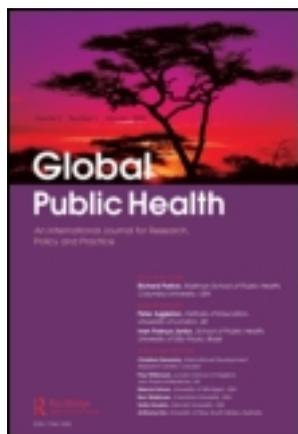


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The impacts of AIDS movements on the policy responses to HIV/AIDS in Brazil and South Africa: A comparative analysis

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Brazil and South Africa were among the first countries profoundly impacted by the HIV/AIDS epidemic and had similar rates of HIV infection in the early 1990s. Today, Brazil has less than 1% adult HIV prevalence, implemented treatment and prevention programmes early in the epidemic, and now has exemplary HIV/AIDS programmes. South Africa, by contrast, has HIV prevalence of 18% and was, until recently, infamous for its delayed and inappropriate response to the HIV/AIDS epidemic. This article explores how differing relationships between AIDS movements and governments have impacted the evolving policy responses to the AIDS epidemic in both countries, including through AIDS programme finance, leadership and industrial policy related to production of generic medicines.

Keywords: South Africa; Brazil; HIV; AIDS; health policy; civil society; AIDS movements

Introduction

Development experts and social scientists frequently compare Brazil and South Africa because of similarities in levels of human and economic development, recent transitions to democracy, decentralised government structures, complex racial histories and levels of inequality (Table 1). These similarities have informed many of the comparative political analyses in both countries. However, the two countries have had very different public policy responses to the acquired immune deficiency syndrome (AIDS) epidemic. We examine the role of each country's AIDS movement with the state to explain these differences.

HIV/AIDS in Brazil and South Africa

In 1988, Brazil had the second highest number of reported AIDS cases in the world, second only to the USA (Jornal do Brasil 1988). Today, Brazil is widely recognised as a model for its public policy response to AIDS. Brazil implemented numerous HIV

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Table 1. Human development indicators of South Africa and Brazil.

| | South Africa | Brazil |
|---|--------------|--------|
| <i>Education</i> | | |
| Literacy rate ^a | 89% | 90% |
| Expenditure on Education (% of GDP), 2008 ^a | 5% | 5% |
| Mean years of schooling (adults) ^a | 8 | 7 |
| <i>Economic development</i> | | |
| GDP per capita (2008 PPP in US\$) ^a | 10,140 | 10,847 |
| GINI coefficient, 2008 ^a | 55.0 | 57.8 |
| Unemployment rate total (% of labour force), 2008 ^b | 22.9 | 8.2 |
| <i>Health</i> | | |
| Public expenditure on health (% of GDP), 2008 ^a | 3.6 | 3.5 |
| Life expectancy at birth, annual estimates (years), 2008 ^a | 52.0 | 72.9 |
| Under-five mortality rate (per 1000 live births), 2008 ^a | 67 | 22 |
| Prevalence of undernourishment (% of population) ^a | 5 | 6 |

^aUnited Nations Human Development Indicators 2008. UN Development Programme. Available from: <http://hdr.undp.org/en/> [Accessed 11 March 2011].

^bWorld Statistics Pocketbook 2010. UN Statistics Division. Available from: <http://data.un.org/> [Accessed 11 March 2011].

prevention programmes since the 1980s, and began offering antiretroviral treatment to people living with HIV/AIDS (PLWHA) in the early 1990s. Since 1996, Brazil has provided free and universal access to highly active antiretroviral treatment (HAART); Brazil began scaling up provision of HAART to all PLWHA in 1997. HIV prevalence remains below 1% and Brazil has all but eliminated mother-to-child (vertical) transmission of HIV (Berkman *et al.* 2005, Dourado *et al.* 2006). Brazil is also known for its global efforts to promote universal access to HAART beyond its own borders, and to promote its impacts on global health, human rights and trade laws related to access to essential medicines (Nunn *et al.* 2009a, 2009b).

