Brazil and the AIDS Crisis

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Summary and Keywords

The response to the AIDS crisis in Brazil has been the focus of significant attention around the world—both as a model of social mobilization that other countries might follow and as an example of the difficulty of sustaining mobilization without necessary political support. It is possible to identify at least four reasonably distinct phases in the Brazilian response to HIV and AIDS, beginning in 1983 (when the first case of AIDS in Brazil was officially reported) and running through mid-2019. An initial phase, lasting roughly a decade, from 1983 to 1992, was marked by significant conflicts between activists from affected communities and government officials, but precisely because of the broader political context of re-democratization was also the period in which many of the key ethical and political principles were elaborated that would come to provide a foundation for the Brazilian response to the epidemic thereafter. A second phase ran from 1993 to roughly the beginning of the new millennium, when these ethical and political principles were put into practice in the construction of a full-blown and highly successful national program for the prevention and control of the epidemic. During the third phase, from 2001 to 2010, the response to the epidemic increasingly became part of Brazilian foreign policy in ways that had important impacts on the global response to the epidemic. Finally, a fourth phase, from 2011 to late 2019, has been marked by the gradual dismantling of the Brazilian response to the epidemic, at first through relatively unplanned omissions on the part of the federal government, and then through a very conscious set of policy decisions aimed at deprioritizing the strategic importance of HIV- and AIDS-related public health issues in Brazil.

Keywords: AIDS, re-democratization, social movements, activism, human rights, World Bank loans, treatment access, foreign policy, intellectual property

Suffering and Solidarity (1983–1992)

The HIV/AIDS epidemic emerged in Brazil during the early 1980s, during a period of intense globalization and significant restructuring of both the economy and the political system (after nearly two decades of military authoritarian dictatorship), during the period known as “abertura” or political “opening.”¹ A formal amnesty had been issued by the military regime, and political exiles were returning to Brazil as the re-democratization of
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Brazilian society and politics accelerated. It was a time when the social movements that had been engaged in underground struggles against the dictatorship would increasingly come out into the open and engage in a growing debate about the reconstruction of democratic life. In some instances, these were what have been described as the “old” social movements of industrial capitalism, including political parties, such as the Brazilian Communist Party. In other instances, they were newer formulations, more in keeping with what would come to be understood as the “new” social movements, such as the newly formed Worker’s Party (PT) that sought to modernize the socialist movement, as well as more identity-based movements, such as the Afro-Brazilian or black movement, the women’s movement, and the nascent gay and lesbian movement.²

The Importance of Re-democratization as the Historical Context of the Emerging Epidemic

It was in this context that diverse social movements interacted to build a response to the AIDS crisis in Brazil. These movements initially included the liberation theology in the Brazilian Catholic Church, the public health sanitary reform movement, and the nascent gay and lesbian and feminist movements that had started to take shape in Brazil in the 1970s and early 1980s. It was the interaction of these diverse social movements during the early years of the epidemic that led to the articulation of a set of key ethical and political principles that provided the foundation for social mobilization in response to the epidemic, as well as a relatively successful policy response over the course of ensuing decades. This social and policy response took place during a period when medicine still offered next to nothing to mitigate the immense suffering experienced by people with HIV and AIDS, and it was primarily through mobilization at the grassroots level, driven by these social movements, that the Brazilian response to the AIDS crisis was constructed. Four key ethical and political principles emerged from this mobilization that would shape the Brazilian response to HIV and AIDS over a number of decades: the first was the importance of solidarity as the key to addressing what was perceived at the time to be an incurable and inevitably fatal condition; the second was the articulation of respect for diversity that could be perceived in the range of populations and communities that were affected by HIV infection; the third was the need to defend the basic rights of citizenship of all those who were living with or vulnerable to HIV infection; and the fourth was the idea of the fundamental right to health of all Brazilian citizens that would be formally articulated in the new 1988 Brazilian constitution, and that would come to serve as the basis for progressive public policies in response to HIV and AIDS over the next two decades. Together these key ethical–political principles constituted a kind of moral architecture for how Brazilian society would respond to the AIDS crisis.

Perhaps in Brazil even more than in many other societies, the Catholic Church has traditionally encompassed a wide range of theological, social, and political perspectives, as is evident in the role played since the 1960s by Brazilian Catholics in the emergence of the liberation theology movement within the Church more broadly. Although moral conservatism has long been associated with important segments of the Church in Brazil, more progressive tendencies have also been present, and have tended to organize themselves,
even within the National Conference of Brazilian Bishops (CNBB), around the overriding responsibility to minister to the most marginalized segments of Brazilian society. Thus, just as the Church sought to defend notions of moral good and virtue, it also sought to defend goals related to social solidarity and fraternity, and progressive segments of the Church played a central role in serving and defending the poor, the sick, and the helpless in what was widely understood to be a profoundly unjust social order.\(^3\) It was because of this commitment, most clearly articulated by the leading spokesmen of the liberation theology movement, that segments of the Church had come to play a key role in resisting the abuses of the military authoritarian dictatorship and participating in the political struggle for re-democratization. Leading progressive bishops such as Dom Paulo Evaristo Arns in São Paulo and Dom Hélder Câmara in Recife had been at the forefront of the human rights movement during the worst years of the authoritarian regime, and together with a wide range of other religious leaders, theologians (such as Leonardo Boff), as well as laypersons influenced by liberation theology, were deeply involved in the social and political mobilization that took place during abertura.\(^4\)

Among the most powerful aspects of the liberation theology movement was its organization of Catholic Church practice through the model of base communities, and its commitment to bottom-up social mobilization by lay practitioners as opposed to the orthodox, Church hierarchy. Equally important was its commitment to a “preferential option for the poor”—positioning the Church, or at least its progressive wing, in relation to the struggle for social justice in Brazil and in the world. Indeed, while poverty was central to the concerns of liberation theology, all forms of marginalization and oppression were called into question. Although excluded from the hierarchy of the Church, women, for example, played a key role in the base communities, and stigma and discrimination on the basis of race and even, perhaps more surprisingly, homosexuality were taken seriously and explored as part of the broader process of liberation.\(^5\) Indeed, one of the key features of the liberation theology movement that has sometimes been overlooked or unappreciated was precisely its commitment to widespread cultural transformation—to rethinking and reorganizing the structures of perception and thought that were seen to uphold an unjust social order. It was precisely this focus that built a bridge between the liberation theology movement and a broader range of evolving social movements such as the popular education movement, associated with the work of educators such as Paulo Freire, whose Pedagogy of the Oppressed had exercised especially important influence with regard to many issues, including illiteracy, and Herbert de Souza, whose trajectory as a charismatic leader in the Catholic youth movement had extended, like Freire’s, across years of exile, to emerge as one of the most important figures in the re-democratization movement that took shape in the late 1970s and early 1980s.\(^6\)

