

**THE AIDS EPIDEMIC IN BRAZIL, INDIA AND SOUTH AFRICA: A
COMPARATIVE EVALUATION OF STATE RESPONSES**

*Dissertation submitted to Jawaharlal Nehru University in partial fulfilment of the
requirements for the award of the degree of*

MASTER OF PHILOSOPHY

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20th July 2007

DECLARATION

I declare that the dissertation entitled “The AIDS Epidemic in Brazil, India and South Africa: A Comparative Evaluation of State Responses” submitted by me in partial fulfilment of the requirements for the award of the degree of MASTER OF PHILOSOPHY is my own work. The dissertation has not been submitted for any other degree of this University or any other university.

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CERTIFICATE

We recommend that this dissertation be placed before the examiners for evaluation.

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Abbreviations and Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ANC	African National Congress
ART	Anti Retroviral Therapy
ACT	AIDS Communication Team
CBO	Community Based Organisation
CIA	Central Investigation Agency
CIB	Comissao Intermanagers Bipartite
CIT	Comissao Intermanagers Tripartite
CSWs	Commercial Sex Workers
GDP	Gross Domestic Product
HAART	Highly Active Anti Retroviral Therapy
DFID	Department for International Development
HDI	Human Development Index
HIV	Human Immunodeficiency Virus
IBSA	India-Brazil-South Africa Forum
IDSA	Institute for Democracy in South Africa
IDUs	Injecting Drug Users
MSM	Male having Sex with Male
MTCT	Mother to Child Transmission
IEC	Information, Education and Communication
NACO	National AIDS Control Organisation
NACOSA	National AIDS Convention of South Africa
NACP	National AIDS Control Programme
NAP	Nation AIDS Programme
NGO	Non-Governmental Organisation
PLWA	People Living with HIV/AIDS
SANAC	South African National AIDS Council
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
SUS	Sistema Unico Saude
TRG	Target Resource Group
UNAIDS	Joint United Nations Programme on HIV/AIDS
UN	United Nations Organisation
UNCHR	United Nations Commission on Human Rights
UNDP	United Nations Development Project
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNSC	United Nations Security Council
VCT	Voluntary Counseling and Testing
WHO	World Health Organisation
WTO	World Trade Organisation

"In June of 1981 we saw a young gay man with the most devastating immune deficiency we had ever seen. We said, 'we don't know what this is, but we hope we don't ever see another case like again'."

(Source: WHO 2001)

CHAPTER I

Introduction: The New Millennium Pandemic

The human immunodeficiency virus (HIV), which causes acquired immunodeficiency syndrome (AIDS), is the leading cause of deaths among the adults worldwide (Narain 2006). According to the Joint United Nations Programme on HIV and AIDS (UNAIDS) report tabled at the International AIDS conference 2006, 2.8 million people lost their lives to AIDS by the end of year 2005. Further it is estimated that as many as 38.6 million are infected globally by the virus (UNAIDS 2006). Hunter (2005) predicts that even if a cure against HIV and AIDS is found some day, the toll of death and suffering by 2010 will far exceed any other recorded human catastrophe, previous epidemic, natural disaster, war, or incident of genocidal violence (Hunter 2005:26).

Despite determined efforts to hold the epidemic in check, it shows no signs of declining. The disease has spread widely, affecting all continents and all countries of the world. In the process, it has stretched the health care systems, wrecks the economies and destroys the very fabric of what constitutes a nation: individual, families and communities, political institutions, military and police forces. Thus because of these concerns, HIV and AIDS is now considered not only a health problem, but also a development as well as a security threat (Narain 2006, Garrett 2002, Singer 2002, Jacob 2005).

International relations (IR) as a discipline, has been slow to address the AIDS crisis. Boone and Batesell (2001) notes that the IR scholars have conceived the HIV and AIDS issue as too biological, too sociological, too behavioural and too cultural. The authors further adds, "In spite of the rising out cry surrounding the AIDS epidemic in international fora like the United Nations Security Council (UNSC) and increasing politicisation of the issue as it affects arenas such as human rights, development, security, and North-South relations, the scholars have devoted little attention to the subject" (Boone and Batesell 2001:4). Also Lanegran and Hyden lamented in 1993, "Here is a major global issue with potential ramifications as great as any war, yet hardly any political scientist shows scientific interest in it" (Lanegran and Hyden 1993:247).

On the contrary one can find a wealth of literature on HIV and AIDS concentrating more on the dynamics of the spread and prevention of the disease as well on its socio-economic and security implications. However, substantial work has not yet been done on comparative accounts in terms of cross regional analysis of nature of state responses. Recognising the severity of the situation, scholars in IR must now address the challenges posed by the new millennium pandemic and the political debates it has generated. At the same time they should recognized the fact as Boone and Batesell (2001) stated in their article that the epidemic is more connected to the problems that preoccupy IR scholars, such as the state, democratisation, civil society, globalisation, global governance and security (Boone and Batesell 2001:4-5).

Recently many scholars have come up with some hypothetical accounts describing nature of state response to AIDS epidemic. Some of the major studies are; regime type (Sen 2000); bureaucratic capacity (Boone and Batesell 2001); the quality of leadership (Whiteside 1999); nature of political institutions and strength of national community (Gauri and Lieberman 2004); historical institutionalism and cultural analysis (Gomez 2005); state-society relationship and strengthened health bureaucracy (Huang 2006); and international influence Richard Parker (1990). But these studies do not clearly define the variance in state responses.

For instance Sen (2000) maintains, "The explanation may lie in 'regime type', if we can interpret that term broadly. Democracy, for all its weaknesses, has the advantage of forcing government to be moderately responsive to the needs of the people. Dictatorships let people starve because they do not fear the political consequences of doing so", the author adds (Sen 2000 quoted in Boone and Batesell 2001:11). Sen's explanation is controversial in the sense that the epidemic is at its full-blown stage in the two big democracies (India and South Africa) of the world. Further the two African nation states vis-à-vis Uganda and Senegal which emerged as successful cases of state responses in combating the AIDS epidemic witnessed a long history of civil war and are usually not counted as democracies (Geddes 1999).

Whiteside (1999) highlights the concept of leadership as an important component of effective AIDS policies. Uganda has been cited as an interesting example in support of his argument. But this again raises as many questions as it answers. As seen in case of South Africa, the then President Nelson Mandela has been internationally recognised as the most responsible and a leader with immense qualities and is also a Noble Peace Prize winner but what happened on the states' HIV and AIDS front during his tenure is a well defined story. Even in case of Brazil, most of the presidents who were in power during the outbreak of the epidemic have been described as extremely weak and unremarkable leaders (Gauri and Lieberman 2004:30-31). Thus it is very controversial in correlating a good leader with an effective response against a pandemic. The study believes that leadership must be seen in the broader political context and is affected by time and place-specific political incentives. Uganda's case of an effective response in combating HIV and AIDS epidemic presents another interesting example of this sort which also goes against Whiteside's findings.

Writing on the nature of state responses to the epidemic, Boone and Batesell (2001) in their article argues that levels of economic development and bureaucratic capacity are always factors in explaining the scope and effectiveness of state response to crisis. However, this explanation is not immediately satisfying in the sense that the two states (India and South Africa) in terms of economic and bureaucratic levels of development have the good records and some successful cases like Uganda and Senegal has worst records. Now if wealth and bureaucratic capacity alone do not account for variation in state response, what does?

Gauri and Lieberman (2004:11-13) notes that two factors explain the divergent responses: the centralisation of pre-existing political institutions and the strength of national political community. They argue that a strong solidarity around a common notion of national political community and states characterised by decentralised political institutions results in aggressive and timely response. One problem with this analysis is that the argument of decentralisation of institutions is not clearly defined as decentralisation at which level; political sphere or decentralisation of AIDS combating

institutions. Further in several cases like Zambia, Ethiopia and even South Africa decentralisation has always led to many difficulties in making a successful and coordinated effort to combat the AIDS epidemic. Mohiddin and Johnston (2006) in their article gives a very clear picture of this dilemma. They pointed out that difficulties with decentralisation include a lack of supervision and control, little interest (and hence funds) in HIV and AIDS by some local decision-makers, inequities in service provision. They further added that the evidence demonstrates the existence of a lack of clarity regarding the powers and functions of decentralised levels of government, poor financial frameworks for fiscal decentralisation, and poor capacity of local officials and councillors at a local level (Mohiddin and Johnston 2006:3).

Huang's (2006) assessment of state-society relationship and strengthened health bureaucracy in influencing the state to generate an effective and timely response against any drastic pandemic is a welcome initiative in this regard. The author comparing the Chinese state response to SARS (Severe Acute Respiratory Syndrome) and the AIDS epidemic argues that it is not only a committed leadership that influence the state decision making in prioritising issues like HIV and AIDS on the state agenda but also an energised health bureaucracy and state-society relationship matters most in generating effective AIDS policies (Huang 2006:124). The study falls short in explaining the argument in a comparative account. The argument holds true to some extent in case of Brazil but it fails to explain when looked in context of India and South Africa which also harbours effective health bureaucracies and civil societies. Thus the variables put forth by the author further create some confusions and questions too as why the situation in India and South Africa is different. Further the argument of strong health bureaucracy becomes confusing in context of the Ugandan state response. Uganda emerged as a successful state response in bringing down the HIV and AIDS cases in the state but the bureaucratic institution pertaining to health was far incapable than cases like India and other developing nation states (Mohiddin and Johnston 2006:126). Now the question rises, why this is so?

Richard Parker (1990) attempted to explain this dichotomy by correlating an effective state response with mounting international pressure. He argues that international influences were particularly important in making a state to adopt an effective AIDS policy. He places Brazil as an interesting example in this context. The argument appears quite credible when specifically seen in case of Brazil where the international actors do played a vital role in combating the epidemic. But when assessing the argument in context of other states like India and South Africa, it creates more problems than solutions. In both these states the intervention programmes were carried out with the help of many international organisations and also there was heavy pressure from all over the world on the states to make an effective response right from the inception of the virus, but these influences doesn't made any positive effect in this regard. And now both the states are global leaders in having greater number of HIV and AIDS cases.

This study begins to fill this gap by taking up the question of why some states have responded to the HIV and AIDS epidemic more aggressively and attained greater success rate than others. The study will attempt to answer the general question by comparing state responses of three nation states. My interest extends to Brazil, India and South Africa in combating the AIDS epidemic where one might have expected similar state responses, but in which substantially different state responses are observed. Comparing state responses to the AIDS epidemic could generate more nuanced understandings of the sources of state capacity, responsiveness, and legitimacy in the proposed case studies context. The intensity of the epidemic and policies adopted by the states in combating the menace shall be the main focus of this work.

Brazil, India and South Africa are similar in many respects, and these similarities make these three countries good comparative case studies for examining state response to AIDS epidemic.

- More interestingly India, Brazil and South Africa, representing three major democracies in three different corners of the globe, happens to be the sole members of forum of developing countries IBSA (India-Brazil-South Africa), set up under the 'Brasilia Declaration' in 2003 aiming South-South cooperation in sharing "opportunities, experiences, achievements and complementarities" (Devraj 2006).
- The per capita income is about the same in these three states, and the distribution of wealth is very unequal (World Bank 2004).
- The discovery of AIDS cases occurred in these states during the mid-1980s, and the disease was initially prevalent in urban centres. By the early 1990s, these states feared a major epidemic (Gauri and Lieberman 2004).

The selection of these cases was also motivated by the following reasons:

First and foremost Brazil, India and South Africa happen to be the worst and arguably the best cases of state response to HIV and AIDS among the larger, highly decentralised federations, respectively. Therefore, I have intentionally chosen these case studies to understand the dramatic differences in state response.

Second, there are many structural similarities between the three cases: that is, all of them are large federations covering thousands of miles of territory.

Finally, during the initial outbreak federal elites in India and South Africa cases were somewhat unresponsive while Brazil has taken early and aggressive response (Gauri and Lieberman 2004:2).

This introductory chapter will begin by providing the core argument of the study and then it will detail the theoretical arguments surrounding the origin of HIV and AIDS. In order to make better understanding of the AIDS problem, the virology of AIDS and

its epidemiological patterns has also been addressed. Next the study will present an overview of global scenario of AIDS epidemic in general and those of chosen studies i.e. Brazil, India and South Africa in particular. The general international discourse around HIV and AIDS and the socio-economic implications of AIDS epidemic has also been addressed. Subsequently the chapter then address the debate on the AIDS epidemic as a security threat to the nation states. Finally, it will conclude by detailing the method of the study and a brief description about the subsequent chapters of the study. The primary task of the chapter is to frame the relevance of the study in the current scenario and most importantly, it will try to make the point that AIDS is as much a political issue as a health issue.