In 1988, South Africa's HIV prevalence was also just under 1% (ASSA 2010). Today, however, 5.6 million South Africans are living with HIV – the largest number in any one country in the world (UNAIDS 2010a). Approximately 18% of South African adults aged 15–49 live with HIV/AIDS, which has dramatically reduced life expectancy in South Africa (Table 1; UNAIDS 2010a). During the Mbeki Presidency (1999–2008), South Africa was infamous for its poor leadership related to HIV/AIDS, AIDS denialism by President Mbeki and its tardy response to the epidemic, particularly regarding access to medicines for treatment. In contrast with other countries, which have had limited responses to the AIDS epidemic, South Africa's political leaders have explicitly *denied* that HIV is the cause of AIDS (Kalichman 2009). Moreover, although in 2000 the Western Cape Province began to provide HAART through a pilot programme in Khayelitsha (an African township outside Cape Town), South Africa only began a national HAART rollout in the public sector in 2004 (Coetzee *et al.* 2004, Nattrass 2007, 2008). HAART coverage has since improved, but as of mid-2009, only 35–39% of those in need of treatment were accessing it (UNAIDS 2010a). Similarly, only 57% of South African women received services for prevention of mother-to-child transmission (hereafter PMTCT) as recently as 2007 (UNAIDS 2010a). South Africa's delayed use of HAART for

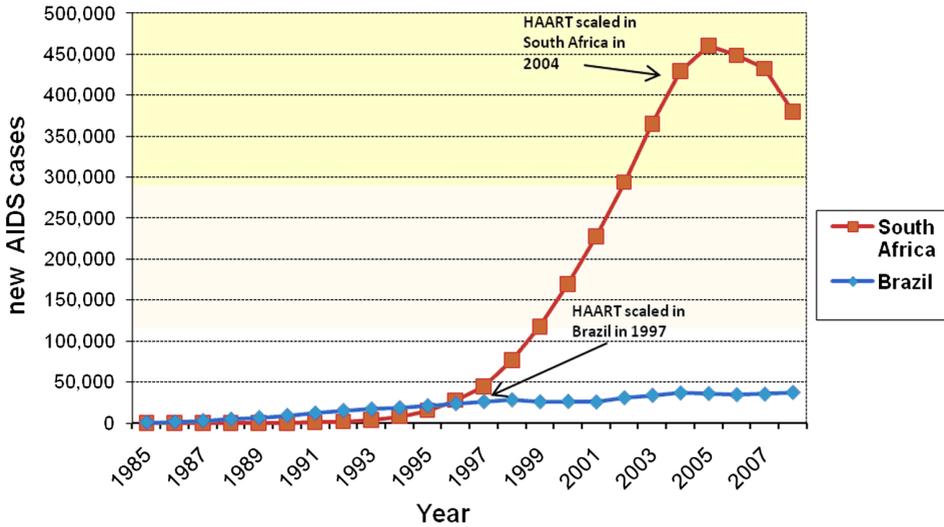


Figure 1. New AIDS cases in South Africa and Brazil: 1985–2008. Data sources: Brazilian Health Ministry, 2011, and Actuarial Society of South Africa AIDS Models, 2011

prevention and treatment has been estimated to have resulted in hundreds of thousands of preventable deaths (Chigwedere *et al.* 2008, Natrass 2008). Figures 1 and 2 compare trends in new AIDS cases and AIDS-related deaths in Brazil and South Africa from 1985 to 2008.

The nature of the HIV epidemic is very different in Brazil and South Africa. Brazil has a concentrated epidemic, with HIV infections largely limited to several