Like liberation theology, the sanitary reform movement in Brazilian public health and social medicine had also been an important source of resistance to the military regime during the years of dictatorship. While the Brazilian sanitary movement had deep historical roots reaching back to the 19th century, a new sanitary reform movement took shape in the 1970s and was evident in the work of writers such as Sérgio Arouca (who published one of the most influential studies in this tradition, O Dilema Preventista, in 1975) and
others, focusing on the need for democratic reform of the Brazilian health system.\footnote{The common struggle for reproductive health and rights became one of the most important points of intersection for the feminist, sanitary reform, and base community movements.}

Drawing heavily on historical materialism and Marxist theory, and seeking to bring together medical practice and social change, the new sanitary reform movement organized a series of events over the course of the 1970s aimed at providing increasing opportunities for popular participation and what it described as social control (\textit{controle social}) in relation to public health. In the early 1980s, as the \textit{abertura} process began to make possible democratic elections at the municipal and state levels, leading figures in the sanitary reform movement began to return from exile and to move from their base in universities and research institutions into the municipal and state secretariats of health. In 1986, after José Sarney became the first civilian president of Brazil following a succession of military presidents, the 8th National Health Conference was convened in Brasília and initiated planning for the Sistema Único de Saúde (SUS, the Unified Health System), which would be formally created in the so-called “Democratic Constitution” of 1988, in order to ensure access to healthcare for all of the Brazilian population. Previously, medical care had been the province of the Instituto Nacional de Assistência Médica da Previdência Social (INAMPS), and had been restricted to those workers who were formally employed, and who through their employers made tax contributions to the social welfare system, effectively excluding large segments of the Brazilian population who were considered “indigent” and were left to be cared for by philanthropic agencies and health service providers such as those maintained by the Catholic Church.\footnote{In responding to the emerging AIDS crisis, the gay and lesbian and feminist movements interacted significantly over time in forging what would later come to be known as a uniquely “Brazilian” approach to the epidemic.}

Finally, also in the late 1970s and early 1980s, both the emerging Brazilian feminist movement and the nascent gay and lesbian movement began to take shape. Both movements quickly came to see healthcare as one of the key areas of intervention in seeking to remedy inequalities in relation to both gender and sexuality. PAISM, a progressive plan for an Integral Women’s Health Program in the public health system, was one of the key platforms for the Brazilian women’s movement in the 1980s.\footnote{The Emergence of AIDS Activism in Brazil}

The Emergence of AIDS Activism in Brazil

Independent of their many differences, what brought these various social movements together in HIV and AIDS activism was their common concern with the re-democratization of Brazilian society, and their commitment to combating the marginalization and oppression that they perceived in the dynamics driving the epidemic. The AIDS movement was thus heavily marked, particularly in the early 1980s, by a commitment to opposition politics, and by the conviction that the organization and mobilization of civil society would be fundamental in order to further guarantee the successful return to civilian rule under a
democratically elected government. The existence of activist political pressure was crucial in providing the stimulus for early governmental program development—particularly in states such as São Paulo, where the opposition to the military regime had been elected to power as part of the first round of re-democratization.

These tendencies were especially apparent in the foundation of organizations such as the Support Group for AIDS Prevention in São Paulo (GAPA-SP) and the Brazilian Interdisciplinary AIDS Association (ABIA) in the mid-1980s. Founded in 1985, nearly a year before the Ministry of Health’s National AIDS Program was fully functional, GAPA-SP brought together gay activists, health professionals, social workers, and other community activists, most of whom had in one way or another been directly affected by the growing epidemic. Key members of GAPA-SP included Paulo César Bonfim, Aurea Abade, and Nelson Solano, who were among the most important leaders of the emerging AIDS activist movement. They focused on the fight for better conditions in relation to care and treatment, as well as for more aggressive campaigns aimed at raising public awareness and developing prevention programs. Staffed primarily by volunteers, GAPA-SP developed an effective relationship with the São Paulo State AIDS Program, at times working together toward common objectives (such as the internment of patients otherwise rejected by both private and public hospitals), and at times in opposition when the only course seemed to be to denounce government inactivity.

ABIA, which began to take shape in Rio de Janeiro in 1986 and was formally incorporated in 1987, was closely associated with the broader non-governmental organization (NGO) movement and focused on advocacy for more effective government policies at the local, state, and federal levels. Originally comprised of a diverse range of professionals and community leaders, including progressive religious leaders such as Dom Mauro Morelli, ABIA was nonetheless very much the conception of Herbert de Souza, more popularly known as Betinho, a hemophiliac who was himself seropositive, and whose two brothers had early on been stricken with AIDS. Betinho had been a well-known progressive Catholic youth leader and political activist before going into exile in the 1960s, and he was one of the leading figures in the re-democratization movement following his return in the early 1980s. He had previously founded the Brazilian Institute for Social and Economic Analysis (IBASE), one of the largest and most influential NGOs in the country and a leading institution in the fight to re-democratize Brazilian society. In founding ABIA to specifically address the question of AIDS, Betinho and his colleagues consciously rejected taking any direct role in the care or treatment of people with HIV and AIDS, arguing that these functions were an obligation of the state. ABIA therefore focused its attention on criticizing government policy—or the lack of it, particularly at the federal level. With unusual access to news media, ABIA quickly emerged as the most vocal and influential critic of the National AIDS Program during the late 1980s and early 1990s.

With different nuances, much the same range of concerns present in GAPA-SP (with its focus on pressure for local-level services and its role in providing at least some services and medications that the state failed to provide) and in ABIA (with its commitment to advocacy for more effective policymaking at every level and its call for more innovative preven-
From roughly 1988 to 1990, the AIDS activist movement in Brazil grew rapidly. In virtually every major urban center in the country, at least one AIDS service organization (ASOs)—both NGOs and community-based organizations—emerged and quickly became a key point of reference for information concerning the epidemic. In some locations, particularly where government programs were newer or less well developed, these NGOs often served as the major source of information about AIDS, not only for the lay public, but for more specialized audiences such as the news media as well. They played key roles in providing medications for opportunistic infections to people who would otherwise be unable to afford them, in developing home care programs and, in some instances, hospices, in developing prevention and education programs, and, perhaps above all, in advocacy work aimed at applying political pressure for better policymaking. While official governmental programs had repeatedly been unable to demonstrate adequate control over the blood supply, for example, activist pressure, led in particular by Betinho and ABIA in close collaboration with associations of people with hemophilia and other AIDS NGOs, was critically important in bringing about congressional passage of the “Lei Henfil” (named after Betinho’s youngest brother, an exceptionally popular political cartoonist who had recently died of AIDS in 1988), insuring that the commercialization of blood supplies would be outlawed in the Democratic Constitution of 1988. Throughout the late 1980s and early 1990s, activists succeeded quite remarkably in intervening at the level of the media and public opinion to gradually bring about important changes in the existing climate of stigma and discrimination. Far more than governmental programs, NGOs were able to draw on the notion of solidarity as a key political concept, and to transform the dominant discourse of prejudice and exclusion of people with HIV and AIDS in favor of a radically different discourse based on solidarity and inclusion.