The goal of the study is to identify factors that are likely to account for cross-country variance in state responses to the AIDS epidemic, with an eye towards the Brazil-India-South Africa comparison. The study identifies four important variables- primacy of states to human security, socio-cultural norms, activism of civil society groups, and rapidly changing strategic environment, which provide a better specified model of cross-country variation in state response to AIDS epidemic.

Based on the pattern of state action in Brazil, India and South Africa in context of three broad areas; establishment of autonomous authority for combating the AIDS epidemic, broadcasting of prevention strategies and the provision of treatment and support to HIV positive people, the study makes the following arguments;

First, the extent of primacy and guarantee of human security by the states results in a more effective and timely state response against any human security threat like HIV and AIDS.

Second, the fundamental barriers to timely and effective state response to the AIDS epidemic are social and cultural norms because of its association with behaviours that are socially and culturally unacceptable. They discourage the states from acknowledging or taking timely action against the AIDS epidemic. However the states

that discusses these issues more openly rising above social and cultural constraints makes aggressive and successful state response to the AIDS epidemic

Third, the degree of activism on the part of civil society groups influences and shapes the state response. Thus, greater the degree of activism shown by these groups, greater it will influence the decision makers in prioritising the epidemic on the agenda.

Lastly, states priorities those issues that are of great strategic importance in relation to the rapidly changing state and international political system. As a result, states deny or minimise the presence and the threats of HIV and AIDS. Thus the AIDS epidemic competes with these other issues for priority on the agenda of states, as a result leading to late and unsuccessful state response. On contrary the states that do not witnessed such strategic changes on the state political sphere show timely as well as more aggressive state response.

Further the study makes a step ahead attempt on Gauri and Lieberman's (2004) argument of importance of decentralisation in establishment of AIDS bureaucracy and argues that guarantee of autonomy and authority of the AIDS policy units becomes imperative as par with the decentralized political environment.

Moreover the study argues that HIV and AIDS has resulted in fostering cross regional most developing countries, where it threatens to assume epidemic proportions far beyond the recourses of governments to control. Further in developing states particularly AIDS poses central challenges to existing social, economic and gender relations. For all these reasons, the unprecedented degree of involvement of nation states rising above national borders in scaling down the new millennium pandemic has implications for both the creation of new form of cross regional cooperation and the idea of global citizenship. Thus the creation of IBSA (India-Brazil-South Africa) forum can be related with the same.

Origin of HIV and AIDS

Though it is very difficult to track back the origin of HIV and AIDS, but certain studies reveal that the virus probably originated in western central Africa in the 1920s or 1930s (Guest 2001). The three main theories regarding the origin of AIDS concerning different aspects are;

The first theory assumes that AIDS originated from isolated ethnic groups. This theory is based on the principle that AIDS was prevalent in human society since long back and only a few years ago it became virulent. This theory pronounces that the disease has come from such an isolated ethnic group that it may have acquired immune system for its virus. Therefore death due to HIV and AIDS in that group was minimal or non-existence. When this virus reaches to other communities, which have no immune system against this, it turns out to be killer or deadly (Guest 2001). This theory does not look significantly sound because the anatomy of every human being is same. It is not possible that the immune system found in one human community would differ from other communities.

The second theory, which is perhaps the most popular, assumes it to stems from some animal. It argues that HIV virus was initially associated with animals like ape and monkey. It later infected human beings and triggered off the epidemic. Several example of diseases that have crossed over from animal to human species have been cited in support of this theory, such as Laumi fever from rodents in Japan, Kyasawan Torest disease from monkey in India, Loss fever from rat in Nigeria (Martin 1993:624).

And the last one, known as the conspiracy theory astonishingly reveals that AIDS virus was developed artificially in the laboratory either accidentally or deliberately with some malicious design. The supporters of this theory claim that an alleged secret society of powerful scientists, politicians and so on deliberately manufactured AIDS in order to wipe out homosexuals, blacks and Hispanics (Martin 1993:624).

Nature and Virology of HIV and AIDS

AIDS is caused by HIV, a member of a family of viruses known as retroviruses. HIV, in common with all viruses, is a parasite. Upon entry into the bloodstream, it invades specific blood cells (T-lymphocytes), which constitute the single key factor in the production of antibodies aimed at resisting diseases. Once HIV has established itself within a T-lymphocyte, the virus is capable of altering the normal functioning of the cells and induces T-lymphocytes to produce more HIVs at the expense of antibody production. The newly replicated HIVs are released from the host cell and invade other healthy T-lymphocytes. The process ends in the complete destruction of T-lymphocytes within the body and a total inability of the body to produce antibodies (Lampthey et al 2002:2-3).

Infected person will pass through 2 stages i.e., Sero-conversion phase, when the person is infected, but does not have sufficient antibodies for the virus to be detectable through laboratory testing and lastly Latent phase, when the person is infective, during which the virus is detectable and the virus starts replicating and beginning its attack on immune system resulting in full – blown AIDS ending in death (Lampthey et al 2002:4).

HIV is transmitted primarily by three methods; sexual intercourse, intravenous exposure to HIV infected blood through transmission, donated organs, and drug use and vertical transmission from mother to child. The patterns and prevalence of these three modes of transmitting HIV vary geographically. On the basis of data from the period when the virus began to spread significantly, the prevalence of each mode, and its specific mechanisms, Mosley and Cowley (1991) distinguishes three epidemiological patterns of HIV infection

Pattern I is typical type of Western Europe, North America, Australia and New Zealand, where the most common form of transmission is male homosexual or bisexual intercourse and the second most is intravenous drug use.

Pattern II, in which heterosexuals are the main group affected, is found in sub-Saharan Africa, and the Caribbean, and parts of South America.

Pattern III is typical of nation states where HIV has recently been introduced. Much of Asia and Eastern Europe fit this pattern. Heterosexuals and intravenous drug users account for most (Mosley and Cowley 1991:20).

Overview of the Global AIDS Epidemic

According to the estimated figure of the UNAIDS, 38.6 million (33.4 million–46.0 million) people worldwide were living with HIV in 2005. An estimated 4.1 million (3.4 million–6.2 million) became newly infected with HIV and an estimated 2.8 million (2.4 million–3.3 million) lost their lives to AIDS (UNAIDS 2006:8).

As per the UNAIDS report (2006) the number of people living with HIV and AIDS by the year 2005 in India is reported as 5.7 million, followed by 5.5 million in South Africa and 0.6 million in Brazil. However as per Indian state statistics, India homes 5.5 million next to South Africa with 5.7 million people living with HIV and AIDS (Pragya 2006). Again more recently NACO's comes up with a new statistics of number of people living with HIV and AIDS. The latest estimate says that the country has an estimated 2.5 million people living with HIV and AIDS, about 3 million fewer cases than previously estimated. The prevalence of HIV in the general population is now 0.36 percent against 0.9 percent as earlier believed (Sinha 2007). This makes India the third worst affected state with the deadly disease after South Africa (5.5 million) and Nigeria (3.1 million).

The immediate cause of the HIV and AIDS in Brazil, India and South Africa is both biological and behavioural, such as, the high prevalence of sexually transmitted diseases (STD) due to unprotected sex or multiple sexual partners, infected blood transfusion, contaminated syringes, unhygienic handling of medical equipment, intravenous drug users, commercial sex workers and truck drivers (UNAIDS 2006).

Sub-Saharan Africa is the most affected area of the world, with more than 23 million people estimated to be infected with the AIDS virus (HIV) or to have full-blown AIDS. Southern Africa remains the epicentre of the epidemic followed East Africa. In East Africa HIV prevalence has either decreased or remains stable in the past several years. West Africa is less severely affected than other parts of sub-Saharan Africa. The epidemic in sub-Saharan Africa is fuelled by ignorance of the disease, lack of access to prevention, inadequate treatment and care services, and stigma and discrimination. While Uganda, Senegal and Zambia have shown signs of containing the epidemic, but the situation in South Africa, Botswana and Zimbabwe is worst (UNAIDS 2006:15-17).

AIDS is not a problem confined to Africa. The rest of the developing world shares it, eighty-five percent of all cases of AIDS are now found in the world's poorer countries. There are full-blown epidemics in other parts of South and Southeast Asia. Latest estimates show that some 8.3 million people were living with HIV in Asia at the end of 2005. India is home to one of the world's largest populations of people living with HIV and AIDS. Thailand and Cambodia has emerged as successful states in combating the epidemic (UNAIDS 2006:23-25).

In Latin America, infection rates are higher among poor populations, some 1.6 million people were living with the virus in 2005. In Brazil, the region's most populous country infection rates have dropped due to the effective state's response to the epidemic (UNAIDS 2006:41-45).

Nation states such as the North America and Western Europe are in a rather different position and the epidemic is not that much severe as compared to other parts of the world. Overall in these regions, approximately 65 000 people were newly infected with HIV in 2005, bringing to 2.0 million the number of people living with HIV (UNAIDS 2006:45-47).

The epidemics in Eastern Europe and central Asia continue to expand. Some 220 000 people were newly infected with HIV in 2005, raising the number to 1.5 million (UNAIDS 2006:33-38).

Lastly in the countries of the Middle East and North Africa except for Sudan, the HIV prevalence is very low and does not exceed 0.1 percent (UNAIDS 2006:48-50).

International Discourse around HIV and AIDS: Then and Now

During the pre-1994 period, especially before 1990, there was much denial in official circles about AIDS. For most of the state leaders, the initial response to the news that AIDS exist was denial. They were more reluctant to publicly discuss the disease. States seemed to perceive AIDS as a problem that affected “other people”. Homophobia, racism and puritanism thwarted a timely and early action. Even the blame for AIDS epidemic was allocated differently in different states and societies. In many developed nation states, high rate of HIV infection was found in the gay community, because of which, AIDS was referred to as the gay plague (Patterson 2005:5).

In most African states, AIDS cases were under-reported, under-recognised and under-diagnosed. The general discourse around AIDS in African states was that they perceive it as intervention by the whites (Patterson 2005:5).

In 1985 Kenya’s President Danial Arap Moi stated that the foreign presses were conducting a hate campaign against his state when it reported that Kenya had 20 AIDS victims (Patterson 2005).

The king of Swaziland only declared the AIDS epidemic a national disaster in 1999 when UNICEF published a report in the Times of Swaziland on the likely long-term negative impact of AIDS on the society (Daly 2001).

The Apartheid regime in South Africa tried to downplay AIDS by portraying it as a disease that only infected deviant homosexuals. Even the post-apartheid state has resembled the Apartheid regime in its tendency to centralize AIDS issue and to use inflammatory rhetoric to deflect criticism. In 1999, the current president of South Africa, Thabo Mbeki, strongly questioned the scientific evidence that HIV is the sole cause of AIDS (Furlong and Ball 2005:127).

Also in America, initially it was seen as Gay disease and was not seen as a threat to public or the state. It was only in 1991 AIDS became a political issue in the U.S during the presidency of George Bush. In Europe AIDS cases were first found among the Africans, which led to the perception that it was an African disease (Patterson 2005).

In Asia, the first AIDS case was reported in 1980s. As in Africa, most Asian nation states turned their backs on AIDS for the first ten years, assuming that the disease was someone else's problem or was restricted to a specific group. Many Asian states deliberately minimized their HIV and AIDS data out of fear that overly adverse reports would deter millions of tourists and international business investment (Hunter 2005:6-7).

At the start of the new century, the AIDS epidemic is finally receiving high-level attention on the international stage. In the 1990s AIDS had been viewed as a purely medical or social service delivery problem but in 1999 it was redefined as a major developmental crisis. It is now widely acknowledged that AIDS is more than a danger to health. Since 2000, AIDS has been on the international policy-making agenda, with high-level discussions that illustrate an entire shift in the international discourse around AIDS as compared to the period of 1990s. A CIA (Central Investigation Agency) report released in January 2000 says AIDS and other infectious diseases will complicate U.S and global security over the next twenty years (Singer 2002:145).

In the following years it emerged at the top of the United Nation's (UN) agenda, second only to military interventionism and peacekeeping. In 2001, the UNSC and General Assembly held special sessions on AIDS. The UNSC sounded the alarm over the security implications of the epidemic, arguing that AIDS' destabilizing impact on societies, militaries, and economies around the world. All member-states of the UN signed the Declaration of Commitment on HIV and AIDS without reservation. This contrast greatly with other special sessions, where signatories often express reservations to final declarations. Finally, the emergence of Global Fund was the first example of state and private actors collaboration into international cooperation on AIDS (UNAIDS 2001). Committees of the U.S Congress and the British parliament held similar hearings. A meeting of African heads of states declared it a 'continental emergency' (Copson 2001 quoted in Singer 2002:145).