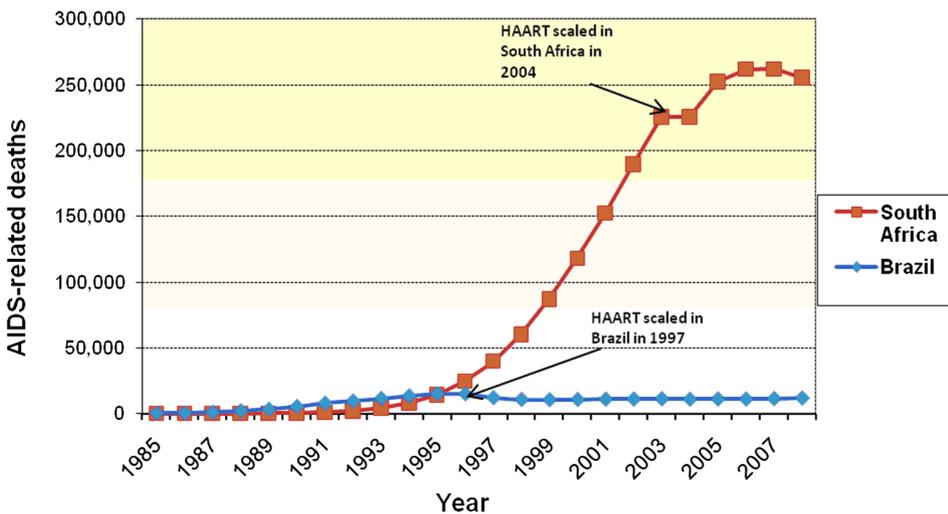


Figure 2. AIDS-related deaths in South Africa and Brazil: 1985–2008. Data sources: Brazilian Health Ministry, 2011, and Actuarial Society of South Africa AIDS Models, 2011

subpopulations, such as men who have sex with men, commercial sex workers and injecting drug users. Brazil's epidemic is now concentrated in urban areas and infection rates have declined dramatically among injecting drug users (Grangeiro *et al.* 2010a, 2010b). The South African epidemic is now a generalised heterosexual epidemic influenced by cross-border migration from Southern and Central Africa (UNAIDS 2010a). In addition to these epidemiological differences, different policy responses in Brazil and South Africa have contributed to the evolution of the epidemic in each country. Structural factors, including politically salient ethnic divisions in South Africa, have been suggested as potential determinants of these policy differences (Gauri and Lieberman 2006). Other explanations point to the relevance of complex political factors, including President Mbeki's AIDS denialism (Nattrass 2007, 2008). In this article, we explore some of these complex factors and posit that the difference in relationships between social movements and the government in the two countries has played an important role in shaping their respective public policy responses to the AIDS epidemic. Differing policy responses, in turn, help explain different trends in new AIDS cases, AIDS-related deaths and life expectancy in South Africa and Brazil (see Figures 1 and 2 and Table 1).

History of Brazilian and South African AIDS movements and public policy responses to the epidemic

Brazil's transition to democracy began in the 1980s, and Brazil adopted a new democratic constitution outlawing the dictatorship in 1988. The country's transition to democracy continued into the 1990s. South Africa's democratic transition began in 1990 with the 'unbanning' of the African National Congress (ANC), and the country's first democratic elections held in 1994. HIV/AIDS first surfaced in both countries in the early 1980s, and evolved alongside their democratic transitions. During the relatively early stages of the epidemics, around 1990, Brazil and South Africa had similar HIV prevalence rates; (Jornal do Brasil 1988, Braga 1996, Braga and Carsten 1998, ASSA 2010). Understanding the divergence that occurred in these countries' epidemics over time requires nuanced examination of their public policy responses, which we argue were strongly influenced by the interactions between the government and their respective AIDS social movements.

AIDS emerged in Brazil in 1981 as a mysterious disease affecting gay men. It was associated with heavy stigma and discrimination; many people living with HIV were turned away from care services, lost their jobs and were abandoned by their families (Galvão 2000). The AIDS crisis grew during the 1980s. In the late 1980s, civil society groups in São Paulo and Rio de Janeiro rallied around the issue, formed non-government organisations and began demanding that the government develop HIV/AIDS education and prevention programmes (Galvão 2000).

Brazil is renowned for its long-term partnerships between civil society and its National AIDS and STD Programme (hereafter NAP; Galvão 1997, 2000). Informal partnerships between civil society organisations and the state date back to Brazil's earliest response to the AIDS epidemic, when members of the *sanitarista* health reform movement began education and anti-stigma campaigns (Parker 1997, Galvão 2000). The *sanitarista* health reform movement advocated for democratic governance in the 1970s and 1980s as a means to promote universal access to health services for all Brazilians. During the late 1980s and early 1990s, the emerging AIDS movement

both promoted equitable access to treatment, care and prevention services, and launched anti-stigma and education campaigns. This helped jump start public policy dialogue and prompted the Health Ministry to begin to address Brazil's epidemic. During this time, numerous different types of NGOs emerged, including direct care organisations, organisations that promoted HIV/AIDS education and awareness and advocacy organisations. The NAP was created in 1988, and during the 1990s, the AIDS movement grew, as did its collaboration with the government (Galvão 2000, 2002, Nunn 2009).

