
Abstract:

This paper examines the forces that shaped national responses to the HIV/AIDS crisis. It focuses on the democratic regimes of Brazil and South Africa in order to analyze the factors that shaped the government responses of the two countries. This paper finds that perceptions of shared risk formed differently in Brazil and South Africa and it was these perceptions that were the driving force behind the speed and scope of the government responses.
Introduction

“AIDS does not discriminate.” This is an often repeated mantra by AIDS activists and officials and one that I heard multiple times as a child growing up in Botswana, a country where 30% of adults are infected with HIV. The government of Botswana had huge billboards erected with this statement emblazoned in bold red letters for everyone to see; “Aids does not discriminate.” Bio-medically this statement is true; the human immunodeficiency virus does not discriminate when it enters the body and starts attacking CD4+ cells leaving the immune system weak and susceptible to opportunistic diseases. However, scholars have long realized that the transmission of HIV is as much a social phenomenon as it is a biological one and leaders and citizens have rightly understood the disease along geographic, social, ethnic, religious and political lines. AIDS has caused an estimated 36 million deaths worldwide since its discovery; a 2012 UNAIDS report estimates that approximately 35.3 million people are living with HIV globally (UNAIDS, 2012). HIV/AIDS is truly a global crisis, it has infected young, old, black, white, Christian and Muslim from almost every country in the world. In fact, HIV/AIDS has been described as the first global public health crisis and yet given the magnitude of this crisis and the threat to the health and security of its citizens, the government responses to HIV/AIDS, particularly in the developing world, have been underwhelming.

The threat of AIDS developed simultaneously in most countries and we expect, all things being equal, similar responses from countries that have similar levels of political and economic development. However, many countries have shown vastly different policy approaches in dealing with the same disease. South Africa, the richest
country in Africa at the start of the outbreak, responded slowly to the crisis and even denied the very basic fact that HIV causes AIDS. On the other hand, Brazil, a country with similar resources to South Africa in many ways, managed to craft a quick and aggressive response to the crisis and has managed to contain the disease. This paper deals with this puzzle. Why have countries such as Brazil and South Africa that are both democratic and endowed with similar amounts of resources responded differently to the same disease? Alternative theories that go beyond the political and economic environment of South Africa and Brazil are needed in order to explain the contrasting paths adopted by these two countries. This paper examines the role of perceptions of shared risk in government responses of HIV/AIDS. This paper explores the ways in which perceptions of shared risk were formed in Brazil and South Africa and aims to explain how these perceptions explain the vastly divergent responses to the AIDS epidemic of the South African and Brazilian governments. The central claim of this paper is that perceptions of shared risk formed differently in Brazil and South Africa and these perceptions of shared risk shaped the different policy responses. Brazil had high share perceptions of risk, whilst South Africa had low perception of risk. These perceptions then shaped government through a number of different mechanisms.

**Formation of Perception of Risk**

British anthropologist Mary Douglas argued in 1980 that even though magnitudes of threats are objective, the perceptions of risk associated with that threat are subjective. She and many scholars have argued that perceptions of risk are “politically and socially constructed” (Douglas, 1980; Tilly 1992). These perceptions are shaped by group coherence and dissemination of information. This section of this paper aims to explore
the theoretical foundations of subjective formations of perceptions of shared risk within a community.

**Group Coherence**

Perceptions of risk, particularly with regards to AIDS, may be shaped in part by group coherence and ethnic fragmentation (Lieberman, 2009). HIV/AIDS is usually seen through geographic, social, ethnic, religious and political lines. This is because HIV requires intimate human contact for its transmission and the danger of uncontrolled spread is much less and easily preventable by measures that individuals are free to take (Lieberman, 2009). In a country where ethnic identities (or any other identities such as class identities) are strong, people from different ethnic groups rarely interact with one another. This makes it easier for them to view the social and political life of the country through an ethnic lens and the AIDS epidemic comes to be seen not as a shared problem for the country, but as “belonging” to a particular ethnically defined subpopulation. Members of groups that are perceived to be more deeply affected by AIDS are stigmatized, and this undermines their willingness to make strong demands on their own behalf. Members of groups that are perceived to be less affected see themselves as insulated from the disease, and this causes them to withdraw their support for investments in public health measures that they think will mostly benefit people who they believe have brought the disease on themselves (Lieberman, 2009).

**Dissemination of Information**

Information about HIV/AIDS can also lead to very different formation of perceptions of risk. Information may come from experiences that individuals have or may come through official government channels, but when there is a lack of good information,
individuals may be misinformed about the spread of the disease and how to protect themselves from the risk of infection (Lieberman, 2009).