According to the World Bank, AIDS is the single biggest threat to economic development. The disease lowers the productivity of workers and reduces incentives for foreign investment. Even more worrisome is the growing perception that AIDS fuels civil conflict and contributes to the failure of the states. By exacerbating economic underdevelopment, the illness intensifies resource struggles, thus fuelling civil conflicts. It will also gradually reduce the ability of national, regional and international militaries to provide political stability and thus posing a securing threat to nation states (World Bank 2004).

For the first time in 2002 political leaders all over the world openly discussed AIDS at an international conference on HIV and AIDS in Barcelona. It was seen as a first ever increased in political commitment against AIDS epidemic. In another politically symbolic example, 18 African first ladies met in July 2002 to form an organization to combat AIDS. And U.S President George W. Bush used the high profile venue of his 2003 State of the Union address to propose an increase in U.S funding for AIDS programme in 14 countries (Patterson 2005:173).

Socio-Economic Implications of HIV and AIDS

HIV and AIDS is much more than a health crisis. Its effects extend to nearly every dimension of social and economic life, especially in the worst-affected states. It has social and economic effects as it makes sick and dependent and finally kills, those who should be the most productive, caring and thrusting in their societies (Lemptey et al 2002).

More specifically HIV and AIDS inflict the following socio-economic implications;

HIV infection is widely stigmatised because of its association with the behaviours that may be considered socially unacceptable by many societies. People living with the virus are frequently subject to discrimination and rights abuses, many have been thrown out of jobs and have been denied proper basic treatment and sometimes even been killed (Lemptey et al 2002:8-9).

HIV and AIDS systematically erode both the resources of state capacity and its instrumental components, thereby weakening the state. Lemptey (2002) identify three broad categories-economic, demographic, and social, to classify the consequences of the HIV and AIDS epidemic related to state capacity. He adds that the harmful implications of HIV and AIDS on one category often influence and affect other categories. For example, demographic changes brought about by the HIV and AIDS epidemic affect economic activity at the micro as well as macro-level, which can influence social relationships and security within and between states (Lemptey 2002:20-22).

Further HIV and AIDS reduce human capital, thus undermining the technical capacity necessary for states to perform their functions. It initially reduces an individual's human capital, which then reaches to the systems level, diminishing the overall technical capacity of an agency, bureaucracy, or military organization. As HIV and AIDS erode human capital, technical capacity, instrumental rationality, and reach and

responsiveness, the political system becomes less resilient and legitimate (Jacob 2005).

One of the most significant ways HIV and AIDS undermine state capacity is by reducing the productivity and level of economic activity within a state. As noted, HIV and AIDS reduce human capital and productivity levels.

It has also been noticed that HIV and AIDS makes regulation and administration of state bureaucracies difficult, as infected individuals leave important positions, adequate replacements cannot be found, and demands on state bureaucracies, particularly those associated with healthcare and social and human services, grow. As Waal (2003) demonstrates that HIV and AIDS hurts the functioning of state bureaucracies by eroding human resources and experience networks. He notes, "... the pandemic is likely to further undermine the effectiveness of bureaucracies and bureaucratic norms. At the minimum, HIV and AIDS will impede the objective of building the capable state" (Waal 2003:7-9).

HIV AIDS and Security

The link between HIV AIDS and security has been much debated by various scholars and there are now strong opinions that the epidemic is posing a big security threat to the nation states (Singer 2002). Claims are also made that HIV and AIDS gravely affects human and international security, most particularly via armed forces (Prins and Barnett 2006).

Even UNSC recognizing the security implications of HIV and AIDS debate a health issue for the first time in January 2000. By subsequently adopting Resolution 1308(2000), it highlighted the potential threat the epidemic poses for international security, particularly in conflict peacekeeping settings. This increased international attention on HIV and AIDS in the context of security signals a shift from the traditional understanding of security as the absence of armed conflict to a wider

definition of human security which encompasses the fundamental conditions for people to live safe, secure, healthy and productive lives (Garrett 2002).

The following conclusions have been drawn from the debates, that how HIV and AIDS is a security threat to international peace and stability.

First, as Garrett (2002) and Jacob (2005) notes in their article that mostly the armed forces increasing fell victim to AIDS as much or more than the general population, thus posing serious problems for law and order.

Second, HIV and AIDS affects and eventually breakdown community structure. Public administration, governance and social services become unsustainable in the process, and both coping capacity and policing capacity are reduced. As a result, communal conflict is likely to increase (Prins and Barnett 2006).

Third, HIV and AIDS declines the life expectancy of hard hit states which is an important threat to the security of such states, as it will lead to diminishing state capacity (Garrett 2002).

Method of the Study

An in-depth understanding of the nature of state responses to AIDS epidemic in Brazil, India and South Africa is the basic objective of this study. For the requisite information, it would make use of primary as well as secondary sources. In the area of AIDS, while much has been written on the socio-economic and political implications of the epidemic, less has been done comparing state responses of developing countries especially from a cross regional perspective. Thus the present study intends to carry out a comparative analysis of state responses to the menace in the three nation states vis-à-vis Brazil, India and South Africa; Brazil being widely recognized as the leading example of successful state response in scaling down the epidemic while as India is

seen as a state on the verge of failure in responding to AIDS and lastly South Africa declared as the abject failure state in combating HIV and AIDS.

This study has been divided into five chapters including this introductory part as the first chapter entitled, '*Introduction: The New Millennium Pandemic*'.

The second chapter namely, '*The AIDS Epidemic and the State Response in Brazil*' deals with the status of AIDS epidemic and the state response in Brazil. The policies of the state that makes Brazil a successful case of state response to the AIDS epidemic has also been dealt with special attention.

In chapter three, '*The AIDS Epidemic and the State Response in India*', the nature of state response to the proliferating epidemic has been analysed. The epidemiology of AIDS and the subsequent state response in India has also been focused. The rapidity of AIDS proliferation is so alarming that India has been described as a new area of great concern. In the light of this fact, its analysis becomes very relevant.

The following chapter titled, '*The AIDS Epidemic and the State Response in South Africa*', details the epidemic of AIDS in South Africa and the whole range of state response to the epidemic. Besides, it also incorporates the pitfalls in state response that led to the full-blown stage of AIDS in South Africa.

The concluding chapter is divided into two sections. The first section namely '*Comparing State Responses: Brazil, India and South Africa*', presents a comparative analysis of the nature of state responses in Brazil, India and South Africa based on the three broad areas of state action. The section then explains the dichotomy in state responses to the AIDS epidemic with the help of four important variables.

The last section titled '*Conclusion: Lessons learnt so far*', presents a brief summary of principle findings in the light of the study. The section concludes by enlisting few

lessons learned from the experiences of Brazil's successful state response and South Africa's abject failed state response in order to combat the menace in India.

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"Brazil has handled HIV/AIDS problems with much innovation and effectiveness, thereby creating good practices that other countries can learn from. Hence we must draw lessons from Brazil's experience so that your example can save lives and help development elsewhere: in Latin America, in Asia, in Africa, in Europe. We must learn from Brazil. We must learn fast".

(Source: UNESCO 2003)

CHAPTER II

The AIDS Epidemic and the State Response in Brazil

The AIDS epidemic poses a big threat to the well being of the present generation, and responding to the AIDS crisis constitutes a major challenge for all societies. Brazil is seen as a regional and global leader in the fight against HIV and AIDS and the state has generously allocated resources to the cause, at the national, regional, and local levels. The Brazilian states' response to the new millennium pandemic stands as both a model and an inspiration.

This chapter focuses on some of the key steps taken by the Brazilian state in response to the AIDS epidemic that helps it in scaling down the number of HIV and AIDS cases in the state. The chapter begins with examining the socio-cultural and political set up of the Brazilian state for more nuanced understanding of wide range of initiatives that helped Brazil in generating an effective and successful response to the AIDS epidemic.

Introduction

Brazil is a federal republic of the South American continent bounded on the North by Venezuela, Guyana, Suriname, and French Guiana; on the East by the Atlantic Ocean; on the South by Uruguay; on the West by Argentina, Paraguay, Bolivia and Peru; and on the Northwest by Columbia. The republic has a common frontier with every country of South America except Chile and Ecuador. Occupying nearly one-half of the entire area of South America, Brazil is the largest country in South America and the fifth largest country in the world after the USSR, China, Canada and the US, in terms of land area. It has more people than all the other South American nations combined (Barry and Turner 2005).

The total area of Brazil is 8,511,965 sq. km (CIA 2006). Most of the people of Brazil live near the Atlantic Ocean, notably in the giant cities of Sao-Paulo and Rio de Janeiro, but the capital is inland, at Brasilia. It is generally classed as a lower-middle income country, but extremes of both wealth and poverty are apparent among its 186 million inhabitants. Approximately three-fourth of Brazil's people live in the urban

areas. Sao-Paulo and Rio de Janeiro, the nation's two largest cities, are the most heavily populated cities in South America (Barry and Turner 2005).

About 90% of the inhabitants of Brazil are Roman Catholic. Brazilian Catholicism is intermixed with West African and indigenous religious traditions. Brazil is monolingual (Brazilian Portuguese). In addition, there are some 5 million Protestants and a small community of Jews. Portuguese is the official language of Brazil. Many Brazilians, especially in the cities of the South, speak German and Italian (Barry and Turner 2005). Brazil comprises 26 states and one federal district (Brasilia), the national capital since 1960. States are grouped into regions¹.

Population

Brazil has 186.5 million inhabitants, the world's fifth-largest population living in an area of 8.5 million km. As per the Brazilian Institute for Geography and Statistics (IBGE), the organization responsible for the national census, there are five categories or ethnicities in Brazil: White, Black, Asian, Pardo, and Indigenous. Approximately 54 percent of the population of Brazil is White, 40 percent mixed White and Black, and 5 percent Black. There are some 260,000 native Indians. Despite these distinct ethnic origins, the large amount of intermarriage among groups has given modern Brazil a highly blended society and popular culture (IBGE 2001 quoted in Bacon et al 2004:21-22).

Culture

The culture of modern Brazil has been formed from a rich background of ethnic traditions. The early Portuguese settler borrowed many customs and words from the original Indian population. During the colonial period millions of black African slaves

¹ See Figure I.

who were brought into Brazil and added an African element to Brazilian cultural life (Barry and Turner 2005).

Brazil, however, is a predominantly European formed society, settled largely by the Portuguese, Italians, Germans and Spaniards. The European origins are the bases of Brazilian family life, which is a rigid, patriarchal structure that permeates all areas of Brazilian life (Burns and Bradford 1980).

Further Brazil's social culture is unique as it is not that traditional conservative type and it allows an open space for discourses on all issues like sex, which are mostly treated against cultural norms in different societies across the globe. Sexuality and sexual expression are integral to Brazilian culture and are discussed openly. While some cultures associate sex with shame and corruption, however Brazilians see it as something that should be celebrated. Further the sexual minorities are not looked down and prostitution is legalized (Armus 2003:290-310).

Politics and Economy

Brazil is a federal state, the Brazilian federal power is divided among the executive, legislative, and judicial branches. The president serves four years, with the possibility of re-election to one additional term. The legislative branch is split into an upper house, with three senators for each of the 26 states plus the federal district; and a lower house with 518 deputies drawn proportionately from the states (Barry and Turner 2005).

Although it was declared a republic in 1889, Brazil spent most of the following century under series of military dictatorships. The period between mid-20th century and until 1985 saw massive changes on the political sphere on the state. The power at the centre in Brazil rotated between military and civilian dictatorship at different periods. These developments result in the instability in the economic growth of the state, which further brought debt crisis and rampant inflation. During this period as

Bacon et al. notes, the state faced massive economic crisis, inequalities in socio-economic status, with highly inadequate spending on public health (Bacon et al. 2004:25).

Later with the adoption of 1988 constitution and the restoration of democracy in 1994 the state witnessed some socio-economic improvements. The 1988 constitution divides public spending equally among the federal, state, and municipal layers of state. The constitution treats health as a universal right, with the state responsible for economic and social policies aimed at reducing the risk of illness and ensuring access to comprehensive care (Bacon et al. 2004:25-26).

Market opening and economic stabilization under the elected government has significantly enhanced Brazil's growth prospects. The Brazilian economy was again under stress because of uncertainty on the political sphere. However the subsequent democratic elections established economic stability (Bacon et al. 2004:27).

Land and Resources

A vast region of highlands, known as the Brazilian highlands or Brazilian Plateau and the basin of the Amazon River are the dominant physiographic features of Brazil. The plateau is an eroded tableland occupying most of the Southeast half of the country. The basin of the Amazon River occupies more than one-third of the surface of the country. Climatic conditions in Brazil range from tropical to sub-temperate (Barry and Turner 2005).