In developing this intervention at the level of public opinion, charismatic leadership on the part of individuals such as Paulo César Bonfim, from GAPA-SP, and Betinho, from ABIA, was crucially important, as they were able to occupy significant space in the news media and, in a sense, to personalize AIDS—to give the epidemic a human face, not simply as an affliction of anonymous others, but as an epidemic affecting flesh and blood individuals, leaders in civil society, who may not all have been household names, but whose human faces increasingly entered the living rooms of growing numbers of Brazilian families through the nightly news. Particularly important in this sense was the role of Herbert Daniel, a writer and former political exile who had begun working with ABIA shortly after
its foundation. When Daniel was diagnosed with AIDS in late 1988, he became the key figure in mobilizing the earliest organizations of people living with HIV and AIDS in Brazil, founding the Grupo Pela VIDDA-Rio de Janeiro (Pela VIDDA-RJ) in early 1989, originally as a project of ABIA and later as an independent organization. Very shortly after the foundation of the Pela VIDDA-RJ, with Daniel as its first president, additional chapters of Pela VIDDA were formed in other major cities such as São Paulo, Curitiba, and Vitória, and together these organizations began to play a central role in focusing attention on AIDS-related stigma and discrimination, and in developing a focus on human and civil rights as central to the fight against AIDS. Legal aid programs established by organizations such as Pela VIDDA-RJ and GAPA-SP were especially important in bringing strategic lawsuits to court in defense of the civil rights (related to housing, employee benefits, and so on) of people with HIV.

Throughout the late 1980s and early 1990s, these advocacy activities quickly established AIDS activist organizations as what might be described as the “moral conscience” of the epidemic. AIDS activists and NGOs became the most outspoken critics of inadequate government policies, particularly in relation to the slow action taken by the federal government, both during the Sarney and, especially, the Collor governments. From 1990 to 1992, during the Collor government, while the National AIDS Program languished and delayed taking action, an almost complete polarization between the federal government and the AIDS activist movement grew increasingly antagonistic. This sharply divisive relationship began to improve only in late 1992, with Collor’s eventual resignation, when a revitalized National AIDS Program acted quickly to renew its contacts with AIDS activists and NGOs, and to negotiate with the World Bank for the first of a series of major loans for AIDS prevention and control.


The final months of the Collor administration and the transitional government of Itamar Franco, from December 29, 2002, to the end of 1994, followed by the election of Fernando Henrique Cardoso, whose administration took power in 2005, marked a fundamental turnaround in the development of Brazil’s response to the epidemic. At least in part, the focus of activist energy began to shift from civil society to the state, most clearly manifested in the Brazilian National AIDS Program (NAP), creating over time what João Biehl has aptly described as “the activist state” as the key agent leading the Brazilian response to the AIDS crisis. This would manifest itself in many different ways, but was already evident in the steps taken by the NAP in the Ministry of Health to produce the proposal for the first World Bank loan for AIDS prevention and control (which would come to be known as “AIDS I”: activist participation was enlisted from the very beginning in the elaboration of the proposal for the first loan, which formally began in 1994, and was later followed by a series of successive Bank loans over nearly two decades. Key NGO representatives were hired as consultants and charged with drafting initial proposals for compo-
nents dealing with support for community-based initiatives, prevention programs, and AIDS in the workplace initiatives.\footnote{Brazil and the AIDS Crisis}

The World Bank Loans for AIDS in Brazil

Over the course of the next three years the elaboration, approval, and implementation of the first World Bank Project would profoundly transform not only the nature of the work carried out by the AIDS service organizations, but also the relations between the activist community and the National AIDS Program. Among the most visible components of AIDS I was direct financial support provided by the Ministry of Health for NGO projects. While the exact amount that was destined for NGO support is not entirely clear, as it was drawn from a number of different budget lines within the complex structure of the project, according to information from National AIDS Program staff, something in the vicinity of US$12 million was to be spent on the support of more than 200 NGO projects over the three years of the project.\footnote{The World Bank Loans for AIDS in Brazil} Projects of diverse types—ranging from hospices for people with AIDS, to prevention intervention for high risk populations, to AIDS in the workplace programs—could be submitted each time the Ministry sent out a call for funding proposals, and would be evaluated by a technical advisory committee appointed by the Coordinator of the NAP. On average, projects were normally estimated at a budget of approximately US$50,000, though the budget limit for any given project (as well as for each different organization) was a total of US$100,000 per year, to be disbursed through a series of payments depending upon submission and approval of regular narrative and financial project reports (these financial totals would vary over time, particularly after the devaluation of the Brazilian Real, and the ceiling for both projects and total organizational support available from the Ministry of Health would decline during the later years of the World Bank Project and during the second World Bank Project [AIDS II] that was initiated in 1998).

In spite of delays in the final approval and signing of the loan agreement for AIDS I, by using matching funds from the Brazilian Treasury, the Ministry of Health moved ahead rapidly in initiating its funding program for NGO projects in 1993, nearly a year before the agreement with the World Bank had been formally finalized, guaranteeing a relatively high degree of NGO approval for the World Bank Project as a whole. In 1993 alone, the NAP approved seventy-five projects, with a total value of US$4 million dollars, submitted by AIDS NGOs, religious organizations, feminist groups, trade unions, and a range of other civil society organizations.\footnote{The World Bank Loans for AIDS in Brazil} Not surprisingly, this heavy influx of funding made available through the federal government stimulated a range of activities that otherwise would in all probability have been impossible. Among other things, it succeeded in attracting NGOs from a range of other areas, such as women’s health, which had become increasingly involved in AIDS-related work, but many of whom developed formal projects for the first time in response to the NAP’s call for proposals. At the same time, funds also became available, in many cases for the first time, to smaller, less experienced or sophisticated organizations that would have had difficulty in raising funds from private donors or international cooperation agencies. And it clearly stimulated a veritable explosion in the number of AIDS service organizations, as new organizations were formed in some
cases with almost no other function than to compete for funding from the World Bank Project: by 1995, according to some estimates, the ranks of the AIDS NGOs had grown to as many as 400 organizations, many of which surely would not have existed if it were not for the funds provided through the World Bank loan.27