The media serves as a filter through which both lay people and experts - both policy officials and health professionals - receive news and interpret events (Nelkin 1989). The selection and coverage of particular health stories can set the agenda of public discourse and affect the priorities that guide an individual’s perception of risk. This paper builds off of the work of Evan Lieberman by providing insights into new mechanisms through which perceptions of risk can affect government policy.

**Effect of Shared Risk on Government Policy**

This section provides a theoretical understanding of how perceptions of risk are translated into government policy and advances the argument that perceptions of shared risk can have a large impact on how governments respond to public health crises. New policies and state capacities often develop in response to new threats. Whilst the magnitude of these threats is objective, the perception of shared risk based on these threats is subjective (Douglas, 1992). This perception can determine the speed and scope of government action in a number of ways. In any society, risks are socially and politically constructed (Douglas, 1992) and “adoption and implementation of public health policies require culturally credible constructions of risk to the public’s health” (Nathanson, 1996). External threats, particularly threats to sovereign countries, are usually viewed as a shared threat and will produce a quick response from government. In some cases, external threats increase the power of government especially when the threats are framed as a threat to the way of life of a country’s citizens.

If perceptions of shared risks are low throughout the populace, then its likely that
the governing elite will also view the risk to the society as a whole as low. This will mean that they are less likely to enact policy because their constituents don’t demand it. The elite will also not think there is a credible threat to society. Many scholars have pointed out that the main channel in which Brazil was able to respond so quickly to the disease was through formation of strong civil society groups that worked closely with government in order to implement policies to combat the HIV/AIDS crisis (Rich, 2012; Nunn, 2009). Social movements focus political pressure on governments and are another mechanism through which shared perceptions of risk shape government policy. Social movements begin with widespread discontent within a community about a policy or social condition (Macionis, 2001; Hopper, 1950).

**Alternative Theories**

There are numerous theories that scholars have used to establish a causal relationship between the HIV/AIDS responses of South Africa and Brazil and other factors like regime type, political leadership, civil society, economics etc. These factors may have affected the policy responses of South Africa and Brazil and thus require some attention and explanation. These theories may, and probably explain some of the difference in policy responses in South Africa and Brazil; I present my theory as an additional theory that may explain some of the difference.

**Regime type**

Democracies, some studies have been shown, are better able to enact favorable social policies because the government is held accountable for its actions or inaction. Democracies may provide civil society with the ability to speak up and petition government (Sen, 1999). There is no reason why this logic does not apply to the
HIV/AIDS crisis. Alternatively, authoritarian regimes may also, in some instances, be better at combating public health crises. In fact some studies have found a negative relationship between democracy and aggressive public policy. This may be, as Erwin Ackerknecht points out, due to the fact that effect HIV/AIDS policies sometimes restrict individual liberties and may be used more effectively in an authoritarian regime that is less sensitive to negative reactions from its citizens (Gerring et al, 2006). The aggressive responses of Cuba, Uganda and Zimbabwe provide some evidence that authoritarian regimes can be responsive to HIV/AIDS. On the whole, there is evidence for a positive and negative correlation between aggressive government response and democratic regimes. In the case of Brazil and South Africa, I focus on their responses after their transition to democracy and thus only focus on how their democratic governments responded to the disease.

**Leadership**

Strong leadership is often seen as one of main causal forces behind policy making. Many political scientists have found that personality traits of leaders determine the speed and scope of a response to HIV/AIDS (Bayer and Kirp, 1992). They argue that then President of South Africa, Thabo Mbeki’s stance on HIV/AIDS and his failure to provide anti-retroviral drugs is the main reason for South Africa’s slow response to HIV/AIDS. This argument may have good explanatory power with regards to the case of South Africa, but not so much with Brazil. It is easy to look at Thabo Mbeki and conclude that his notions of HIV/AIDS caused the stunted response to the epidemic, but there were other factors that influenced Mbeki. The strategies required for implementing HIV/AIDS policies require that states, headed by their leaders, intervene in the most private matters:
sexual conduct, drug use, childbirth and breast-feeding. The state must demand citizens to make sacrifices and change their behavior and in order to do so, the state usually needs a compelling narrative that highlights the risks associated with the failure of such policies and changes in behavior. Democratic leaders respond to the demands of the constituents and rarely enact policy that would require their constituents to do something they did not want or see the need to do. Whilst not an implausible causal mechanism for policy responses, leadership as history shows is not the main factor that affects government responses. Additionally, leadership does not provide a strong argument in the case of Brazil where most of the presidents during the outbreak were not particularly strong presidents (Lieberman, 2009).