Brazil is self-sufficient in food, and agriculture and food products make up 35 percent of its exports. State-of-the-art agricultural technologies are largely used in the South and Central parts of the country. Brazil is the world's largest producer of sugarcane, coffee, frozen concentrated orange juice, and tropical fruits. Livestock production also plays a major role in the Brazilian economy, and the country has the world's largest

commercial cattle inventory (Ministry of Agriculture Brazil 2000 quoted in Bacon et al 2004).

Heavy industry represents 34 percent of GDP (Gross Domestic Product) and is concentrated in the Southeast, particularly Sao Paulo State. Products include steel, commercial aircraft, chemicals, petrochemicals, footwear, machinery, automobiles and parts, consumer goods, cement, and lumber (Barry and Turner 2005).

On Brazil's mineral resources Bacon et al. (2004) details that mining in South-central Brazil is a historically important part of the economy, and mineral resources are extensive. Large iron and manganese reserves are important sources of industrial raw materials and export earnings. Deposits of nickel, tin, chromate, bauxite, beryllium, copper, lead, tungsten, zinc, gold, and other minerals are exploited. Brazil is a leading producer of hydroelectric power. Brazil also produces most of the oil and petroleum products for domestic consumption, with limited dependence on imports (Bacon et al. 2004:29).

Education

Approximately 85 percent of the population aged 15 or more years is literate. Primary education in Brazil is free and compulsory for children between the ages of 7-15 years. The state spends 10.9 percent of total state expenditure on education. Literacy has risen considerably from 82.0 percent in 1990 to 88.6 percent in 2004. Brazil's adult (15 years and older) literacy rate is higher than that for all medium-level human development nation states. The states' female literacy rate (88.8 percent) is fractionally higher than their male counterparts (88.4 percent) (World Bank 2003).

Health Sector

UNDP reported that in 2004, the state spent 3.4 percent of GDP on health, with private health expenditure at 4.4 percent of GDP, the latter representing 57.9 percent of all

health spending. Earlier in 2001 the state spending on health was 3.2 percent in 2001. With this increased in states' spending on health, health indicators have shown progress in the last 30 years, with increased life expectancy and decreased mortality rates. However regional differences in health outcomes persist with the lowest indicators in the Northeast and the highest in the South/Southeast. In 2004, 76 percent of the total population had sustained access to improved sanitation, and 90 percent had sustained access to an improved water source (UNDP 2006).

Brazil has a strong domestic pharmaceutical industry, with 500 companies and 47,000 employees. Brazil manufactures its own drugs like BCG, tetanus toxoid, yellow fever, human and canine rabies, and DPT/pertussis vaccine. Further the Brazilian state also enacted a constitution of treatment guarantee for every citizen in 1988. To facilitate the better implementation of the legislation, the federal government created the SUS (Sistema Único de Saúde, or Unified Health System) in 1990. SUS, which is mainly funded by social security contributions, is responsible for universal health promotion and care, including policy formulation, epidemiology, public health promotion, and disease treatment (Ministry of Health: 2001 quoted in Pembrey 2006).

Municipalities are mainly responsible for patient care and health promotion, whereas the state addresses disease prevention and ensures that municipalities have adequate resources to carry out their responsibilities. As per the Ministry of Health document, "Municipalities are also free to trade resources among themselves. Each municipality also has its own health council, responsible for evaluating local resources and evaluating health program needs. This evaluation system facilitates the eventual reallocation of financial resources and strengthening of the regional network that provides health assistance to the local population. Health councils at each level of government, comprising representatives from government, health professionals, and consumers, also regulate SUS activities at their respective levels. To integrate the different levels of responsibilities-municipal, state, and federal, there are two commissions in place: Comissao Intermanageres Tripartite (CIT) and Comissao Intermanageres Bipartite (CIB). These commissions integrate the above-mentioned

levels regarding resources, responsibilities, and program implementation". (Ministry of Health: 2001 quoted in Pembrey 2006).

Human Development

Brazil has made important steps in improving living conditions, as reflected in its Human Development Index (HDI). Brazil ranks 69th on the world HDI list. HDI scores for Brazil are increasing, from 0.647 in 1975 to 0.684 in 1980 to 0.699 in 1985 to 0.720 in 1990 to 0.749 in 1995 to 0.784 in 2000 to 0.792 in 2004 (UNDP 2006).

AIDS History and Incidence

The country's first AIDS case was recorded in 1982 in the state of Sao Paulo. Miners who travel between southern Venezuela and Brazil are believed to have introduced HIV and AIDS in areas close to the Venezuela border through sex with local women (Frasca 2005:195 quoted in Pembrey 2006).

A state report in December 2001 reports 520,000 cases of AIDS over the period 1988-2001 in Brazil. Since then, additional cases have been identified in other regions. In 2002, UNAIDS and the Brazilian Ministry of Health estimated that there were 610,000 Brazilians living with HIV and AIDS at the end of 2001, with adult prevalence at 0.7 percent (Ministry of Health Brazil 2002 quoted in Bacon et al. 2004). In July 2005, UNAIDS released revised country-level data, estimating that there were 660,000 Brazilians living with HIV and AIDS at the end of 2003, with adult prevalence at 0.9 percent (UNAIDS 2005).

As per a study by USAID, the HIV and AIDS epidemic in Brazil appears to be stabilizing. The study maintains that since 1999, all regions but the South has experienced a decrease in incidence of newly reported AIDS cases. The incidence of AIDS has remained stable over the last five years at around 20,000 new cases per year through 2001, the most recent year with complete reporting. HIV prevalence also

appears to be stabilizing across all sentinel surveillance studies conducted in the last four years, the study adds (USAID 2004).

Hacker et al. (2006) notes that states from the North and Northeast present the lowest rates and the smallest number of municipalities reporting AIDS cases, restricted to their respective capitals or main metropolitan areas. In the Central West, rates were found to be higher, and in some states such as Goiás and Mato Grosso do Sul, AIDS cases were spread across different municipalities. States located in the South and Southeast especially (São Paulo and Santa Catarina) contained the municipalities with the highest rates. In some municipalities (including several from the states of Santa Catarina and Rio Grande do Sul, Brazil's southernmost states), the AIDS incidence rates appear to be increasing. In Santa Catarina, the most heavily affected municipalities are Laguna, Joinville, Blumenau, Jaraguá do Sul, and Lages. In Rio Grande do Sul, the incidence has been increasing in all municipalities, with the single exception of Porto Alegre and Passo Fundo, where the incidence rates appear to have stabilized (Hacker et al. 2006:753-757).

Current Status

The current status of HIV and AIDS cases in Brazil when compared to previous figures is entirely different. Brazil shows an encouraging decrease both in terms of deaths due to AIDS and number of people living with HIV and AIDS. As per the report of UNAIDS presented in the International AIDS Conference in Toronto, out of total 186,112,784 population of Brazil (July 2005 est.), approximately 620,000 number of people are living with HIV and AIDS by the end of 2005. The report also says that 14,000 deaths are reported due to AIDS during 2005, which is far lesser than the previously recorded cases in Brazil. Further, the report estimates that by the end of 2005, only 0.5 percent of adults (ages 15-49) were living with HIV and AIDS. The number of women (ages 15-49) living with HIV and AIDS by the end of 2005 as per the study of UNAIDS is merely 220,000 (UNAIDS 2006).

Transmission Pattern

Based on AIDS case reporting, Bastos et al. (2003) maintains that the HIV and AIDS epidemic in Brazil has moved from men to women, from homosexual acquisition to heterosexual acquisition, from socio-economically more-advantaged to less-advantaged groups, and, to a lesser degree, from the cities of the industrialised Southeast into other parts of the country. (Bastos et al. 2003:137-144).

A report by Brazilian Ministry of Health (2005) states that in the early days of the epidemic AIDS cases are more concentrated among men who have sex with men, but with the passage of time there has been a shift towards heterosexual transmission, particularly to women in stable relationships with bisexual or injection drug-using male sexual partners (Ministry of Health Brazil 2005 quoted in Pembrey 2006).

Mesquita et al. (2001) gives a details account of this shift in transmission pattern. The authors note that heterosexual transmission is followed by transmission through injection of drugs. Injecting drug users (IDUs) accounted for a large proportion of HIV cases in the early stages of Brazil's epidemic. Quoting a study conducted in Santos, a port city in São Paulo state, they adds that among drug users HIV prevalence declined during a period when the preferred method of cocaine administration shifted from injecting cocaine to smoking crack, suggesting that needle-sharing had been contributing to the epidemic. Further this increased incidence of AIDS among IDUs is followed by a wave of sexually transmitted AIDS among their sexual partners, particularly women (Mesquita, F. et al. 2001:299).

The proportion of cases due to mother-to-child transmission remained roughly constant until 1999, accounting for 3-4 percent of cases; it fell to 1.7 percent in 2001. Later it witnessed a steady decline, this can be attributed to the availability of ARVs (Anti-retroviral drugs), which significantly reduce the chances of transmission occurring through this route (Levi et al. 2002:2373-2383).

Since the early years of the epidemic, the transmission of HIV and AIDS also saw a shift from more- to less-educated members of the population. In 1983, 50 percent of cases had completed university, whereas 25 percent had completed elementary school only. By 1998, 70 percent of cases had completed elementary school only, whereas less than 25 percent had a university education (Fonseca et al. 2002:678-685).

Knowledge and Awareness Regarding HIV and AIDS

The knowledge and awareness regarding HIV and AIDS varies among different population groups. Based on the public polling organization IBOPE findings, Bacon et al. (2004) states that there is an increase in condom use with casual partners, from 64 percent in 1999 to 76 percent in 2003, thus reflecting an increase in awareness about the deadly disease (Bacon et al. 2004:41).

Further the authors adds that among 17- to 19-year-old male personnels in the armed forces there was an increase in condom, from 38 percent to 50 percent, with generally higher rates of condom use in the South and Southeast and lower rates in the North and Northeast (Bacon et al. 2004:41).

On the basis of a study of 500 MSM (male having sex with male) the author states that there is a much higher rate of unprotected anal intercourse: 34 percent with steady partners and 28 percent with casual partners (Bacon et al. 2004:42).

According to the authors a number of studies shows that there is uniformly high levels of knowledge about HIV and AIDS transmission and prevention level, yet at the same time high rates of unprotected sex with both casual and steady partners have also been reported (Bacon et al. 2004:42).

Further studies among low-income and incarcerated youth show high levels of sexual activity, early sexual initiation, and generally high levels of HIV and AIDS knowledge

and awareness, particularly regarding routes of transmission and use of condoms and clean needles as prevention (Peres et al 2002 quoted in Bacon et al 2004:42).

A nationwide evaluation of HIV prevention programs for female commercial sex workers revealed high levels of knowledge and awareness, but significant barriers to implementing safe-sex practices, including fear of violence, increased payments for unsafe sex, and competition for clients. In addition, non street-based CSW (commercial sex workers) reported more safe sex practices than did street-based CSW (Andrade et al 2002 quoted in Bacon et al 2004:43).

Discourse Around HIV and AIDS

AIDS had been the focus of little attention in Brazil-since no confirmed cases were reported prior to 1983, when the disease was already reaching nearly epidemic proportions in the United States and Europe. Until that time many Brazilians, who were influenced by the local news media, saw AIDS as a rather peculiar disease affecting the wealthy homosexual population of the United States. Even the federal state initially viewed it as a health problem mainly associated with the affluent gay community and was mainly attributed as a gay cancer or gay plague (Parker 1987:155). State had taken no significant action in response to the epidemic. There was no adequate national programme for controlling the epidemic, which in turns fuel the statistics of number of AIDS cases. Gauri and Lieberman (2004) in their paper notes that, early in the epidemic, within the Ministry of Health in Brasilia, some officials argued that AIDS did not satisfy the epidemiological criteria of transcendence, magnitude, and vulnerability necessary to warrant a response from public institutions.

This view changed radically, however, from 1983 onwards when alarming cases of AIDS had been reported in Brazil. AIDS was beginning to be recognized as a significant health problem. Media played a vital role in presenting the severity of the situation, when it comes up with the report attributing the death of some famous

personalities with AIDS. A completely new discourse around HIV and AIDS develops amongst the Brazilians. They now began to recognize the fact that AIDS is not more a disease of others. From that time on, AIDS began to inch its ways into Brazilian consciousness in a new way-increasingly less distant, increasingly closer to home (Parker 1987:156).