The Politics of Treatment Access

During this period the “pauperization” of the epidemic—its impact on the poorest and most marginalized sectors of Brazilian society—became increasingly clear, but clinical interventions and treatment options became more effective, offering for the first time the possibility of meaningful clinical interventions capable of transforming AIDS into a chronic, but nonetheless manageable, health condition. In 1991, the NAP had taken the pioneering step of approving the free distribution of AZT as one of the key medications that would be guaranteed for all who needed access to it, regardless of social or economic status.28 This policy drew criticism from many international observers, who viewed it as ill-advised from an economic point of view, especially given the still relatively limited effectiveness of treatment with AZT. But it was defended both by AIDS activists as well as by Brazilian public health policymakers, who argued that it was in keeping with the right to health as defined in the 1988 constitution. This argument was reinforced as part of the negotiations for the first World Bank loan for HIV and AIDS prevention and control beginning in 1994 precisely because the loan covered the cost of a significant scale-up of prevention services, and to live up to the goal of SUS as based on an “integral” approach to health (i.e., one that integrated prevention and treatment services in a single unified system), the Ministry of Health would need to find a way to cover the cost of treatment and care (which the World Bank refused to cover with funds from the loan) in order to complement the scaling up of prevention. As research in the mid-1990s began to confirm the effectiveness of combination antiretroviral therapies, pressure grew for the Brazilian government to guarantee access to the new generation of antiretroviral medications being developed. At the 11th International Conference on AIDS, held in July 1996 in Vancouver, Canada, the presentation of scientific evidence in relation to antiretroviral therapies, together with information about their elevated costs, led members of the Brazilian delegation to the conference to stage a demonstration in the pharmaceutical exhibit area and to develop a strategy for advocacy in relation to treatment access in Brazil. Upon returning from Vancouver, an alliance of activists, administrators, and policymakers was quickly formed, and sought to build a coalition crossing political party lines—ranging from the left-wing PT to more center and right-wing parties, such as the Liberal Front Party (PFL)—with the goal of building a wide base of political support for legislation that would guarantee access medication. In less than six months following the Vancouver conference, Federal Law 9.313/96 (which became known popularly as the Lei Sarney [the Sarney Law], after the relatively conservative former president and now senator, José Sarney, who sponsored the legislation in the Brazilian Congress) was passed, guaranteeing universal access to antiretroviral therapies for all Brazilian citizens who might need them.29
The Lei Sarney was passed almost exactly in the middle of the first World Bank loan to the Government of Brazil for AIDS prevention and control. It wound up having a significant impact because it helped to leverage a major increase in the financial commitment made by the Brazilian Finance Ministry from the National Treasury to cover the cost of AIDS treatment: the matching funds in the order of US$90 million from the National Treasury had already been committed as part of the negotiation for the World Bank loan, and the cost of funding new antiretroviral medications created an additional burden. But once again the decision was made to move forward, justified as an issue of basic human rights, predicated on the 1988 Democratic Constitution with its focus on integral/integrated health services and health as a basic right of all citizens. The key argument, defended by activists along with policymakers, was that treatment access was an ethically based political decision—a strategy that proved to be remarkably effective, and within just a few years both the financial and human resources necessary for universal access to even the furthest and most remote reaches of the country had begun to be provided.

### Structural Interventions and Human Rights

While virtually all of the international attention that has focused on the Brazilian response to the epidemic has concentrated heavily on its groundbreaking treatment access program, it is important to note that the implementation of this program, beginning in 1996, was also linked to a second major policy focus: an emphasis on poverty and structural vulnerability as key social and economic drivers of the epidemic. This focus built heavily on the research and activism of social science and collective health researchers, which helped to provide the conceptual framework for the second major World Bank loan initiated in 1998. The first World Bank loan had been developed using a more traditional epidemiological risk group emphasis, and was probably less conceptually groundbreaking than the political alliance (between civil society organizations, service providers, administrators, and policymakers) that it produced. But by the time the second loan agreement was prepared, in part as a response to ongoing activist and social research emphasis on the pauperization of the epidemic, poverty had increasingly come to be understood as a key driver of the epidemic and was therefore the primary focus for the proposed activities. This focus had also been intensified after 1997, when the leadership of the NAP turned over and it became the responsibility first of Pedro Chequer and then of Paulo Roberto Teixeira, both of whom had deep political roots in PT activism. The symbiotic relationship of this new focus with poverty, together with treatment access, made political sense precisely because the socio-demographic profile of the evolving epidemic would exclude those most affected (i.e., the urban poor) unless access to treatment was guaranteed by the state.

Once again, even though the World Bank loans were primarily focused on prevention rather than on treatment and care, the strategic use of both conceptualization and funding from the loan to leverage the commitment of national financial resources proved crucial. This was linked, in turn, to the extremely effective use of data collection and research activities aimed at monitoring the response to the epidemic over time. The National AIDS Program staff, for example, rather ingeniously elaborated their own economic ar-
guments, focusing on the reduced hospital costs and the increased economic productivity of HIV-infected citizens—because access to treatment and care significantly extends the age until which people living with HIV are able to work, and because investing in treatment reduces the financial “burden” that they would otherwise place on healthcare services.

The growing focus on structural violence—especially in relation to poverty, but also gender and race, as key axes of inequality along which the epidemic was seen to travel—had been clearly articulated in Marxist analyses of health and illness in Brazil for decades; and this vision was in large part translated into the analysis of HIV and AIDS by researchers whose work was rooted in this tradition, as reflected in the writings of analysts such as Sergio Arouca and others.30 To the extent that Brazilian policymakers and analysts found themselves responding to international trends, it was in large part by reaffirming the importance of their own deeply rooted vision of health, human rights, and social justice in the face of the neoliberal policies of international agencies, such as the World Bank and the World Health Organization, in negotiating their own national alternative to such approaches. Through this negotiation they sought to push such agencies in the direction of policies and approaches based on quite different assumptions that consider human life and dignity over economic efficiency.

The “Brazilian Model” (2000–2010)

By the end of the 1990s, the Brazilian National AIDS Program had come to be seen as a kind of model response to the epidemic, and was widely recognized as an example of what the United Nations describes as “best practices.” Indeed, UNAIDS funded the publication of a book-length report (with versions in English, French, Spanish, and Portuguese) on the AIDS response in Brazil as a contribution to its Best Practices publications series.31 The international press also discovered the “Brazilian model” for responding to the epidemic and begun to publicize its effectiveness. While Tina Rosenberg’s article “Look at Brazil” in the New York Times Magazine was perhaps the best known characterization, it was followed by extensive coverage not only in the commercial press, but also in televised media (e.g., the PBS News Hour) and in the world of development and philanthropy.32 The Brazilian AIDS Program had not only managed to produce generic versions of many important first-generation antiretrovirals, but had also put in place treatment access policies across the country, demonstrating that healthcare systems in middle-income countries could make effective use of combination antiretroviral therapies.