Methods and Case Selection

Brazil and South Africa are often used in comparative analyses because of their economic and political similarities. Brazil and South have similar levels of human and economic development and are both considered middle-income countries that are both relatively industrialized. The two countries also share similar level of income inequality and both have decentralized government structures. Most importantly, Brazil and South Africa are examples of developing countries that have the capacity to produce ARV drugs within their borders. Although Brazil and South Africa have very different prevalent rates today, the two countries faced similar threats at the beginning of the HIV/AIDS epidemic. In 1988, South Africa’s HIV prevalence was similar to Brazil at just under 1% of the total population (ASSA, 2010). Since then South Africa’s prevalence rate has ballooned to 18% whilst Brazil’s has remained at under 1% (UNAIDS, 2010). The epidemic followed a similar initial trajectory in both countries; the
first case of AIDS was reported in Brazil in 1982 and in South Africa in 1985. In the first
decade, HIV/AIDS most visibly affected urban, white, educated gay men in both
countries. Using Brazil and South Africa also allows us to control for the level of
development and for the onset of the disease in the two countries. The disease started off
similarly in the two countries and both governments had the capacity to deal with the
growing threat of HIV/AIDS. The cases have similarities in multiple variables, but show
vast differences in the dependent variable, which is the government response.

The key explanatory variable in the analysis is the shared perception of risk and
how it affects government policy. Perception of risk is measured at certain time periods
using survey data of different sections of the population. This paper will examine survey
data form the multiple sources in order to assess the levels of perception of risk in South
Africa and Brazil. Data on government responses will be from multiple sources and aim
to quantify the government responses of the two governments in order to understand the
link between perceptions of risk and government policy.

Empirical Section

This section of the paper provides empirical measures of perception of risks and
government response in Brazil and South Africa.

Measuring Risk Perception

There have been multiple empirical analyses concerned with measuring the
perception of risk amongst certain sections of the Brazilian and South African population.
I present some of these findings in this section of the paper.
In 2003, Neide de Souza Praça conducted a study which measured the perception of risk and knowledge of AIDS of post partum women admitted to maternity hospitals. She used survey data collected at two philanthropic hospitals in São Paulo. Data was collected from January to March in 2000 and the sample size comprised 384 women; all the women were interviewed 12 hours after delivery. Data was collected on their STD/AIDS knowledge, economic status and most importantly on "whether she considered herself at risk for HIV infection" (Praça, 2003). Statistical analysis was performed using Chi-square test and multiple logistic regressions and found that 29% of post partum women considered themselves at risk for HIV infection.

Another study collected data on the perception of risk of homosexual/bisexual men in Brazil. Survey data was collected from volunteers aged between 18 and 50 who reported having had male homosexual intercourse within the last year (Bastos et al, 1999). The study found that 185 or 72% of the volunteers interviewed perceived themselves as being `vulnerable’ or at risk of contracting HIV (Bastos et al, 1999).

Another, more comprehensive study by Maria Paula Ferreira sought to measure the perception of risk of the whole Brazilian population. The study used data collected in 1998 and 2005 from a national survey on sexual behavior and HIV/AIDS risk perception (Ferreira, 2008). This study found, amongst other things, that the proportion of people who considered they had some kind of risk regarding AIDS also decreased, going from 51.1% in the previous survey to 33.8% in 2005 (Ferreira, 2008). We would expect perceptions of HIV/AIDS in Brazil to be lower than in South Africa, as the South African people have prevalence rates in 2005, but that is not the case.
South Africa

A 2010 study done by Chris Kenyon at the University of Cape Town used survey data to measure perceptions and determinants of risk in South Africa. The study used data from the Cape Area Panel Survey (CAPS) and collected information on 2224 South Africans aged between 14-24 residing in Cape Town. The study found that only 19% of the youth in Cape Town regard themselves as being at ‘some or great risk of contracting HIV’ (Kenyon, 2010). South African youth still do not understand the dangers of concurrent sexual partners sufficiently well. There is an urgent need to devise culturally appropriate ways to better communicate this risk, as well as deal with the myriad of structural and other factors necessary to allow young people to develop the autonomy and capacity for critical thinking necessary to effect behavior change.