The situation in Brazil has continued to worsen alarmingly, despite of states various measures to deal with it. By that time, Brazil moved into fourth place behind United States, France and Haiti in the list of nations with highest number of confirmed AIDS cases. Recognizing the severity of the situation the state began to address the epidemic on war footing. This was the period from 1985 and onwards. Dramatic changes occurred into the discourse surrounding HIV and AIDS. AIDS was seen not only as a health problem but was linked as a political as well as an economic problem or more we can say a national problem (Ortells 2003). This shift in discourse marks the Brazilian successful response to the AIDS epidemic, which later on became a model for rest of the developing states struggling in combating the new millennium pandemic.

State Response

Brazil's response to the HIV and AIDS epidemic emerged in the mid-1980s in the context of a decade of political transition and economic turbulence, when Brazil experienced democratisation, the gradual reconstruction of civil society, and the formulation of a new social agenda for issues such as education and health. It was at just this time that Brazilian newspapers began describing a 'new disease' and the first AIDS cases were reported in the country (Meneses 1983 quoted in Bacon et al. 2004:52). The Brazilian state launched number of programmes, include guaranteed human rights for PLWHAs (people living with HIV and AIDS), testing and treatment facilities, education initiatives, and disposable syringe and condom promotion programs. These programs have all proved successful (Okie 2006).

Early responses to the epidemic came from NGOs advocating for the rights of populations initially affected by the epidemic, particularly gay men. Since then the organisations of the civil society, mainly those organisations of people dealing with HIV and AIDS have been key partners of the Brazilian state in order to contribute to the accomplishment of policies of assistance, prevention and human rights. (Brazilian Ministry of Health 2001 quoted in Pembrey: 2006).

At the state level, in 1983 the first governmental AIDS program the São Paulo State AIDS Programme was set up in São Paulo. In 1985 Brazil established the first AIDS bureaucracy in the form of National AIDS Program (NAP) within the Ministry of Health. Further in 1988, the inter-ministerial National Commission to Control AIDS was established. The Commission was mainly comprised of representatives from Ministries of Education, Labour, and Justice, the principal association of lawyers in Brazil, various universities, and four NGOs. The NAP assumed significant authority when in 1992 with the aid of World Bank its complete autonomy was ensured. Thus since 1992 the NAP has been responsible for the formulation of AIDS policy (Brazilian Ministry of Health 2001 quoted in Pembrey: 2006).

The goals of the states' AIDS program include the continued roll-out of the treatment program, continued reduction in the costs of drug and supply acquisition, continued access to treatment of opportunistic infections, and continued decentralization of the program through involvement of state and local governments and civil society, as well as an improvement in monitoring and evaluation of the program's accomplishments and shortcomings. This exists alongside efforts to improve the funding of the national health care system in general (Brazilian Ministry of Health 2001 in Pembrey: 2006).

What makes Brazilian response a model state response?

While many countries have struggled to curb the spread of HIV and to care for those affected by it, Brazil's response has been seen as a success story. Working alongside civil society groups, the Brazilian state has made aggressive efforts to minimize the

impact of the epidemic. By the end of 2005, 620,000 Brazilians were living with HIV, half the number that estimates in the previous decade had predicted. The number of people dying from AIDS-related illnesses has also fallen by 50 percent and HIV-related hospitalizations have decreased by 70-80 percent since the late 1990s (UNAIDS 2006).

Today the National AIDS Program is committed to the following principles which help the state in producing an effective response too the AIDS epidemic:

➤ **Guaranteeing the human rights of people living with HIV and AIDS and universal and free access to HIV and AIDS treatment, including antiretroviral**

One of the most important lessons from Brazil is its defence of human rights as a paradigm of health. In 1988, Brazil enacted a federal constitution which recognized the right to healthcare. Under this principle, Brazilian citizens with HIV have the right to treatment, just like those with tuberculosis. The principle further ensures that all Brazilian citizens receive health services for free, including people with HIV, people who have an HIV-related opportunistic disease, and people already in the AIDS stage. As a result, in the history of the response to the HIV pandemic, Brazil is best known for its pioneering decision in 1996 to offer free combination antiretroviral therapy to all citizens with AIDS. Today, in Brazil, access to treatment has progressed from being regarded as a legal right to being recognised as an absolute human right, by the state at all levels (Okie 2006:1978).

Alongside free distribution of ARVs (anti retro-viral drugs), the ability of the Brazilian state to reduce the procurement costs of ARVs has been crucial to the success of the national HIV program. This has been made possible by the local production, by public health labs in Rio de Janeiro, of seven of the ARVs currently available in Brazil. For drugs that are not manufactured locally, Brazil has sought to negotiate the best possible prices with international drug companies, using the ability to break patents and produce drugs domestically as leverage to overcome resistance (Langevin 2005).

Another indicator of the success is people's adherence to treatment. Following the prescribed treatment is both vitally important and easily forgotten; people are prone to stop treatment for medical problems as soon as they see the first sign of improvement. But in the case of antiretroviral therapies, a failure to follow the regime can be fatal, causing the virus level in the blood to increase drastically. Since these therapies require people to take several pills a day for life, adherence is often a challenge for models seeking successful treatment. In Brazil the adherence rate has been reported about 60-70 per cent (Ortells 2003:64).

➤ **Working in partnership with civil society and Catholic Church**

Okie (2006) notes that the involvement of civil society, Catholic Church and the people living with HIV and AIDS by the state in the fight against also provides an interesting lesson for the rest of the world. The author adds that this partnership have ensured that stigma and discrimination have been reduced, human rights have been taken into account, moral and religious views have not impeded prevention campaigns and the state has acted swiftly.

➤ **A strong focus on condom promotion**

The Brazilian state has vigorously promoted the use of condoms through media campaigns, advertisements and other prevention initiatives. The NAP develops a number of different strategies to increase the spread of condom use. These include, the manufacture and distribution of generic condoms, the reduction of taxes on condoms, and agreements to be drawn up with manufacturing companies, distributors and retailers in order to reduce the profit margins on condom sale. Besides the male condom, the Brazilian NAP also distributes female condoms. In 2002, the authorities acquired 4 million units and the distribution is aimed at women's health programs, drug users or partners of drug users, sex workers and HIV positive women (Okie 2006).

In 2005, a study of Brazilian adults revealed that 35 percent used a condom during the previous year, compared with 24 percent in 1998. The increase in condom use has not only occurred among the general population, but also among HIV-positive people (Okie 2006).

➤ **A commitment to fighting stigma and discrimination**

Globally, stigma has widely been recognized as a contributing factor to the spread of HIV. Fear of discrimination stops people going for HIV tests, causes denial in communities and can prevent HIV-positive people from admitting their status or from accessing medication. Brazil is a rare example that has managed to minimise this problem. The state has shown vigorous commitment to protecting the rights of marginalised groups who may be affected by HIV and AIDS, such as sex workers, gay men, and drug users. It has also been generous with funding to groups of people living with HIV and AIDS, as well as events such as gay pride marches, which encourage people to respect sexual diversity (Berkman et al 2005).

➤ **Greater emphasis on Universal HIV testing and care**

Encouraging people to access testing is also an important part of Brazil's successful HIV prevention, as HIV-positive people who are aware of their status are less likely to pass infection on to other people. People who test positive can also be directed to support and treatment, and given advice for the future. HIV testing in Brazil either takes place through public health facilities such as hospitals or through centres that provide voluntary counselling and testing. Since the mid-1990s, the availability of ARVs has given people more incentive to get tested and has led to testing becoming more popular and more widely available. Between 1997 and 2002, both the number of VCT centres and the number of HIV tests carried out through the public sector doubled (Bacon et al 2004:55).

The Brazilian state has used media campaigns to promote universal HIV testing. The central message of these campaigns is that everyone should know their status. One major initiative, known by its slogan 'Fique Sabendo' ('Be in the Know'), enlisted the help of models and other celebrities to promote testing (Bacon et al 2004).

➤ **Humanising globalisation**

Although AIDS has always been termed as a 'disease of globalisation'. At the same time, globalisation also creates unprecedented opportunities to advance human welfare, even for those marginalized and impoverished by many of its economic structures and political institutions. This was precisely the globalisation advocated by Brazil as, globalisation of access to global public goods for the benefit of all, for the benefit of the poor, for the least powerful.

Brazil's global leadership in the fight against AIDS demonstrates this promise of globalisation. Based on its constitutional recognition of the right to health and its own battle with AIDS, the nation has ultimately managed to galvanise human cooperation and solidarity across borders and institutions. The state played a leading role in creating the UN Global AIDS, Tuberculosis, and Malaria Fund. UNAIDS has recognized Brazil's influence in global and regional policies and its pioneering treatment with generic drugs as important factors in the increased global access to treatment that has occurred in recent years. The new paradigm adopted during the UN General Assembly's Special Session on HIV and AIDS, which includes an integrated prevention and treatment focus, was based on the Brazilian experience. Brazil's effective lobbying with the international community has played a pivotal role in the following series of declarations and actions (Ortells 2003:72-73):

- The approval of Resolution 33/2001 by the United Nations Commission on Human Rights during its 57th session, establishing access to AIDS drugs as a basic human right.

- The approval of Brazil's May 2001 proposal to the World Health Organisation on the need to have drugs at accessible prices available to all people living with HIV.
- The commitment signed at the UN General Assembly Special Session on HIV and AIDS in June 2001, which reiterates the need for a holistic approach including prevention, care, treatment, and the protection of human rights.
- The establishment of the UN Global AIDS, Tuberculosis, and Malaria Fund, which guarantees equal participation in resource administration to rich and poor countries and thus constitutes a unique case among international funds. The Global AIDS Fund will also finance projects that include distribution of antiretroviral drugs.
- The declaration of the WTO's Fourth Inter-Ministerial Conference, held in Doha, Qatar, in November 2001. This declaration, promoted by Brazil and other countries, defends the pre-eminence of public health above intellectual property rights.

Besides, effective leadership, setting up of National Welfare system, HIV prevention in prisons, protection of AIDS orphans etc. forms the bases of Brazil's successful response to HIV and AIDS (Gauri and Lieberman 2004).

Conclusion

The HIV and AIDS epidemic is the greatest epidemic in the whole history of humanity and, faced with this immense challenge, there is no room for inertia, indifference or arrogance. The chapter demonstrates that Brazil has handled HIV and AIDS problems with much innovation and effectiveness, thereby creating good practices that other states can learn from. The major elements of Brazil's successful state response are;

- Highly decentralized political institution to ensure the rapid progress and development of public health policies.

- A strong relationship between the government and other civil society groups including Catholic Church.
- The provision of free treatment to all, and aggressive efforts to minimize the cost of antiretroviral drugs.
- The innovative and mass broadcasting of prevention strategies.
- A strong focus on minimizing stigma and discrimination and encouraging a culture where people living with HIV are not looked down upon.

The remarkable improvement in HDI also reflects the states' seriousness towards the human welfare issues, which in turn makes the state more responsive towards any untoward human calamity as evident in case of state response to the AIDS epidemic.

Besides the factors like sizable population, more tolerant and open culture, a stable economy and political set up and the healthy condition of education and health system in the state did contribute a lot in making the state response timely and more effective.

It is high time that the states severely affected by the new millennium pandemic must draw lessons from Brazil's experience in order to save lives.

".....We should no longer be guilty of the health of our people".

(Source: M.K. Gandhi 1940 quoted in Amrith 2007)

CHAPTER III

The AIDS Epidemic and the State Response in India

India carries the dubious distinction of being home to the world's largest number of people living with HIV and AIDS. Despite a substantial response from the state and huge in flow of resources over the past few years for the prevention, treatment and care of HIV and AIDS affected people, the UNAIDS figures shows that India harbours highest number of HIV and AIDS cases with 5.7 million surpassing South Africa (UNAIDS 2006).

This chapter examines the state response to the AIDS epidemic right from the inception of the disease to this date and will list some of the lacunae in the state response making it a case of comparative failure. The chapter will begin by briefly outlining the socio-economic and political condition as well as the state of health in India for better understanding of the emergence of current crisis. In doing so the chapter will analyse the state commitment in combating the AIDS epidemic.

Introduction

India is a sovereign, democratic and secular republic, bounded in the northwest by Pakistan; in the north by China (Tibet), Nepal and Bhutan; in the east by Myanmar; and in the southeast, south and southwest by the Indian Ocean.

It covers an area of 32, 87, 263 sq km (Mohammad 2003:4), extending from the snow-covered Himalayan heights to the tropical rain forests of the south. As the seventh largest country in the world, India stands apart from the rest of Asia, marked off as it is by mountains and the sea, which give the country a unique geographical entity. Bounded by the Great Himalayas in the north, it stretches southwards and at the Tropic of Cancer tapers off into the Indian Ocean between the Bay of Bengal on the east and the Arabian Sea on the west (Mohammad 2003:9).