In the second decade of the epidemic, during the 1990s, these accomplishments were achieved mainly through a highly vertical and centralized administrative structure, heavily dependent on the leadership of the Ministry of Health in Brasilia. Moving into the third decade of the epidemic, a key challenge was thus to decentralize the treatment access program within the broader health system, integrating it into SUS and creating greater ownership on the part of both state and municipal Secretariats of Health. Issues of sustainability and decentralization thus became increasingly critical to the Brazilian re-
sponse to the epidemic after 2001, as well as to successive follow-up loans from the World Bank, which channeled funding from the federal to the state and municipal levels, with more significant levels of matching funds not only from the national treasury but also from state and municipal governments. Almost all funding for civil society projects also shifted from the Ministry of Health to state and municipal Secretariats of Health—increasing local commitment and control, but also presenting a range of new administrative and bureaucratic challenges.

The AIDS Response and Brazilian Foreign Policy

In addition to seeking to decentralize domestic programs, one of the key developments during the 2000s was that AIDS increasingly became an important part of Brazil’s foreign policy agenda. The foundation for this development had already been laid during the 1990s though collaboration with other Latin American countries. Brazilian support had been essential for the creation of HORIZONTEC, the Horizontal Technical Cooperation Group for Latin America and the Caribbean, in 1995, and Brazil continued to play perhaps the leading role in supporting collaboration and cooperation between HIV/AIDS programs in the region over the 2000s.\(^{33}\) While the Secretariat for HORIZONTEC would theoretically have rotated, and in fact moved a number of times to other countries, including Cuba, the majority of the resources underwriting regional collaboration were provided by the Brazilian government. By 2005, the Secretariat had returned to Brasília, acknowledging Brazil’s influential leadership role across the region. Treatment access based on the Brazilian model began to be adopted by almost all of the other Latin American countries. Brazil also played a growing role, primarily working through HORIZONTEC, in capacity-building efforts with other AIDS programs in the region, assisting them in procuring as well as in distributing medications through their own national healthcare systems. This included the ongoing provision of generics produced in Brazil and distributed to smaller countries such as Bolivia and Paraguay as part of cooperative agreements.\(^{34}\)

In addition to its extensive technical and financial cooperation with other Latin American countries, the Brazilian government pursued active cooperation with the efforts of other countries in parts of Africa and even Asia as part of the Lula administration’s foreign policy emphasis on increased South–South cooperation. Collaborative agreements were implemented with other lusophone countries (including Angola and Mozambique) to develop technical cooperation, capacity building, and the exchange of personnel. Cooperation around medication production and procurement was also developed with other important middle-income countries, including both India and South Africa, and exchanges of cooperation missions were an important part of Brazil’s rapidly expanding relations with China. A broad policy of alliances with other developing countries was used to build greater global consensus in relation to health initiatives, and succeeded, for example, in having the United Nations Human Rights Commission declare access to HIV treatment as part of the fundamental human right to health. Brazil also played a leading role in building a bloc of nations arguing for the right to HIV treatment access as a central part of the Consen-
sus Statement that was adopted at the 2001 United Nations General Assembly Special Session (UNGASS) on HIV/AIDS.

Intellectual Property and Trade Relations

Brazil’s capacity to produce medications domestically was essential in strengthening the government’s position in negotiating with international pharmaceutical companies. It made the possibility of compulsory licensing a credible threat if pharmaceutical companies priced their patented products at a rate outside the price range that was reasonable within the context of the Brazilian market. Seeking to pressure the Brazilian government in order to avoid the possibility of compulsory licensing becoming a reality, “Big Pharma” used its influence with the United States, convincing the US government to use its power in the World Trade Organization (WTO) to denounce Brazil for breaking patents that it argued should have been protected under the terms of the TRIPS (Trade Related Aspects of Intellectual Property) Agreement. Subsequently, the WTO accepted these arguments in February 2001. Later, in April 2001, the United Nations Human Rights Commission determined that in light of the urgency of the global HIV pandemic, access to medications should be considered a basic human right. This was a major victory not only for Brazil, but for all developing countries, because it identified “public health emergencies” as a legitimate justification for breaking patents through compulsory licensing or parallel importing. This outcome was then further reinforced in November 2001, when the WTO issued its Doha Declaration on TRIPS and Public Health, affirming that “the TRIPS Agreement does not and should not prevent Members from taking measures to protect public health.”

Brazil had played a key role in the negotiations leading up to the Doha Declaration, and based on this Declaration it was then able to use the language of trade agreements to defend the right to access to essential medicines. This tactic was repeated regularly from 2002 to 2007 in order to strengthen Brazil’s position in negotiating with the pharmaceutical industry, as well as to challenge more restrictive interpretations of TRIPS within the various negotiations coordinated by the WTO.

Throughout this period, the Brazilian government had to act aggressively in order to counteract international pressures and protect the National AIDS Program. It used the specter of compulsory licensing effectively, without having to follow through in actually breaking patents on the basis of declaring a national public health emergency in relation to the HIV/AIDS epidemic. On May 4, 2007, however, following negotiations between the Ministry of Health (led at the time by Minister José Gomes Temporão) and Merck Pharmaceutical, Brazilian president Luiz Inácio Lula da Silva signed a decree to implement a compulsory license for Efavirenz, a medication that was being used by 38 percent of people on antiretrovirals in the country and thus significantly affecting the sustainability of Brazil’s policy for universal free access to HIV treatment. But reaching this outcome was far from easy. On the contrary, it required extensive advocacy on the part of treatment access activists over a long period of time, building a broad coalition that included advocates from a range of different areas such as sustainable development and food security as well as HIV and AIDS working to pressure the Brazilian government to move forward. ABIA played an especially important role in this process by leading the creation of
GTPI/REBRIP (the Working Group on Intellectual Property of the Brazilian Network on Integration of Peoples). Founded in 2003, GTPI worked out of a Secretariat hosted at ABIA and hired first one and then two attorneys specializing in intellectual property rights as full-time employees to work on building the legal and political case for compulsory licensing. Long before the government finally chose to move forward in issuing the compulsory license for Efavirenz, these groups had lobbied a wide range of organizations and social movements to build pressure on the federal government to take action. In May 2005, with support from 138 organizations (primarily from Brazil, but also including a number of international organizations), the GTPI issued its “Declaration of Civil Society Regarding the Brazilian Negotiations for Voluntary License for AIDS Drugs.” It continued to apply pressure over the course of the next two years until the Lula administration finally agreed to move forward in May 2007.