Another study collected data in 1999 from 2,716 participants and used it to explore factors predicting risk perception (Macintyre, 2003). It was carried out in KwaZulu-Natal in 1999. KwaZulu-Natal (KZN) is situated on the east coast along the Indian Ocean, and with a population of 8.4 million is the most populous province in South Africa. The dependent variable was whether the adolescent perceives himself or herself at no risk or at any risk based on his or her response to the following question: Do you think you have no risk, a small risk, a moderate or a great risk of getting the AIDS virus in the next 12 months (Macintyre, 2003)? Overall, 76% of the respondents said they were at no risk, while 24% said they were at some risk of getting the AIDS virus—13% reported they were at a small risk, 4% reported a moderate risk, and 7% said they were at great risk (Macintyre, 2003).
Discussion

The data presented in this section show how sections of the Brazilian and South African populations perceived their level of risk at different times throughout the AIDS crisis. This data shows that South Africans perceived themselves as having a lower risk of contracting HIV even though they faced much higher prevalence rates. These studies focused on the role of information in determining the perceptions of risk and found that there was very little to no association between individuals who perceived themselves and how much they knew about contracting the disease or if they knew someone who had the disease. Indeed, very low perception of risk, even in relatively high prevalence situations has been reported in a number of settings. For example, a study done in Ethiopia found that only 17% of men and 2% of women, despite high and correct knowledge of HIV transmission, acknowledged that they were at any risk of HIV (Sahlu, 1999). In Tanzania two recent studies showed increases in perception of high risk among young men and women in Dar Es Salaam, though they still underestimate their own risk relative to data from the national surveillance system. Of the Tanzanian students interviewed, 25% felt that they were at personal risk of having HIV whilst 41% thought their friends were at great risk (Maswanya et al., 1999). In Zambia 52% of the young people interviewed in a cross-sectional study knew someone with AIDS, but 72% adolescents did not think they were at risk of getting AIDS (Maswanya et al, 2001).

Measuring Government Policy

The following section aims to quantify the government responses of South Africa and Brazil. The data shows that whereas South Africa did not make AIDS policy a priority, Brazil was quick to respond to the crisis. The main variable I use to quantify the
government responses is expenditures on HIV/AIDS prevention and treatment programs. The different policies of Brazil and South Africa, I argue, were determined to some extent by the different perceptions of shared risk in the two countries and I delineate possible mechanisms through which this can happen.

Brazil

Brazil's national budget included a reference to AIDS control as early as 1988, when it was included in the program to control sexually transmitted diseases (Orgamento da União, Projeto da Lei, Vol. 1, 1988). The figure below shows Brazil’s spending from 1997 to 2009.

South Africa

South Africa increased spending on HIV/AIDS programs, but it was not until the 1997 budget speech in South Africa that AIDS was even mentioned in the formal presentation of that country's budget, and it was not until 2000 that the expenditure Estimates of the budget would reveal specific line items dedicated to expenditure.
on HIV/AIDS. The South African government also famously resisted the use of antiretroviral (ARV) drug mono therapy for the prevention of mother to child transmission (PMTCT); an inexpensive and effective strategy for reducing Pediatric AIDS (Nattrass, 2004).

Discussion

The different policy responses of South Africa and Brazil were determined, in part, by the different perceptions of shared risk. South Africa’s weak government response is evidenced by the failure of its leaders to address the AIDS crisis and Brazil’s strong response is evidenced by the way in which civil society galvanized and pressurized government to act.

South Africa

The South African public and their leaders, Thabo Mbeki and Nelson Mandela, did not view AIDS as a large threat to themselves or to the society as a whole. Hence, the public failed to pressure the government into action and the government continued to enact policies based upon denialist propaganda. This is evidenced first by Mandela’s admission that during an interview with the British Broadcasting Channel in 1994 that he “wanted to win” the 1994 election and in order to do so he “didn't talk about Aids” (Fourie, 2010). HIV/AIDS was such a stigmatized topic that the president even acknowledging its existence was seen as detrimental to his political campaign. If perceptions of risk were high during 1994 election, then HIV/AIDS prevention and treatment policies would have been a sure way to gain support for the Mandela’s election campaign.
Low perceptions of shared risk continued to impact government policy when Thabo Mbeki became president in 2009. Mbeki embraced what was known as AIDS ‘denialism’; he believed that HIV did not cause AIDS and instead resulted from poor socio-economic factors and poor nutrition (Fourie, 2010). Mbeki believed that mainstream scientists were espousing “centuries-old white racist beliefs and concepts about Africans” (Fourie, 2004) that aimed to portray African people as savage and promiscuous. This belief was based somewhat on the fact that Mbeki had spent most of his adult life fighting against racism, but the political environment and low perceptions of risk allowed and even encouraged such a stance from Mbeki. AIDS was seen as a ‘white man’s disease’ or as a ‘gay cancer’ and the majority of the South African population viewed themselves as insulated from the disease (Cohen, 1999). Mbeki further argued that AZT was toxic and that it weakened the immune system and could lead to mutations in babies (Kaufman, 2004).