Several leaders of Brazil's AIDS movement had strong links to political leadership, the democratisation movement and the media. Using clever media tactics and public protests, the movement heightened public awareness about the AIDS epidemic and pressured politicians to publicly address the AIDS crisis, helping prompt an early public policy response to the epidemic. The AIDS movement's ongoing informal partnerships with policy-makers were formalised in the early 1990s, when AIDS activists were asked by the NAP to help draft World Bank loan proposals for AIDS assistance. Brazil's AIDS programme was a well-functioning bureaucracy by the mid-1990s, and the World Bank loans help institutionalise formal partnerships between civil society and the state (Nunn 2009).

South Africa's historical response to the HIV/AIDS epidemic has been quite different. HIV was first noticed in the early 1980s when two white male homosexual airline flight attendants died of AIDS. By 1987, however, HIV had a strong and growing presence in the general population (Grundlingh 2001). The apartheid government initially did little to combat the epidemic and its early efforts to promote HIV/AIDS awareness were ineffective in large part because the government lacked credibility with the black majority. By 1990, when the ANC began negotiating with the apartheid government over the transition to democracy, South Africa's first antenatal HIV surveillance surveys had identified a growing generalised epidemic. A comprehensive AIDS plan was developed in 1993 and formally adopted by the ANC-led transitional Government of National Unity in 1994 (Nattrass 2003, 2007).

In contrast with Brazil, where the AIDS movement partnered closely with the federal AIDS programme, in South Africa the AIDS movement has functioned largely independently of the state. During apartheid in the early 1990s there was a cooperative relationship between the ANC and health practitioners concerned about AIDS; a substantive plan was developed to combat AIDS in a way which envisaged strong collaboration between government and civil society. However, the ANC government ultimately did not prioritise HIV/AIDS; even pilot PMTCT programmes introduced in the 1990s had been eliminated by 1998. The Mbeki administration (1999–2008) excluded AIDS opinion leaders, scientists and activists from AIDS advisory bodies, and his infamous AIDS denialism promoted highly contentious relationships between the South African state and the AIDS movement (Nattrass 2003, 2006, 2007, Geffen 2010).

While the Brazilian AIDS movement impacted public policy at the state and national levels as early as the late 1980s, AIDS activists and health professionals in South Africa initially relied on the ANC to coordinate AIDS policy after the democratic transition. However, after the ANC failed to prioritise AIDS policy, particularly AIDS treatment, frustrations ran high. In 1993, the AIDS Law Project was established to use legal processes to promote and advance the rights of PLWHA. Over the years a number of organisations, ranging from those involved in advocacy

to those intended to offer direct care and support, were created at both national and provincial levels. The Treatment Action Campaign (TAC) was founded in December 1998 to promote an enhanced public policy response to AIDS. Over the next decade, the TAC developed a national network which built grassroots support for AIDS policy reform, promoted treatment literacy and HIV prevention, and worked to destigmatise HIV/AIDS. The TAC also pressured government with widespread social mobilisation, public protests, media campaigns and legal action to promote and enforce policy change. In 2002, the TAC, in partnership with the AIDS Law Project, brought and won a case against the government to force the implementation of a national PMTCT programme. The following year, the TAC commenced a civil disobedience campaign which, amongst other positive changes, resulted in President Mbeki's cabinet overruling his opposition to providing HAART in the public sector, culminating in the country's first commitment to providing HAART. These victories were, nonetheless, hampered by the Mbeki administration's AIDS denialism, ongoing opposition to HAART rollout and PMTCT programmes, and promotion of unproven medical therapies for AIDS treatment (Nattrass 2008).

In summary, although social movements in both Brazil and South Africa collaborated with public actors and institutions in the early responses to the epidemic, their relationships with the state were increasingly divergent. In Brazil, activists played key roles in health policy development, working with the National AIDS Programme since the early 1990s; in South Africa, AIDS activists have contested and challenged AIDS policy through today. We posit that these relationships between civil society and the state in Brazil and South Africa impacted leadership, AIDS finance, local drug production and the judicial branch of government's response to the AIDS epidemic in each country.

Leadership and public policy response

Brazil's and South Africa's differing public policy experiences have been strongly impacted by political leadership; leadership, in turn, was impacted by the differing relationships that exist between civil society and the state in the two countries.