The case of compulsory licensing for Efavirenz highlights the importance of building strategic alliances involving people in government as well as activists—something that Brazil’s public health system is perhaps especially well suited to doing, precisely because there is a fairly regular movement of university-based researchers as well as civil society activists into (and out of) policymaking and administrative positions in government. But it would be incorrect to think that without widespread grassroots mobilization compulsory licensing would have taken place just two years later, in May 2007. Even the ceremony itself, broadcast live on the government-sponsored cable television network, with José Marcos de Oliveira, the HIV-positive civil society representative of the AIDS movement on the National Health Council, charged with ensuring “social control” of government health policy, speaking first, followed by Minister Temporão and then by President Lula, in what in many ways may be seen as the high point in Brazil’s treatment access policy.

Policy Innovation and Independence

Just as the National AIDS Program has had to resist international pressure to change its universal treatment access program, it has also had to resist pressure to change its open approach to the prevention of sexual transmission. Again, the NAP has proceeded proactively to defend the importance of sexual diversity, and to resist pressures to curtail the rights of vulnerable populations and communities. In 2001, for example, the Brazilian delegation was deeply involved in debates over the role of gay and lesbian organizations among the non-governmental agencies involved in the UNGASS on HIV/AIDS. In 2005, the NAP went even further in taking the unprecedented step of refusing roughly US$40 million in US support because of a Bush administration requirement that HIV/AIDS organizations seeking funding to provide services in other countries must pledge to oppose commercial sex work. Under Bush administration policy, even groups whose HIV/AIDS work in other countries had nothing to do with commercial sex workers were required to make a written pledge opposing commercial sex work, or risk losing US federal funding. In addition, the Bush administration could refuse to fund HIV/AIDS groups that did not accept Bush’s social agenda on issues such as sexual abstinence and drug use (policies stemming from two 2003 laws, one involving HIV/AIDS funding and another regarding sex trafficking). Brazilian officials wrote to USAID to explain the government’s decision to
refuse the remainder of a US$48 million HIV/AIDS grant that began in 2003 and was scheduled to run through 2008, because of the Brazilian government’s unwillingness to accept these policy conditions. It is important to remark that AIDS-related policies are heavily motivated by ideological positions, often used strategically to win political popularity.

Just as HIV/AIDS organizations such as ABIA (and many others) had played a key role in providing domestic political support for Brazilian policy decisions related to intellectual property rights, a broad-based coalition of organizations followed the lead of key advocates from organizations such as Davida and the Brazilian Network of Sex Professionals in providing political support for a firm political stance on the part of the Brazilian government, in spite of the fact that US support for HIV prevention would be directed almost entirely to NGOs.

Whether in relation to treatment and care, or in relation to prevention, then, the HIV/AIDS epidemic increasingly became part of Brazilian foreign policy, articulated in ways that consistently placed Brazil at the cutting edge of what were seen as the most “progressive” responses to the global pandemic—often positioning itself in direct opposition to seemingly more powerful, and certainly more conservative, international actors such as the United States. While the positions of the Brazilian government have received the most attention in this regard, it is important to be aware of just how much these positions were enabled not from above, but from below, thanks to grassroots activism and strategic advocacy aimed at building political coalitions capable of defending such policies in relation to a broader moral vision of what is right and just. While José Serra, the Brazilian Minister of Health at the time (in the Fernando Henrique Cardoso government), could speak before the UNGASS on HIV/AIDS in 2001 to justly highlight the accomplishment of guaranteeing antiretroviral treatment access to all citizens who were living with HIV, Brazilian AIDS activists just as rightly pointed out that “this is not something that you are given – it has to be constructed, together,” as part of a broader process of social mobilization—a process ultimately aimed not just at addressing the epidemic, but also at constructing a more just society.42

**Things Fall Apart (2011–2019)**

Following nearly two decades of impressive successes and growing international recognition and influence, as Brazil’s response to the AIDS crisis moved into its fourth decade, the policies of the federal government began to be called into question by a growing conservative movement in Brazilian politics. The Brazilian government had become well known for having articulated a rights-based approach to HIV during Cardoso’s administration, from 1995 to 2002. This approach was further consolidated and expanded during Lula’s administration, from 2003 to 2010. But beginning in 2011, and increasing over time, the most important political foundation for the Brazilian response to the epidemic seemed to become the object of a sustained attack on the part of conservative political forces in the Brazilian Congress during Dilma Rousseff’s first term of office as Lula’s
Hand-picked successor. A far less agile politician than Lula, Rousseff came under constant fire from a rapidly growing contingent of religious conservatives in both the House and the Senate, and her administration quickly caved to pressure when the Frente Parlamentar Evangélica (Evangelical Parliamentary Front), popularly known as the “bancada evangélica” (the “evangelical bench”), demanded changes in policies related to HIV prevention as a bargaining chip needed in order to assure their support on votes related to the administration’s economic policies.43

The Impact of Religious Conservatism and the Re-biomedicalization of the Epidemic

The result of the new political climate and the growing pressure from religious conservatives in Congress was a series of setbacks for the Brazilian response to AIDS. The first came in 2011 when, under pressure from religious conservatives, the administration opted to abandon a set of materials known as “o kit gay” (“the gay kit”). This “kit”—actually a collection of educational booklets and videos designed for use in public schools as part of a program known as “Escola sem Homofobia” (“School without Homophobia”)—had initially been developed by a group of NGOs at the request of the Ministry of Education, and had subsequently been endorsed by the Ministry of Health and the Brazilian AIDS movement more generally as an important step toward addressing homophobia and stigma as key structural factors that needed to be confronted in order to fight the AIDS epidemic.44

The second setback came later that year, when the President’s office again bowed to pressure from the bancada evangélica and vetoed the Ministry of Health’s media campaign that was set to target young gay men and to be aired as part of World AIDS Day on December 1, 2011. Just months later, in early 2012, the President’s office showed more troubling signs, this time ordering that the Ministry of Health redo its HIV prevention campaign for Carnival, specifically to remove images that depicted young gay men kissing in a nightclub and thinking about condoms as they anticipate having sex.45 A year later, in early June 2013, another campaign was pulled off the air. This one had been developed by the Ministry of Health in conjunction with the Brazilian Network of Prostitutes and had just been launched to mark International Sex Workers’ Day. Part of the campaign consisted of a poster that showed the face of a woman (who was in fact a sex worker activist) under the caption “I’m happy being a prostitute.” In response, Alexandre Padilla, the Minister of Health (from the progressive PT, but with longstanding family ties to the Brazilian Protestant movement, which has increasingly been taken over by the most conservative strains of Evangelical Protestantism), ordered that the campaign be pulled off the air immediately.46 In spite of also having close ties to the PT, Dirceu Greco, the Director of the Ministry’s STI, HIV and Viral Hepatitis Department, was fired shortly afterwards for failing to have secured the necessary authorizations for such a morally controversial campaign.