The climate of India may be broadly described as tropical monsoon type. In general, there are four seasons; the cool one lasts from December to March, the hot season is in April and May, the rainy season is June to September followed by a further dry season

until November. Rainfall however varies considerably, from 100 mm in the northwest desert to over 10,000 mm in parts of northeast (Mohammad 2003:39).

India is a secular state; any worship is permitted, but the state itself has no religion. The principle religions are Hindu 80.5 percent, Muslim 13.4 percent, Christian 2.3 percent, Sikh 1.9 percent, other 1.8 percent and unspecified 0.1 percent (Country Reports 2007).

English enjoys associate status but is the most important language for national, political, and commercial communication; Hindi is the national language and primary tongue of 30 percent of the people; there are 21 other official languages.

India is a republic and comprises of twenty-eight states and seven union territories. All states, the union territory of Pondicherry, and the National Capital Territory of Delhi have elected governments. The other five union territories have centrally appointed administrators.

Population

India's population as on 1 March 2006 stood at 1.028 billion (532.1 million males and 496.4 million females). It accounts about 16.7 percent of the total world population (Country Reports 2007). Having been invaded numerous times over thousands of years, India has absorbed many influences. Despite that religious and ethnic tensions persist, India is remarkably diverse in terms of language, ethnicity, religion, and culture. Religion, caste, and language are major determinants of socio-political organization. The predominant ethnic group is Indo-Aryan (72 percent), followed by Dravidian (25 percent) (Country Reports 2007).

Nearly 72.2 percent of the population is rural (Goa having the most urban state at 49.8 percent and Himachal Pradesh the most rural at 90.2 percent). More than 45 percent of

India's populations are under 20. Twenty-eight percent of India's population lives in urban areas (comprising about 200 towns and cities) (Country Reports 2007).

Culture

India has one of the richest and most exciting cultures. The Indus Valley civilisation is one of the oldest civilisations in the world. Aryan tribes from the northwest infiltrated onto Indian lands about 1500 B.C., their merger with the earlier Dravidian inhabitants created the classical Indian culture. Later on, the invasion by Turks followed by British colonialism has resulted in the emergence of most unique diversified Indian culture (Barry and Turner 2005).

As compared to the cultures of the west population, the Indian culture is more traditionalist and is mostly driven by strong societal and cultural norms like monogamy, universal marriage, virtual non-existence of homosexual behaviour, mother goddess worship, and societal proscriptions against an explicit focus on sex and sexuality in public social interactions and discourse,

Politics and Economy

India is a sovereign, socialist, democratic republic democratic state with executive power vested in the President. The president serves for 5 years and is elected by the members of Electoral College consisting of members of both the houses of parliament and the elected members of the legislative assembly of states. There is an elected council of Ministers with the Prime Minister as the head to aid and advise the President.

Prior to independence India witnessed a series of foreign rules. Those of European traders, beginning in the late 15th century, followed Arab incursions starting in the 8th century and Turkish in the 12th. By the 19th century, Britain had assumed political control of virtually all India lands. Non-violent resistance to British colonialism

brought independence in 1947. The independence from the British rule also marks the division of the Indian subcontinent. The subcontinent was divided into the secular state of India and the smaller Muslim state of Pakistan. A third war between the two states in 1971 resulted in East Pakistan becoming the separate nation of Bangladesh (Mohammad 2003:3-4).

In the later decades India faces burning problems such as the ongoing dispute with Pakistan over Kashmir, massive overpopulation, environmental degradation, extensive poverty, and ethnic and religious conflict.

India's diverse economy encompasses traditional village farming, modern agriculture, handicrafts, a wide range of modern industries, and a multitude of services. Services are the major source of economic growth, accounting for half of India's output with less than one quarter of its labour force. About three-fifths of the work force is in agriculture. The economy has posted an average growth rate of more than 7 percent in the decade since 1994, reducing poverty by about 10 percentage points. India achieved 7.6 percent GDP growth in 2005, significantly expanding manufacturing (Knox, P. and Agnew, J. 1998).

Land and Resources

The physical form of the Indian subcontinent is the result of vast geological subcontinent. India is mainly composed of three major landforms (Mohammad 2003:14), the peninsular plateaus (Central highlands, Peninsular plateaus, Coastal plains, Islands), the Himalayan mountains (Northern mountains), and the Indo-Gangetic plains (Great Plains, Thar Desert).

India is an agricultural state. About seventy percent of the population depends on agriculture. One-third of the national income comes from agriculture. India ranks first in the world in the production of tea and groundnuts. It ranks second in the world in the production of rice, sugarcane, jute and oil seeds (Sharma 2002:32).

India is quite rich in minerals. India has huge deposits of iron-ore in Jharkhand, Orissa, Madhya Pradesh, Karnataka and Maharashtra. It accounts for one-fourth of the world's finest iron-ore deposits. Coal also forms an important mineral resource in the country. Bihar and West Bengal are the largest coal deposits in India. Beside these, India has rich deposits of mica, manganese and bauxite (Sharma 2002:45-47).

Education

The overall literacy rate of India is quite encouraging as compared to other countries of the continent and has shown increase in the level of literacy rate with 49.3 percent in 1990 to 61.0 percent in 2004. The total state expenditure on education is 10.7 percent. However, the literacy rate varies significantly by states and union territories. Mizoram topped the literacy rate with 90 percent followed by Kerala with 87 percent. The state of Bihar shows the lowest literacy rate with 23 percent and Rajasthan and Uttar Pradesh with slightly higher 25 and 30 percent respectively (UNDP 2006).

There are also acute gender disparities in literacy and education. The percentage of women literacy rate is much lesser than the men counterparts with 47.8 percent in females and 73.4 percent in males. Moreover, compared with boys, girls are more often kept at home (UNDP 2006).

Health Sector

Health status in the state is generally low compared to industrialized countries. Amrith (2007) quoting a report by UNDP (2004), notes that since independence the Indian state has spent a smaller proportion of its resources on public health than just about any state in the world. A direct outcome of this situation is that access to health care is poor for a large section of the society, which lives in poverty and in areas remote from primary health care centres (World Bank 2003).

In addition, the country bears a heavy burden of both communicable and non-communicable diseases. There are numerous challenges within the health sector, including the less number of medical and para-medical staff than that required by prescribed norms, the poor infrastructure and the generally poor quality of services delivered by both the public and private sectors. A high proportion of the population continues to suffer and die from preventable infections, pregnancy and childbirth-related complications, and malnutrition (Amrith 2007:114-121). Moreover, in July 2003, the World Bank noted that India's progress in health indicators has been slowing down sharply (World Bank 2003).

Further the World Bank (2003) document reports that the public health facilities suffer from poor management, low-quality service, and underfunding. In public health facilities, the availability of medicines is frequently negligible. The equipment in many public hospitals is often obsolete and unusable, and infrastructure is dilapidated.

State expenditure in the health sector is also very poor and is declining day by day. In the period prior to liberalisation, grants to the states from the central for the health sector comprised 19.9 percent of the states' health expenditure. However, following liberalisation, this component of central grants fell to 1.2 percent of GDP in 2004. This decline is most noticeable in the case of specific-purpose central grants for public health and disease control programs. The other component of health expenditure, family welfare, also faced a decline of central grants. There is also large variance in health financing among Indian states, and the gap between rich and poor states regarding public resources for health is increasing (UNDP 2006).

Human Development

The HDI of India shows an encouraging increase as compare to the statistics of previous years and now India has climbed to the 126th rank on the world HDI chart. The HDI increases from 0.413 in 1975 to 0.439 in 1980 to 0.477 in 1985 to 0.515 in 1990 to 0.548 in 1995 to 0.577 in 2000 to 0.616 in 2004 (UNDP 2006).

AIDS History and Incidence

The first case of HIV infection in India was reported among commercial sex workers in Chennai, the capital of southern state of Tamil Nadu in 1986 (Shaukat and Panakadan 2006:158 quoted in Narain 2006). Soon after HIV infection and AIDS cases have been reported from almost all the states and union territories of the state. There was rapid spread of the epidemic from urban to rural areas and from high-risk groups to the general population. Studies in selected areas of the state among certain groups now reveal that the epidemic has developed as rapidly in India as was observed in some African countries in the mid-1980s (UNAIDS 2002).

Initially, HIV spread among female sex workers and their male clients, STI clinic patients, and professional blood donors. It subsequently began to spread among populations including women attending antenatal clinics. By 1990, HIV prevalence among sex workers in Maharashtra and among IDUs in Manipur had surpassed 5 percent. By 1994 in Maharashtra, HIV was no longer restricted to these subpopulations, but had spread to the general population. HIV was also spreading in Gujarat and Tamil Nadu, where prevalence among high-risk groups was over 5 percent (UNAIDS 2002).

As per the UNAIDS (2002) report, by the year 1998 HIV had spread rapidly in the four large southern states, not only within high-risk groups but also in the general population, where it was over 1 percent. Infection rates among women attending ANCs (Anti-natal clinics) were 3.3 percent in Tamil Nadu and 5.3 percent in Manipur. Among IDUs in Manipur, HIV prevalence was 76 percent and in Mumbai, 64.4 percent.

In 1999, HIV prevalence in the ANC survey in Tamil Nadu had risen to 6.5 percent. In some Mumbai sites, about 60 percent of sex workers were infected with HIV. HIV infection among STI patients was 30 percent in Andhra Pradesh and 14 to 60 percent in Maharashtra (UNAIDS 2002).

By 2001, an estimated 15 to 35 percent of truck drivers nationwide were HIV-positive. HIV prevalence in the general population had surpassed 1 percent in six states (Maharashtra, Manipur, Andhra Pradesh, Tamil Nadu, Karnataka and Nagaland). These states accounted for 75 percent of the country's estimated HIV cases (UNAIDS 2002).

Current Situation

India is experiencing rapid and extensive spread of HIV. This is particularly worrisome since India is home to a population of over 1 billion. As a single nation it has more people than the continents of Africa, Australia and Latin America combined. The situation is graver in states like Tamil Nadu, Maharashtra, Andhra Pradesh and Karnataka. A report by World Bank released at the 16th International AIDS Conference says that India is home to 60 percent of South Asia's HIV patients. The NACO and UNAIDS paints a contrasting pictures of HIV and AIDS estimates in India. According to the estimated figure of the UNAIDS (United Nations Programme on HIV/AIDS) and WHO (World Health Organization), the number of people living with HIV and AIDS by the year 2006 is projected at 46 million. An estimated 4.1 million became newly infected with HIV and an estimated 2.8 million lost their lives to AIDS. Out of this 46 million, it has estimated that India alone has 5.7 million as compared to 5.3 million in 2003 (UNAIDS 2006). The UNAIDS statistics reveals that India is the most infected country surpassing South Africa. However, as per Indian state statistics, India homes 5.5 million next to South Africa with 5.7 million people living with HIV and AIDS (The Times of India, 03/06/2006).

The UNAIDS report estimates that 5.6 million adults aged 15 and over are living with HIV and among them the number of women (aged 15 and above) living with the virus is estimated as 1.6 million roughly 1.0 million ahead of the number recorded in 2003. The report further says that by the end of 2005 number of deaths due to AIDS lies within the range of 270000-680000 (UNAIDS 2006).

According to NACO's latest estimate, the state has an estimated 2.5 million people living with HIV and AIDS, about 3 million fewer cases than previously estimated. The prevalence of HIV in the general population is now 0.36 percent against 0.9 percent as earlier believed (Sinha, 2007). This makes India the third worst affected state with the deadly disease after South Africa (5.5 million) and Nigeria (3.1 million). Till now India was placed in second place by the state with 5.5 million and in first place by UNAIDS with an estimated 5.7 cases.

Transmission Pattern

The predominant mode of transmission of the HIV infection in India is through heterosexual contact (85.7 percent), followed by injecting drug use (2.2 percent), blood transfusion and blood product infusion (2.6 percent), prenatal transmission as 2.7 percent and others as 6.8 percent (Narain, 2006:161-163).

A report by NACO (2001) states that HIV is spreading beyond at risk groups to the general population, and from urban to rural areas. The number of women infected is steadily raising i.e. one in every four AIDS cases reported is a woman. It is increasingly affecting young people in the sexually active age group. The majority of the HIV infections (87.7 percent) are in the age group of 15-44 year.

The spread of HIV within the state is as different as the societal patterns between its different regions, states and metropolitan areas. The epidemic varies, from states with mainly heterosexual transmission of HIV, to some states where injecting drug use is the main route of HIV transmission (NACO 2001).