Since the onset of the AIDS epidemic in Brazil, AIDS activists worked with the government in developing and implementing the country's public policies (Galvão 2000, 2002). It is difficult to overestimate the impact of these relationships on the leadership role taken by government with respect to AIDS policy in Brazil. For example, since the mid-1990s, every director of the NAP has been either part of the AIDS movement or a *sanitarista*. These strong ties to civil society have helped solidify the role of civil society in promoting, lobbying for and implementing AIDS programmes (Nunn 2009).

Access to treatment in Brazil, for example, had been sporadic until 1996, when Brazil's Congress passed a law guaranteeing free and universal access to HAART. The law coincided with mounting social pressure to respond to the AIDS crisis and also prompted radical rises in HAART costs. In response, Health Minister Jose Serra began implementing creative strategies to scale treatment while addressing rising costs; this included producing off-patent drugs in public factories. These policies were implemented at the same time that *sanitaristas* assumed leadership at the NAP who prioritised development of health infrastructure to distribute HAART nationwide. HAART was available in public clinics on a massive scale as early as 1997.

As a result of these changes, by 1998 most people who needed HAART were able to receive it. Access to HAART in Brazil has continued to improve dramatically; the number of PLWHA receiving treatment grew from 35,000 in 1997 to over 200,000 in 2009 (UNAIDS 2010a). Today HAART is offered in hundreds of clinics, even in remote areas of the country. AIDS-related mortality and morbidity have declined dramatically as a result of widespread access to HAART (Guimarães 2000, Marins *et al.* 2003, Dourado *et al.* 2006).

All of these public policies had critical implications for the epidemiology of the Brazilian AIDS epidemic: treatment decreases a person's HIV viral load, which in turn significantly reduces the probability of transmitting HIV to others (Quinn *et al.* 2000, Das *et al.* 2010, Donnell *et al.* 2010, Cohen *et al.* 2011). Early introduction of HAART likely explains Brazil's dramatically lower AIDS and AIDS-related mortality rates (see Figures 1 and 2). Offering treatment is also thought to have helped destigmatise the disease and to prompt thousands of people to get tested for HIV (Galvão 2005). Though less has been written about prevention in Brazil, the NAP, in partnership with HIV/AIDS NGOs, also took an outspoken leadership role in sponsoring nationwide HIV testing and prevention campaigns that include targeted outreach to vulnerable populations including sex workers, injecting drug users and pregnant women (NAP 2005).

Leadership related to HIV/AIDS issues in South Africa has been markedly different. By the time Nelson Mandela became the first democratically elected President in 1994, almost 8% of pregnant women presenting at government clinics were HIV positive (Nattrass 2007). The Mandela government did not prioritise AIDS and, due in part to a series of political scandals, the collaborative relationship between the ANC and progressive health professionals soured. The government-sponsored National Association of People Living with AIDS (NAPWA) was formed in 1994 to provide a voice for people living with AIDS, but tensions over strategic direction emerged within the body. In 1998, a group of activists from within and outside NAPWA formed the TAC, which to this day spearheads South African civil society leadership related to HIV/AIDS (Geffen 2010).

In contrast with Brazil, where the collaborative relationship between civil society and government developed in the early 1990s, dealings between the AIDS movement and the public sector in South Africa have been primarily adversarial. When Mbeki became President in 1999, the TAC launched campaigns aimed at government to promote widespread provision of drugs for PMTCT and to lower antiretroviral prices. The relationship with the state was further stressed as Mbeki and Health Minister Tshabalala-Msimang questioned the efficacy of HAART, promoted unproven AIDS therapies and failed to support lowering antiretroviral treatment prices (Nattrass 2007, Geffen 2010). Although the TAC was eventually able to win the support of both the trade union movement and Mbeki's presidential cabinet, poor presidential leadership stymied progress in expanding PMTCT access and had notable impacts on population health outcomes.

Under Mbeki's leadership, the South African state resisted rather than embraced its AIDS movement. The TAC was strategic in maintaining its loyalty to the ANC but nonetheless strongly opposed Mbeki and Tshabalala-Msimang's AIDS policies (Geffen 2010). The overt conflict between the government and civil society largely ended in 2009, when Jacob Zuma became President, appointed a new Health Minister and prioritised AIDS policy. However, this was only after millions of

individuals had died of AIDS-related causes (see Figure 2). Since Zuma's election, the government has worked to increase the number of people on HAART (Motsoaledi 2010); approximately one million people are now estimated to receive treatment and an ambitious 'Know Your HIV Status' campaign was launched in mid-2010 that is designed to reduce HIV incidence by 50%. However, there is still tremendous unmet need for HAART and other AIDS-related services in South Africa; approximately 1.9 million people in need of treatment still do not have access (UNAIDS 2010a).