South African government policies or lack thereof, came about as a result of the low perceptions of risk amongst the political elite and the public at large. Low perceptions of risk fostered and encouraged an environment in which the government of South Africa felt no pressure to enact policies aimed at mitigating the effects of the spread of HIV/AIDS. A Harvard Study done in 2009 estimated that Mbeki’s denialist policies resulted in the premature deaths of 375 000 innocent South Africans” (Chigwedere, 2008). The study concluded that from the 333, 000 South Africans who died for lack of treatment and the 35,000 babies who died because they were infected with H.I.V. the South African populace together lost at least 3.8 million years of life (Chigwedere, 2008). South African satirist Pieter Dirk Uys succinctly summarized the
newly democratic South African government’s underwhelming response to HIV/AIDS when he said, “In the old South Africa we killed people. Now we're just letting them die” (Campbell, 2003).

**Brazil**

Perception of risk amongst the general populace can translate into government policy through a number of different channels. In Brazil, a shared perception of risk manifested itself in social movements that focused political pressure on government bureaucrats. Social movements begin with widespread discontent within a community about a policy or social condition (Macionis, 2001; Hopper, 1950). Widespread discontent will more likely develop when citizens have shared conceptions of the consequences of government inaction. In the HIV/AIDS case, social movements become agents through which shared perceptions of risk shaped government policy.

The AIDS movement that took shape in the 1980s brought together two seemingly unlikely social movement partners: the progressive Catholic Church, the sanitary reform movement and the gay liberation movement (Parker, 2011). This coalition of civil society and social movement actors succeeded in reaching out to other social movements and in broadening its political base by involving the feminist and women’s health movements, the black movement, the popular health movement and other health-related movements which involved people living with other health conditions such as diabetes, drug addiction and mental health conditions (Parker, 2011). This increasingly broad base of support made it possible to pass legislation aimed at guaranteeing universal access to antiretroviral treatment in 1996. Additionally, this broad base provided a mechanism to monitor the effective implementation of this legislation,
and to sustain political support for treatment access independent of the costs associated with it. It was this broad-based AIDS movement that monitored availability of medications through local health posts, and the scale up of equipment and infrastructure, to ensure that conditions existed for successfully implementing HIV treatment access across the country (Parker, 2011).

Another way in which perceptions of shared risks filtered through to the political process is through an “understudied political actor in Latin American politics: activist bureaucrats” (Rich, 2012). Jessica Rich argues that Brazil’s AIDS policy sector was taken over by activist bureaucrats who ensured the successful implementation of their policies by developing allies outside the state. Activist bureaucrats succeeded by mobilizing civil society groups to monitor the actions of local politicians and pressure them to conform to national policy guidelines. They launched this grassroots-style campaign through two mechanisms: by providing resources and institutional opportunities for new civic associations to participate in the political arena, and (2) by supporting the endeavors of social movement leaders to mobilize new civic AIDS associations as political actors (Rich, 2012). Perceptions of shared risk affect government policy through multiple channels. In Brazil, in an environment where perception of shared risk was high, activist bureaucrats formed lasting relationships with civil society that enabled social movements to shape Brazil’s HIV/AIDS government policy.

**Conclusion**

In 2001, during a United Nations Convention, the President of Botswana Festus Mogae stood before the international community and somberly declared that we, the people of Botswana, as a result of the AIDS crisis were “faced with extinction.” As a
citizen of Botswana, Mogae’s sentiments have stuck with me throughout my life and periodically came back to me as I was writing this paper. The magnitude of the threat of AIDS in Sub-Saharan Africa cannot be understated; if the disease does not infect you then it undoubtedly affects you in some way. This makes South Africa’s meager response to this crisis all the more baffling. I have, however, through this paper attempted to gain a better understanding of not only the South African response, but also of the ‘model’ Brazilian response and attempted to provide a different lens through which we can view HIV/AIDS policy. Perceptions of shared risk are another factor that shaped government policy in Brazil and South Africa. My paper contrasted the different ways in which these perceptions manifested themselves in the legislative process in Brazil and South Africa.
Works Cited