In 2003 in yet another study, NACO announced that there has been decline in HIV transmission through blood/blood products from 6.07 percent in 1999 to 2.99 percent. NACO also announced that HIV transmission via IDU had also declined, from 5.29 percent of new infections in 1999 to 2.87 percent. At the same time, the study also

proclaimed that the percent of mother-to-child transmission had increased, from 0.33 percent in 1999 to 2.61 percent (NACO 2004).

Recent survey conducted by anthropology Department of Delhi University in two cities, Lucknow and Delhi, reveals that commercial sex workers cause almost 43 percent of HIV infections. The study adds that the rate of heterosexual transmission of the virus outnumbered other modes and a large number of male patients got infected from commercial sex workers. The second highest mode of the infection as per the study is through blood and blood products (Kaushika 2006).

The pattern of HIV transmission also differs among different states. Maharashtra, Tamil Nadu, Karnataka, Andhra Pradesh, Manipur and Nagaland forms the high prevalent states. In these states heterosexual transmission reportedly accounts for the majority of HIV infections whereas injection drug use has been driving the epidemic in Manipur and Nagaland. However, prevalence among IDUs is also high in Tamil Nadu and Maharashtra. Besides eight states (Uttar Pradesh, Bihar Rajasthan, Madhya Pradesh, Chattisgarh, Jharkhand, Uttranchal, Goa and Orissa) are attributed as low HIV prevalent states. Nevertheless recent studies reveal that these states are also becoming more vulnerable (UNAIDS 2006).

Further the UNAIDS (2006) document states that there is a marked increase in HIV prevalence among men who have sex with men (MSM) in India. In 2001, MSM prevalence was 24 percent in Mumbai (Maharashtra) and 2.4 in Chennai.

Knowledge and Awareness Regarding HIV and AIDS

According to a study by NACO overall awareness of HIV and AIDS in India varies among states and union territories with higher degree of awareness among populations in states of Kerala, Maharashtra, Tamil Nadu, Karnataka, Andhra Pradesh, Goa and Delhi. However, the knowledge about the epidemic was far less in states of Bihar, Rajasthan, Uttar Pradesh, Punjab and Madhya Pradesh (NACO 2001).

There were also major urban-rural differentials: 89 percent of urban versus only 72 percent in rural areas. Further awareness of AIDS was particularly low among women than man (NACO 2001). The study maintains that awareness among sex workers, homosexuals, and IDUs is much higher than in the general population. The study reports that overall, 94 percent of sex workers reported that they had heard of HIV and AIDS.

Further it adds that among homosexuals, 97 percent reported awareness of the disease, with relatively little variation among large cities: 99 percent of MSM in Mumbai (Maharashtra), 98 percent in Chennai (Tamil Nadu), 96 percent in Bangalore (Karnataka), and 94 percent in Calcutta (West Bengal) reported that they had heard of HIV and AIDS. The overall knowledge of HIV and AIDS among IDUs in India is 97 percent, with 100 percent reporting knowledge in Manipur, 98 percent in Chennai, 96 percent in Calcutta, and 95 percent in Mumbai (NACO 2001).

India has an enormous population of young people, with about 385 million people under age 15. Among reported AIDS cases to date, those under age 30 represent 39.7 percent of cases. In a study by MAMTA Health Institute for Mother and Child, it reported that knowledge among adolescents regarding safer sex and condoms is inadequate and inconsistent. In yet another study FXB India highlighted that adolescent girls are highly vulnerable to HIV given their lack of sexual and HIV and AIDS education (Ekstrand et al. 2003).

Belaku Trust and India's National Institute of Mental Health and Neurosciences deployed a cross-sectional survey of 1,500 rural and semi rural 14- and 15-year-old school-going adolescents in south India. They found strong gender disparities in HIV and AIDS knowledge, information sources, and consequences of sex. Although overall knowledge of HIV and AIDS was low, rural residence, being female, and low socioeconomic status was correlated with low awareness of HIV transmission and prevention (Ekstrand et al. 2003).

Discourse around HIV and AIDS

The discourse around AIDS in India has taken a long while to come to terms with the attention required of it and is, today, still at an incipient stage. During the 1980s when the AIDS virus was attaining an epidemic proportion in Africa, the Indian state made completely ignorant stand on the episode. Even when for the first time AIDS cases were reported in United States in early 1980s, the state was the negative centre of attention with respect to HIV and AIDS (Suneetha and Barnett 2004).

Soon after its spread across the globe, some debates over AIDS initiated in the state. The print media and other sources started bringing reports on AIDS and its dreadful consequences from the affected states (Suneetha and Barnett 2004). However, the Indian state took refuge in postures of denial, on the grounds that AIDS was a foreign disease. Further the belief that traditional social norms makes the state less vulnerable to such an epidemic; the existence of HIV and AIDS was highly ignored and in many cases the disease was implicated as a disease of sex workers and their clients (Karnik 2001:338).

When the first AIDS case was isolated in 1986 in a commercial sex worker, the official response was one of treating AIDS as a problem of vigilance by law and order agencies-suspicion of foreign visitors, confinement by some state governments of individuals (e.g. blood donors, sex workers) found to be HIV positive to prevent them from infecting the rest of society (Karnik 2001:338).

In 1990's when the epidemic was at its initial stage, the Indian state spent more money trying to prove it did not have an HIV and AIDS epidemic than it did on actual prevention. By the mid 1990s, the report of AIDS cases from different sections of the population had given way to an attempt to attribute it as a medical problem. Thus, the virus was viewed generally as well as officially, a health problem, which further worsens the situation.

It is only since 1992 that there has been a serious effort to put into place an infrastructure at state level for tackling the problem of AIDS. A shift in the discourse around AIDS surfaced at least in official circle but still there was gap among general discourse. The epidemic was treated more as a health problem and in more technical term, an economic problem that continues for decades as up to now. As in Brazil where the epidemic was treated as a national problem, India stands far in making such attribution.

State Response

Soon after reporting of the first HIV and AIDS cases in the state in 1986, the state took steps to target screening and prevention efforts to populations at high risk of infection. A high-profile National AIDS Committee was launched, and in 1987 a National AIDS Control Programme (NACP) was established. The programme stressed on surveillance, screening of blood and blood products, and health education (Sankaran 2006:13). By this time, the HIV and AIDS had already attained an epidemic status in the African region and were rapidly spreading in other parts of the world.

Realizing the intensity of the epidemic, the Indian state with the support of World Bank established National AIDS Control Organization (NACO) in 1992 to enhance the ongoing programmes. The same year that NACO was established the state launched NACP I under which State AIDS Control Societies were set up. The purpose of the setting up of State AIDS bodies was to carry out the NACO's AIDS control programmes. NACO's initial efforts were to control sexually transmitted diseases, to promote condom use, to provide testing, counselling, care and support for people with HIV and AIDS, to conduct surveillance, and minimizing harm for injecting drug users, to provide blood safety and blood products and supporting research and product development (NACO 2004).

The phase II (1999-2004) of the NACP was launched on December 15, 1999, and received support from the World Bank, the British Government's Department for

International Development (DFID), and the United States Agency for International Development (USAID). Under its second phase, NACO has decentralised its programmes. NACO grants funds to state AIDS control societies for targeted interventions, blood safety, IEC, youth campaigns, VCT, care and support, and social mobilization. The state AIDS control societies, in turn, contract with over 600 NGOs to implement numerous programme activities. NGOs and associations of PWHA are represented on the executive committees of State AIDS control societies. At the district level, district nodal officers are appointed to oversee implementation of AIDS activities. Some of the specific areas of state response as detailed in a document of NACO are blood safety, control of sexually transmitted diseases, care, treatment and support of people living with HIV and AIDS, condom promotion and school AIDS education programmes (NACO 2004).

When the work on this dissertation was completed the Indian state was about to launch the much-hyped Rs. 11,585-crore phase III (2007-2012) of the NACP. The programme has been designed in consultation with a large number of donors and civil society organisations. The overall goal of the programme is to halt and reverse the epidemic in India over the next five years by integrating programmes for prevention, care, support and treatment (Chhabra 2007:106-107). The main strategies of NACP III are;

- Preventing new infections in high-risk groups and general population.
- Providing greater care, support and treatment to PLHAs.
- Strengthening the infrastructure systems and human resources in prevention, care, support and treatment programmes at the district, state and national level.
- Strengthening the nationwide Strategic Information Management System.

However the efforts remain in a dead letter as no serious steps were taken for effective implementation. Even the prime HIV and AIDS control measure like making HIV screening mandatory in all blood banks initiated only due to the landmark Supreme Court directive in 1996.

Still after more than two decades of HIV and AIDS in India, the issues and concerns remain unaddressed. NACO's initiatives were inadequate in combating the new millennium pandemic and are focused mainly on urban populations rather than rural. Its reluctance to intervene in prevention efforts in rural areas has in a way increased the epidemicity as the rural populations are more vulnerable and large proportion of Indian population resides in these areas. The epidemic is gradually getting concentrated in rural areas with 58 per cent infections being reported from villages. According to Dr. Meenakshi Datta Ghosh, HIV and AIDS is no longer affecting only high-risk groups or urban populations, but is gradually spreading into rural areas and the general population (Pembrey 2006). One can also find an interesting dichotomy in state response in terms of HIV and AIDS awareness programmes. The state run awareness programmes are more concentrated in urban areas as compared to rural areas. Thus increasing susceptibility and lack of community participation in HIV and AIDS prevention programmes.

NACO's commitment in dealing with children and women living with HIV and AIDS is quite dismal as there are no specific guidelines for the treatment, care, and support of HIV positive children and women. As per UNAIDS (2006) report, approximately 700,000 children become infected with HIV and 95 percent of children got the infection from their mothers. The report also reveals an alarming increase in the number of women with HIV and AIDS, reflecting the greater vulnerability of women to HIV and AIDS, especially in rural areas. There are about 16 lakhs women aged 15 and above living with HIV. Despite of these burgeoning statistics, NACO's responses were far short to meet the demands and in their policies, women and children with HIV remains a neglected face.

The AIDS control mechanisms are not well integrated with the basic public health care infrastructural facilities. Surveillance of HIV and AIDS is the weakest link in the health infrastructure and preventive strategy. HIV and AIDS surveillance has been always accorded low priority in national planning and resource allocation causing discrepancies in surveillance mechanisms. Thus resulted in inappropriate

epidemiological data causing confusions in policy planning vis-à-vis policy failure. Epidemiological data remains a major weakness affecting policy planning and even today tell us virtually nothing about what is happening in the rural areas. At the same time, there are discrepancies in the surveillance facilities between the more urbanized and less urbanized states. The more urbanised states like Maharashtra, Tamil Nadu and Karnataka have greater concentration of facilities and technical skills leads them to determine number of cases while in case of less urbanized states like Bihar, U.P and Rajasthan lacks these testing facilities. Thereby HIV and AIDS cases in these states always go unnoticed. In 2003 Dr. R. Feachem then executive director of the Global Fund to Fight AIDS in an interview stated that the epidemic is moving into the general population (Pembrey 2006). Even many surveillance data suggested the same but unfortunately found no takers. Making the situation worst NACO in their prevention policies completely neglected general population and clinged to the approach that the epidemic is limited to high-risk groups such as sex workers, drug users and truck drivers and targeting them is the best strategy (Ekstrand et al, 2003)..

The low status accorded to both prevention and facilities for diagnosis and treatment in rural India is also one of the major reasons for where we are today on the AIDS epidemic map. The supply of anti-retroviral drugs in villages is erratic. Unfortunately, these issues and voices remain relatively unheard. So even 20 years after the entry of AIDS, the issues here remain just as they were. Public health systems have virtually ineffective and therefore seeking treatment is difficult and most villages have no access to these treatment facilities. In general, India's ART treatment rate at the present stage is also dismal. The UNAIDS 2006 report says that only 7 percent of Indians who needed antiretroviral drug therapy actually received it and a meagre number of 1.6 percent of pregnant women who needed treatment to prevent mother-to-child (MCTC) HIV transmission are receiving it. Even as per some official estimates of the 5.5 million people living with HIV, only 60,000 are on these drugs. Of these, only 30,000 are being supplied through the public health system (UNAIDS 2006). Further NACO's claims on treatment measures fell flat in Supreme Court when hearing a bunch of PILs, the court found that against the target of giving ART to one

lakh people by 2005 only 33,000 have got the medication by the same year. Later the policy makers in NACO in a more unfortunate way shifted the target year to 2007 (The Times of India, 1/09/2006).