AIDS finance

The financial resources available to AIDS programmes dramatically impacted the differential public policy responses in Brazil and South Africa. Brazil's NAP has been well-financed and supported since the mid-1990s, while South Africa's AIDS programme has only recently begun to receive sufficient financial support from the state and external donors. These differences have been strongly impacted by civil society in both countries.

Stable, long-term finance of Brazil's AIDS programmes can be traced to the series of large-scale World Bank loans for HIV/AIDS noted earlier. Brazil's first World Bank loan proposal outlined prevention programmes, surveillance and health infrastructure. Linked in part to the participation of AIDS activists in writing the proposals, these loans required Brazil to finance a portion of its proposed AIDS programmes and earmarked resources for NGOs to implement HIV/AIDS education and awareness campaigns. As a result, civil society organisations received millions of dollars in World Bank loans to support their work between 1995 and 2007 (World Bank 1993, World Bank 2003, Vallancourt 2004). By the late 1990s, AIDS activists received financial support; the government was providing NGOs with financial resources to support AIDS advocacy, which culminated in demands from NGOs that the federal government provide and finance drugs for AIDS treatment (Chequer 2005). This formally institutionalised Brazil's history of collaboration between civil society and the state; new federal resources for civic activity and prevention programmes also created incentives for civil society organisations to form. These phenomena added momentum to an already powerful AIDS movement.

Second, ever since Congress approved the law guaranteeing universal access to AIDS treatment in the 1990s, Brazil's NAP has been well-financed. In 2007, the NAP spent approximately US\$850 million on its AIDS treatment programme (UNGASS 2008). Widespread and continuing political support for Brazil's AIDS programme can not only be largely attributed to Brazil's AIDS movement, which has worked with the state to roll out AIDS programmes, but also holds the government accountable for its legal commitments to provide drugs to all people living with HIV/AIDS (Del Bianco 2005, Scheffer *et al.* 2005). In the last decade, in spite of sharp increases in HAART costs, HIV/AIDS spending has been sustained (Nunn *et al.* 2007).

In contrast with Brazil's early domestic commitments and loan arrangements to finance the programmatic components of the AIDS response, there was little national or donor funding in South Africa during the Mandela administration, and what did exist primarily funded policy creation rather than health infrastructure and implementation of AIDS programmes (Schneider and Gilson 1998, Parkhurst and Lush 2004). Some donor funding went to the Mandela government for HIV

education projects, and some provinces, assisted by the TAC and others, applied for international funding for treatment in opposition to national policy. However, these efforts were undermined when Mbeki blocked a Global Fund grant to KwaZulu-Natal (Nattrass 2007). Other provinces, notably the Western Cape, nonetheless defied national policy and formed partnerships with private donors, the Global Fund and the US President's Emergency Plan for AIDS Relief (PEPFAR) to fund and implement PMTCT and treatment programmes. It was only after 2003 that substantial external resources were made available through PEPFAR and the Global Fund (Nattrass 2006) in provinces around the country. There were, however, efforts by civil society to make treatment available as early as 2001 when *Doctors Without Borders* established a pilot antiretroviral treatment project. The programme demonstrated the feasibility and need for community-led approaches in the absence of comprehensive national treatment programmes.

South Africa did not begin to invest significantly in AIDS programming on a national scale until 2003 and 2004, even strongly resisting financing from outside for HAART and PMTCT on the grounds that antiretroviral drugs (ARVs) were toxic and unaffordable (Nattrass 2003, 2007). Even after Mbeki's cabinet committed the government to a HAART rollout, the Constitutional Court ordered the government to provide drugs for PMTCT, and studies demonstrated the cost-effectiveness of treatment, the government was very slow to roll out and finance PMTCT and treatment (Nattrass and Geffen 2005, Nattrass 2006). These policies have contributed to the tragic AIDS-related health outcomes observed in South Africa (see Figures 1 and 2).