At much the same time that it seemed to largely abandon high-profile prevention campaigns for key affected populations in the early 2010s, the Ministry of Health also adopted a growing emphasis on new biomedical and behavioral approaches to the epidemic. While Brazil had previously emphasized structural interventions, during much of
Rousseff’s administration the Ministry of Health and its staff in the HIV and AIDS Department began to design many of its key activities using models imported from abroad. This was already evident starting in 2011, when the major program documents for how to reach key populations with prevention interventions began to be modeled on the US Centers for Disease Control and Prevention (CDC)’s DEBI (Diffusion of Effective Behavior Intervention) program. For the first time in the nearly thirty-year history of the Brazilian government’s response to the epidemic, Ministry of Health guidelines for prevention were based on models developed in the global North, translated and tailored for application in Brazil with support from both the CDC and the US PEPFAR (President’s Emergency Plan for AIDS Relief) program.47 This emphasis on behavioral interventions, as opposed to community mobilization and empowerment models, was extended further beginning in 2013 and 2014, as Brazil adopted the “Test and Treat” approach promoted by UNAIDS as its primary initiative to bring HIV-positive people into treatment, and to effectively use Treatment as Prevention, even enlisting the help of President Rousseff to send out messages on her Twitter account encouraging HIV testing for key populations to commemorate World AIDS Day in 2013.48 The Ministry of Health continued to invest its primary prevention resources in biomedical approaches, planning its traditional Carnival prevention campaign in 2015 around messages promoting HIV testing disseminated through cell phone apps such as Tinder and Hornet.49 Following Rousseff’s impeachment and removal from office in 2016, during the two years of Michel Temer’s administration this emphasis on biomedical approaches to prevention continued with the adoption of pre-exposure prophylaxis (PrEP), especially targeting members of key population groups considered to be at highest risk of infection—but with relatively little success, as infection rates began to increase alarmingly for the first time in decades, especially among young men who have sex with men and transgender women.50

Dismantling the Brazilian Response to AIDS

The gradual decline in the effectiveness of the Brazilian government’s response to the epidemic that had played itself out over much of the 2010s came to a head following the election of Jair Messias Bolsonaro as Brazil’s new president on October 28, 2018. Bolsonaro had become famous over his twenty-eight-year career as a federal deputy from the State of Rio de Janeiro for his outspoken opposition to gay rights and his criticism of public programs for people with HIV. He had frequently been quoted criticizing the use of public funding for medications for people living with HIV, since in his view their infection with HIV was the result of their irresponsible risky behaviors, and AIDS-related prevention programs were little more than a smokescreen for promoting non-normative behaviors and undesirable sexual and gender minority populations.51

Following the new president’s inauguration at the start of January 2019, the Bolsonaro administration moved quickly to begin dismantling the National AIDS Program. They quickly fired Adele Benzaken, the Director of the Department of Surveillance, Prevention and Control of STIs, HIV/AIDS and Viral Hepatitis during Temer’s government, who was seen as a reasonably strong advocate for communities affected by HIV and AIDS.52 Ostensibly, the primary reason for dismissing Benzaken was the department’s publication
of informational material on health promotion for transgender men, which was temporarily withdrawn from circulation and removed from the Ministry of Health’s website so that it could be revised to exclude information about surgical procedures related to genital reconstruction. Shortly thereafter, at the time when the first major public information campaign on AIDS under the Bolsonaro government was announced, these concerns were reinforced when the Ministry of Health explicitly avoided any mention of gay men as a priority population for prevention messaging, focusing instead on vague messages about condom use directed to a generic masculine target population.\textsuperscript{53} The Minister of Health, Luiz Henrique Mandetta, consistently argued that HIV prevention materials should be developed in ways that do not offend family values, and that condom promotion should be aimed at the general population rather than so-called “key populations” who are viewed as especially vulnerable to HIV infection.\textsuperscript{54}

Just a few months later, in May 2019, the Bolsonaro government announced that the Department of STIs, AIDS and Viral Hepatitis would be downgraded in terms of its status within the Ministry of Health and integrated with programs related to a number of other diseases as part of a new Department of Chronic Conditions and STIs.\textsuperscript{55} As a Coordenação (a Coordination, perhaps best translated as an Area) within the newly created department, the new unit would have significantly less administrative autonomy, and would effectively be given equal status to other chronic health conditions (such as tuberculosis and Hansen’s disease). Widely criticized by activists and their allies in the AIDS movement, removing the name AIDS from the new department’s title was seen as both silencing the AIDS movement and effectively burying the once prestigious Brazilian model for the response to HIV and AIDS under a blanket of conservative values.\textsuperscript{56} These misgivings regarding the administrative reorganization were validated only a month later, in July 2019, when the Ministry of Health announced that it was discontinuing a range of social network platforms (Facebook, Twitter, etc.) with information on HIV and AIDS that had been developed over a number of years in order to reach key affected populations such as young gay men, a decision that was understood to be in keeping with Bolsonaro’s stated conviction that his administration should prioritize the interests and needs of the majority population rather than of the minority groups that had been the focus of earlier PT governments.\textsuperscript{57}

In less than a year after taking office, then, the Bolsonaro administration had moved quickly beyond the various focus attacks on the once high-priority AIDS response in Brazil to effectively deprioritize the importance of the epidemic and the populations affected by it. These developments were completely consistent with the policies that Bolsonaro had defended as a candidate, but the speed with which the Brazilian response to AIDS had been dismantled was nonetheless surprising even to those who had anticipated moves in these directions. In just ten months of government, the “Brazilian model” that had been so highly praised internationally had become a victim not just of conservative moral values but of the wave of right-wing populist politics that had rolled across the country in the 2018 elections.\textsuperscript{58}
Discussion of the Literature

The academic literature on HIV and AIDS in Brazil is immense, but only relatively limited research has been published by professionally trained historians—in particular, the work of Marcos Cueto, who is responsible for a significant historical analysis that is currently underway.59 Much of what has been produced and published (and what will be uncovered in initial literature searches) comes not from the field of history, but from public health and health-related social science disciplines such as medical anthropology, medical sociology, and similar disciplines. For a very thorough overview of the scientific literature produced from the beginning of the epidemic through 1997, broken down into the categories of basic science research, clinical science research, epidemiological research, and social and behavioral research, see Bastos and Coutinho, “Tão longe, tão perto…: as pesquisas sobre HIV/AIDS no Brasil.”60 For more recent periods, there are few systematic reviews of the literature to help guide readers seeking a deeper understanding of the history of Brazil’s response to the AIDS crisis, but there is both an extensive published literature (see “FURTHER READING”) and a huge “grey” literature that is available primarily through government agencies and civil society organizations (see “LINKS TO DIGITAL MATERIALS”). Important academic sources can also be accessed through the Coordination for the Improvement of Higher Education (CAPES), Ministry of Education, which includes master’s and doctoral theses defended throughout Brazil since 2013, in full text, and abstracts of theses defended since 1987.61

