	Very weak support
<b>Leadership</b>	<ul style="list-style-type: none"> <li>- Thabo Mbeki infamous remarks, strategies on HIV/AIDS</li> </ul>	<ul style="list-style-type: none"> <li>- Non-aggressive policies associated with “good” leaders in South Africa</li> <li>- Aggressive policies associated with “bad” leaders in Brazil;</li> </ul>	Very weak support

**Table 3: Demonstrated Leadership Capacity of Chief Executives (1982-2004)**

Brazil		South Africa	
Head of State	Leadership capacity	Head of State	Leadership capacity
João Figueiredo (1979-85)	<i>Weak/Moderate</i> – helped to orchestrate political transition	M. Viljoen (1979-84)	<i>Weak</i> – massive protests, challenges
José Sarney (1985-90)	<i>Weak</i> – installed by accident	P.W. Botha (1984-89)	<i>Moderate</i> – country under state of emergency
Fernando Collor de Mello (1990-2)	<i>Weak</i> – impeached	F.W. DeKlerk (1989-94)	<i>Strong</i> – Nobel Peace Prize winner
Itamar Franco (1992-6)	<i>Weak</i> – installed because of impeachment	Nelson Mandela (1994-9)	<i>Strong</i> – Charismatic, Nobel Peace Prize Winner
Fernando Henrique Cardoso (1996-2004)	<i>Strong</i> – re-elected; world leader	Thabo Mbeki (1999-)	<i>Strong</i> – stunning electoral support; world leader

**Figure 1: National Expenditures on HIV/AIDS Brazil and South Africa (1987-2001)**



**Note:** South African ARV expenditures began in 2003; projected Brazilian ARV budgets for 2005 and 2006 were not available; dollar estimates of South African budgets for 2004 – 2006 are based on the present (spot) exchange rate (6.60 ZAR = 1 USD). Data are taken from Ministério da Saúde, *Resposta*, 2004; and Hickey 2004.