Historically, financial commitment and expenditure has not been commensurate with the scale of the South African epidemic. Table 2 illustrates trends in finance and burden of disease attributable to HIV/AIDS in South Africa and Brazil. In 2004, AIDS accounted for 40% of South Africa's disease burden, but only 1.4% of Brazil's disease burden. Even as recently as 2009, Brazil spent three times as much on HIV/AIDS per capita as South Africa. Despite recent improvements under the Zuma administration, there is still tremendous unmet need for treatment; in 2009, thousands of patients on treatment experienced interruption due to treatment funding shortfalls (Zizola 2009). This and other challenges prompted the South African government to announce a 33% increase in spending on HIV/AIDS in 2010

Table 2. HIV/AIDS indicators and HIV/AIDS finance in Brazil and South Africa.

| | Brazil | South Africa |
|--|-----------------|----------------|
| Number of HIV-positive people (2009) ^a | 460,000–810,000 | 5,600,000 |
| HIV Prevalence in 2009 | Less than 1% | 18% |
| Total AIDS spending (US dollars, 2009) ^a | \$623 million | \$2.08 billion |
| Total AIDS spending (\$) per HIV-positive person ^a | \$769–1354 | \$373 |
| % of AIDS spending from domestic sources ^a | 99.0% | 72.7% |
| Total DALYs ^b lost – all causes (2004) ^c | 35,896 | 20,988 |
| Total DALYs lost – AIDS (2004) ^c | 485 | 8545 |
| % of DALYs lost due to AIDS (2004) ^c | 1.40% | 40.70% |

DALYs, disability adjusted life year.

^a2010 UNAIDS Report on the Global AIDS Epidemic.

^bDALYs, a term used to quantify burden of disease. DALYs quantify the number of years of human life lost due to ill-health, disability or early death.

^c2009 WHO Global Health Observatory Database.

(UNAIDS 2010b). Today, South Africa has the largest number of individuals receiving treatment of any country in the world and is reported to spend more on AIDS than any other country (UNAIDS 2010a, 2010b); however, the extent to which this will be sustained over time is unclear.

Industrial policy and local drug production

Brazil has produced generic ARVs in public facilities since the early 1990s. The Health Ministry began increasing local production in the late 1990s when the cost of treatment began to rise precipitously and Brazil's AIDS movement protested AIDS drug stockouts. Brazil's policies stemmed in part from their industrial policies of the 1950s and 1960s, which promoted development of a local generic drug industry as part of the nation's Industrialisation Substitution Importation policies (Bermudez 1995). Since the early 1990s, Brazil has produced generic drugs locally and has threatened to produce drugs under patent in order to induce large-scale price reductions for patented AIDS drugs purchased from multinational pharmaceutical companies (Galvão 2002, Nunn *et al.* 2007).

After Brazil adopted its 1996 law guaranteeing free and universal access to drugs for treatment, the scale up AIDS treatment culminated in rapidly rising costs. This posed enormous fiscal challenges to the Health Ministry. Under mounting social and fiscal pressure, including social activism demanding implementation of this law, Brazil's Health Minister Jose Serra ordered public production of non-patented antiretroviral medicines in Brazil's public factories and subsequently threatened to produce patented medicines locally if multinational pharmaceutical companies did not lower their drug prices. These policies ultimately culminated in US\$1.2 billion in cost savings in Brazil and dramatically reduced the cost of AIDS treatment. These policies have facilitated scale up of AIDS treatment since 2001 both in Brazil and globally (Cohen 2006, Okie 2006, Nunn *et al.* 2007).

Although South Africa also has a local drug industry and capacity to produce generic medicines, the relationship between the AIDS movement and the state culminated in a different set of policies related to local drug production and access to generic medicines. In 1997 South Africa passed the Medicines and Related Substances Act, which governed use of generic medicines in South Africa, and was designed to enhance access to generic medicines. The law was challenged by the Pharmaceutical Manufacturers Association (PMA), which eventually dropped the case in 2001. Although AIDS activists expected the government to use the legislation to import and produce generic AIDS medicines, the South African government never did so, instead focusing on AIDS denialism (Natrass 2007).