Links to Digital Materials

Agência de Notícias da Aids

Associação Brasileira Interdisciplinar de AIDS

Centro de Referência e Treinamento DST/AIDS-SP, Secretaria Estadual de Saúde do Estado de São Paulo

Departamento de Doenças de Condições Crônicas e Infecções Sexualmente Transmissíveis-Ministério da Saúde

Fórum de ONGs/AIDS do Estado de São Paulo

Grupo Incentivo à Vida (GIV)

Grupo Pela Vidda-Rio de Janeiro

Núcleo de Estudos para a Prevenção da AIDS, Universidade de São Paulo

Grupo Pela Vidda-São Paulo

Núcleo de Estudos para a Prevenção da AIDS, Universidade de São Paulo

UNAIDS-Brasil Estatísticas
Brazil and the AIDS Crisis

UNAIDS–Brasil Relatórios e Publicações

UNESCO no Brasil–Pesquisas e avaliações sobre HIV/aids no Brasil

Further Reading


Brazil and the AIDS Crisis


Notes:

(1.) Information on the natural history and the epidemiology of HIV and AIDS in Brazil will not be discussed in detail in this article, as it is readily available from a range of sources. Readers interested in more details on these issues who read Portuguese should consult the epidemiological profiles that are available through the Brazilian Ministry of Health, and in particular the *Boletim Epidemiológico HIV/Aids, Número Especial, Dezembro 2019*. For an English-language summary of epidemiological trends in Brazil produced by staff from the Ministry of Health, see Gerson Fernando Mendes Pereira et al., “HIV/AIDS, STIs and Viral Hepatitis in Brazil: Epidemiological Trends,” *Revista Brasileira de Epidemiologia* 22, Suppl. 1 (2019): e190001. For other useful sources of information available in English, see the regularly updated information compiled by UNAIDS country overview and, especially, the detailed summary on “HIV/AIDS in Brazil” compiled by the


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(15.) Herbert de Souza, _A Cura da AIDS_ (Rio de Janeiro: Relume-Dumará, 1994); Parker, _A Construção da Solidariedade_; and Parker, “Building the Foundations for the Response to HIV/AIDS in Brazil.”

(16.) Galvão, _AIDS no Brasil_.

(17.) Galvão, “As respostas das organizações não-governamentais brasileiras frente à epidemia de HIV/AIDS”; Galvão, _AIDS no Brasil_; and Parker, _A Construção da Solidariedade_.

(18.) Herbert Daniel and Richard Parker, _AIDS: A Terceira Epidemia_ (São Paulo: Iglu Editoria, 1991); and Daniel and Parker, _Sexuality, Politics, and AIDS in Brazil_.

(19.) Galvão, “As respostas das organizações não-governamentais brasileiras frente à epidemia de HIV/AIDS”; Galvão, _AIDS no Brasil_; and Parker, _A Construção da Solidariedade_.

(20.) Parker, _A Construção da Solidariedade_.

(21.) Parker, “Building the Foundations for the Response to HIV/AIDS in Brazil.”


(24.) Galvão, “As respostas das organizações não-governamentais brasileiras frente à epidemia de HIV/AIDS.”


(26.) Burgos Filho, “O impacto do projeto de controle de DST/AIDS para o enfrentamento da AIDS.”
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(27.) Galvão, “As respostas das organizações não-governamentais brasileiras frente à epi-
in Brazil.”

(28.) Parker, Políticas, Instituições e AIDS.


(30.) Maria Cecília de Souza Minayo, Análise da produção intelectual brasileira sobre vio-
lência e saúde (Rio de Janeiro: Panorama ENSP, 1990); and Otávio Cruz Neto and Marcelo
Rasga Moreira, “A Concretização de Políticas Públicas em Direção à Prevenção da Violên-


26; and Christopher Reardon, “AIDS: How Brazil Turned the Tide,” Ford Foundation Re-
port, Summer 2002.

(33.) Horizontec Boletin, Año VIII, N° 2, II Trimestre, 2005.

(34.) Cristina Pimenta et al., Access to AIDS Treatment in Bolivia and Paraguay: Interna-

(35.) The Doha Declaration on TRIPS and Public Health, World Health Organization;
Brazil, Ministry of Health, National AIDS Drug Policy (Brasília: Coordenação Nacional de
DST e AIDS, Ministério da Saude, 2002); and Jane Galvão, “Access to Antiretroviral Drugs

(36.) Celso Amorim, Acting Globally: Memoirs of Brazil’s Assertive Foreign Policy (New

(37.) Maria Auxiliadora Oliveira et al., “Has the Implementation of the TRIPS Agreement
821; and Maristela Basso and Fabrício Polido, Propriedade Intelectual e Preços Diferenci-
ados de Medicamentos Essenciais: Políticas de Saúde Pública para Países em Desenvolvi-

(38.) Luiza Lena, Dez anos da licença compulsória do Efavirenz: caminhos para garantir

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(46.) De la Dehesa, “NGOs, Governmentality, and the Brazilian Response to AIDS: A Multistranded Genealogy of the Current Crisis.”

(47.) Ministério da Saúde, Programa Nacional de DST e Aids, 01/12/2013.

(48.) Tratamento como prevenção apresenta primeiros resultados na epidemia da aids, Ministério da Saúde: Blog da Saúde, December 1, 2014; and Ministério da Saúde divulga ação em aplicativo de relacionamento para prevenção à aids, UNA-SUS, February 1, 2105.

(49.) Ministério da Saúde divulga ação em aplicativo de relacionamento para prevenção à aids, Sistema Universidade Aberta do SUS (UNA-SUS), Coordenado pelo Ministério da Saúde, por meio da atuação conjunta da Secretaria de Gestão do Trabalho e da Educação na Saúde (SGTES/MS) e da Fundação Oswaldo Cruz (Fiocruz)


(52.) ABIA Concerned after the Exoneration of HIV/AIDS and STIs Department Director, ABIA, Global AIDS Policy Watch, January 14, 2019.
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(53.) Nova campanha de prevenção a Aids no Carnaval, do governo Bolsonaro, não cita gays, Diário do Centro do Mundo, February 22, 2019.

(54.) Diretora do departamento de HIV é exonerada, e ONGs reagem, Folha de São Paulo, January 11, 2019.

(55.) Ministério da Saúde rebaixa departamento de combate à Aids a uma coordenadoria, Mestro 1, May 22, 2019.

(56.) Modelo no mundo, departamento de combate ao HIV do Brasil perde status, Exame, May 23, 2019.


(61.) Coordination for the Improvement of Higher Education (CAPES).

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