Unlike in Brazil, where the government took extraordinary efforts to produce and import generic medicines and reduce prices for patented medicines, the South African government has been far less involved in efforts to promote more affordable access to medicines (Kaplan and Laing 2005). In fact, drugs used in the Khayelitsha pilot AIDS treatment programme were initially provided by Brazil's public drug factories (Coetzee *et al.* 2004). In the absence of sustained government policies to promote more equitable and expanded access to HAART and drugs for opportunistic infections, the TAC and other civil society groups have engaged in making drugs more available in a variety of ways. In 2000, the TAC launched public campaigns to protest the high cost of fluconazole, a drug produced by Pfizer

commonly used to treat fungal infections among AIDS patients. Global media outlets covered the controversial decisions of the TAC activists to import generic fluconazole illegally from Thailand to highlight its cost in South Africa, as well as the South African government's subsequent decisions to imprison the TAC activists responsible for importing the medicines (Nattrass 2007). Pfizer ultimately agreed to donate fluconazole to all developing countries with HIV prevalence over 1%, thus making it available in South Africa (Pfizer 2000). Shortly thereafter, amidst global public controversy about high drug costs, Merck also granted local companies voluntary licenses allowing them to import and produce another generic antiretroviral drug called efavirenz in South Africa.

In summary, the civil society movement in Brazil pressured the government to take steps to promote access to medicines and reduce the cost of antiretroviral medications through generic drug production and by negotiating deep discounts with generic pharmaceutical companies. The AIDS movement also worked with the state to promote more affordable access to HAART. In South Africa, by contrast, it was civil society, *without* the state, that made drugs available, pressured drug companies to lower prices and promoted more equitable access to drugs for HAART. The government played a much smaller historical role in producing and promoting access to generic ARVs; most ARVs consumed in South Africa have been produced locally by private firms under voluntary licensing agreements, imported from Indian generic drug firms, donated by multinational pharmaceutical companies or provided by foreign aid organisations.

Role of the courts

The courts have played a key role in promoting access to AIDS treatment in Brazil and South Africa. In both countries, civil society has used the court system to bring cases against the government to promote more equitable access to drugs for AIDS treatment.

Even prior to adoption of Brazil's 1996 law guaranteeing free and universal access to AIDS treatment, civil society organisations sued local, state and federal governments, claiming that the right to health enshrined in Brazil's 1988 constitution included the right to drugs for AIDS treatment. Since the early 1990s, Brazil's courts have consistently ruled that the right to health includes the right to drugs for AIDS treatment (Scheffer *et al.* 2005). Court decisions were important for several reasons: they gave legal standing to the claims of Brazil's AIDS movement and defined the legal obligation of the state to provide antiretroviral medicines. These court decisions were subsequently buttressed and reinforced by the legislative and executive branches of government (Nunn 2009).

The courts also played an active role in the struggle within South Africa for access to antiretroviral treatment. In 1998, despite new evidence that PMTCT could dramatically reduce vertical transmission of HIV, the government refused to provide drugs for PMTCT on grounds it was too costly. The TAC brought a court case against the South African government for failing to provide PMTCT. The high court as well as the constitutional court ruled the government should implement a national PMTCT programme (Nattrass 2003). However, in contrast with Brazil, where political leaders committed to providing drugs for AIDS treatment, the highest leadership in South Africa continued to oppose HAART expansion, publicly denying the efficacy of HAART as a means of treatment for people living with HIV/AIDS

(Nattrass 2003). In spite of the AIDS movement's impact on favourable court rulings, Mbeki's AIDS denialism ultimately impeded implementation of progressive HIV/AIDS policies.

Conclusion

Brazil and South Africa's responses to the AIDS epidemic have been profoundly impacted by the relationships of their AIDS movements with the state during and after their democratic transitions. Although Brazil's AIDS movement often criticised and held the state accountable for responding appropriately to the AIDS epidemic, its early and ongoing collaboration with the state hastened development of democratic institutions. These institutions, and their contributions to access to HAART in particular, have had important and sustained impacts on the country's AIDS epidemic.

South Africa's AIDS movement helped advance HIV/AIDS policy and offered important support to people living with HIV/AIDS during and after the country's transition to democracy. However, for many years, poor political leadership, and particularly AIDS denialism, prevented effective collaboration between the state and the AIDS movement. These challenges ultimately hampered AIDS policy progress and access to HAART over the last two decades, and contributed to the country's current grave HIV/AIDS epidemic.

This preliminary comparative analysis of Brazil and South Africa suggests that both vibrant civil society movements and political leaders who work towards similar public policy objectives are critical for sustained, positive public policy responses to the global HIV/AIDS epidemic. Further research that examines these historical issues in greater detail in Brazil, South Africa and elsewhere would further enhance understanding of the social, political and economic conditions that give rise to effective responses to the AIDS epidemic.

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