Simplest and the most effective preventive measure like condom promotion was not taken in massive scale, sidelining this intrinsic care, NACO invested time, resource and energy in organizing conferences, seminars, which are unreachable to the majority of the HIV and AIDS patient. The case in point is India's anxiousness to host International AIDS Conference in 2012, for which the preliminary preparatory works have commenced on a war footing ground. This gives an impression that the state is more serious in flourishing tourism industry rather than spending few bucks on most affordable prevention measures like condom promotion.

Last but not the least insufficient budgetary allocation and HIV discrimination strains many preventive efforts. This is evident from the previous experiences where NACO was allotted a meagre \$38 million of the states' own funds over the period of 1999-2004 (Pembrey 2006).

Social reaction to people with HIV and AIDS in India further fuels up the crisis. The negative attitudes from health care professionals and responsible institutions have further worsened the situation. For instance in Orissa a young HIV+ couple committed suicide after being ostracized by their locality and surprisingly the State AIDS Cell's anti discrimination unit claims ignorance about the episode. Similarly in another instance Orissa State AIDS Cell was completely unaware of the killing of a youth by his communities in Puri as he was HIV+ (The Times of India, 07/09/2006). Such cases are alarmingly proliferating in various parts of the country. To check this injustice NACO is yet to come up with a concrete legislation. The proposed draft bill against HIV and AIDS discrimination, which was initiated in 2002, is still under considerations of our lawmakers (Das quoted in The Times of India Dated 26th May 2006). The lack of such legislation till this date raises questions on seriousness of states' commitment and strategies.

Conclusion

The chapter has outlined the status of HIV and AIDS as well as its transmission pattern, general discourse and knowledge and awareness among the population groups in India. It has also discussed in brief the socio-economic and political conditions and elaborated more on the state response to the epidemic. Thus it is clear from the above discussion that after initial denials the state as well as international bodies and NGO's have been responding proactively and working cooperatively in combating the epidemic in recent years. However, despite the plausible initiatives and efforts, the HIV and AIDS problems persist in India. India has become a tinderbox of the HIV spread, as is the case in most of the developing nation states. Further the chapter clearly demonstrates that HIV and AIDS prevention and care is not yet part of the mainstream social as well as political process. Despite of the fact that a large group of population is infected by the deadly virus, the state seems more interested in the statistics of HIV and AIDS as reflected in the statements and reports by the health ministry. It is an irony that never before the state use the media and other means of spreading information for prevention and control of HIV and AIDS so heavily as it did in reporting the current feel good data. It may be premature to start celebrating that number of people infected with the dreaded virus has come down by half. In terms of human life affected and further consequences, the number is still large and worrying. The state should not let down the vigil on the most dreadful disease of the century.

Moreover the increasing population, a typical conservative cultural set up, a highly volatile political state of affair both within the state and at the international sphere, a vast population of illiterates and the degrading state of health system can also be correlated with the decrease in the efficacy and degree of priority of states response to human threats like the AIDS epidemic.

"Few nations have addressed the health needs of their people with such callousness and contempt".

(Source: P Sainath 1996 quoted in Amrith 2007)

CHAPTER IV

The AIDS Epidemic and the State Response in South Africa

South Africa constitutes the largest state in African Development community. It has more people living with HIV and AIDS than any nation state worldwide and faces enormous challenges in scaling up its response to the now-mature and generalized HIV and AIDS epidemic. A number of factors have been blamed for the rapid rise in HIV prevalence in South Africa and questions has been raised on the states' response to the epidemic. This chapter will debate some of these issues.

To understand the approach and response of the state in South Africa on the HIV and AIDS question, it is necessary first to look at the political, economical and social context as well as education and the state of health system within which attitudes towards the epidemic have developed

Introduction

South Africa, officially the Republic of South Africa (Afrikaans, Zulu, Xhosa), is a country located at the southern tip of the African continent. It is bounded on the north by Namibia, Botswana and Zimbabwe, northeast by Mozambique and Swaziland, east by the Indian Ocean and south and west by the South Atlantic, with Lesotho forming an enclave.

South Africa covers an area of 1,219,090 sq. km (Barry and Turner 2005:1467). It is located at the southern most region of Africa, with a long coastline that stretches more than 2500 kilometres and across two oceans (the Atlantic and the Indian). South Africa is the world's 25th-largest nation state (after Mali). It is comparable in size to Colombia, and is nearly twice the size of the US state of Texas (Barry and Turner 2005:1467).

South Africa has a great variety of climate zones, from the extreme desert of the southern Namibia in the farthest northwest to the lush subtropical climate in the east along the border with Mozambique and the Indian ocean. Even though South Africa is

classified as semi-arid, there is considerable variation in climate as well as topography.

South Africa is a secular state and freedom of worship is guaranteed by the constitution. Almost 80 percent population professes the Christian faith. Other major religious groups are Hindus, Muslims and Jews. A sizeable minority of the population subscribe to traditional African faiths (Barry and Turner 2005:1468).

South Africa has eleven official languages: Afrikaans, English, Ndebele, Northern Sotho, Southern Sotho, Tsonga, Tswana, Vanda, Xhosa and Zulu (Barry and Turner 2005:1470). In this regard it is second only to India in number. While each language is technically equal to every other, English has emerged recently as the chief-among-peers as it is the most widely spoken language across racial barriers as well as globally, even though it is not the most widely spoken language by population.

Many white South Africans also speak other European languages, such as Portuguese (also spoken by Angolan and Mozambican blacks), German, and Greek, while many Asians and Indians in South Africa speak South Asian languages, such as Telugu, Hindi, Gujarati and Tamil (Barry and Turner 2005).

When apartheid ended in 1994, the South African state abolished the four former provinces of South Africa (Cape Province, Natal, Orange Free State, and Transvaal) and replaced them with nine fully integrated provinces. The new provinces are usually much smaller than the former provinces. The nine provinces are further sub-divided into 52 districts: 6 metropolitan and 46 district municipalities. The 46 district municipalities are further subdivided into 231 local municipalities. The district municipalities also contain 20 district management areas (mostly game parks) that are directly governed by the district municipalities. The six metropolitan municipalities perform the functions of both district and local municipalities (Barry and Turner 2005).

Population

South Africa is a nation of over 47 million people of diverse origins, cultures, languages, and beliefs. There are five racial categories in South Africa: Black African (79.5 percent), White (9.2 percent), Coloured (8.9 percent), and Indian or Asian (2.5 percent). South Africa has a yearly population growth rate of 0.40 percent (CIA 2006).

By far the major part of the population classified itself as African or black, but it is not culturally or linguistically homogeneous. Major ethnic groups include the Zulu, Xhosa, Basotho (South Sotho), Bapedi (North Sotho), Venda, Tswana, Tsonga, Swazi and Ndebele, all of which speak Bantu languages. Some, such as the Zulu, Xhosa, Bapedi and Venda groups, are unique to South Africa. Other groups are distributed across the borders with South Africa's neighbours (CIA 2006).

The white population descends largely from colonial immigrants: Dutch, German, French Huguenot, and British. Culturally and linguistically, they are divided into the Afrikaners, who speak Afrikaans, and English-speaking groups, many of whom originated from British immigrants (CIA 2006).

The term "Coloured" is still largely used for the people of mixed race descended from slaves brought in from East and Central Africa and these include the indigenous Khoisan, indigenous African Blacks, Whites (mostly the Dutch/Afrikaner and British settlers) and other European (such as Portuguese) and Asian (such as Burmese). The majority speak Afrikaans (Barry and Turner 2005).

The major part of the Asian population of the country is Indian in origin. There is also a significant group of Chinese South Africans (Barry and Turner 2005).

Culture

It may be argued that there is no "single" culture in South Africa because of its ethnic diversity. The country's black majority has a rich culture mainly derived from their respective ethnic traditions (CIA, 2006).

The white minority's lifestyle is similar in many respects to that of whites found in Western Europe, North America and Australia.

Coloureds tend to relate more to white South African culture rather than black South African culture, especially Afrikaans-speaking Coloured people whose language and religious beliefs are similar or identical to white Afrikaners.

Asians, predominantly of Indian origin, preserve their own cultural heritage, languages and religious beliefs, being either Christian, Hindu or Sunni Muslim and speaking English, with Indian languages like Hindi, Telugu, Tamil or Gujarati being spoken less frequently. Most Indians live lifestyles similar to that of whites (CIA 2006).

Politics and Economy

South Africa is a Federal republic with President as the head of the State. Parliament is the legislative authority and it consists of four hundred members of the National Assembly (the lower house) and the ninety members of the National Council of Provinces (the upper house). Members of the lower house are elected on a population basis by proportional representation: half of the members are elected from national lists and half are elected from provincial lists. Ten members are elected to represent each province in the National Council of Provinces, regardless of the population of the province. Elections for both chambers are held every five years. The government is formed in the lower house, and the leader of the majority party in the National Assembly is the President (Barry and Turner 2005:1479-81).

Racial strife between the white minority and the black majority has played a large part in the country's history and politics, culminating in apartheid, which was instituted in 1948 by the National Party. Apartheid legislation was gradually removed in 1990 after a long and sometimes violent struggle (including economic sanctions from the international community) by the Black majority as well as many White, Coloured, and Indian South Africans and the first multi-racial elections were held in 1994. The state is one of the few in Africa never to have had regular elections be held for almost a century; however, the vast majority of black South Africans were not enfranchised until 1994 (Barry and Turner 2005:1479-81).

South Africa is a middle-income state with an abundant supply of resources, well-developed financial, legal, communications, energy, and transport sectors. The economy of South Africa is the largest and best developed on the continent, with modern infrastructure common throughout the state. South Africa positions amongst the fifty countries wealthiest in the world (CIA 2006).

South Africa has one of the highest rates of income inequality in the world. Consecutive growth rates in the last ten years are helping lower unemployment; however, daunting economic problems remain. Other problems are crime, corruption, and HIV and AIDS (CIA 2006).

Land and Resources

The physical form of South Africa mainly composed of three major plateau forms; Highveld, Bushveld and Lowveld. From the east, the land quickly rises over a mountainous escarpment towards the interior plateau known as the Highveld. The interior of South Africa is a giant, rather flat. The Free State is particularly flat due to the fact that it lies centrally on the high plateau. To the north of Johannesburg, the altitude drops beyond the Highveld's escarpment, and turns into the lower lying Bushveld, an area of mixed dry forest and an abundance of wildlife. East of the

Highveld, beyond the eastern escarpment, the Lowveld stretches towards the Indian Ocean.

South Africa has a large agricultural sector and is a net exporter of farming products. There are almost a thousand agricultural cooperatives and agribusinesses throughout the country. Although the commercial farming sector is relatively well developed, people in some rural areas still survive on subsistence agriculture. It is the eighth largest wine producer in the world, and the eleventh largest producer of sunflower seed. South Africa is a net exporter of agricultural products and foodstuffs, the largest number of exported items being sugar, grapes, citrus, nectarines, wine and deciduous fruit. The largest locally produced crop is maize (corn), and it has been estimated that 9 million tons are produced every year².

South Africa is quite rich in mineral resources. It has huge deposits of iron-ore, gold and diamond. Coal also forms an important mineral resources in the country. Beside these, South Africa has rich deposits of mica, manganese, nickel, tin, chromate, bauxite, beryllium, copper, lead, tungsten, and zinc (Barry and Turner 2005).

Education

As per UNDP Human Development Report (2006) South Africa has an impressive literacy rate as compared to India. The state's adult literacy rate has increased from 81.2 percent in 1990 to 82.4 percent in 2004. The state spends 13.9 percent of total state expenditure on education (UNDP 2006).

Approximately 18.3 percent of population over 20 years of age had no schooling/basic education. There is also great disparity in literacy and education among different provinces as well as the rural and urban territories. The percentage of women literacy rate is much lesser than the men counterparts i.e. 48.9 percent in females and 84.1 percent in males (UNDP 2006).

² see South Africa online: Agriculture, available at www.southafrica.co.za

Health Sector

The UNDP Human Development Report (2006) states that South Africa spends 3.2 percent of GDP on health. Despite redistributive policies in the early post-apartheid period, South Africa's health care infrastructure remains highly inequitable. WHO ranks South Africa a "high TB burden" country, with the world's seventh-highest burden of TB (WHO 2003). Most of the rural areas are deprived of access to basic health services.

Other constraints include under-funding, high rates of treatment, overcrowding at treatment facilities, inadequate staff training and managerial and organizational weaknesses (HST 2003).

Human Development

Although South Africa's HDI rank is ahead of India i.e. 121 but it has shown dramatic decrease in the past few years with 0.653 in 1975 to 0.673 in 1980 to 0.703 in 1985 to 0.735 in 1990 to 0.741 in 1995 to 0.691 in 2000 to 0.653 in 2004 (UNDP 2006).

AIDS History and Incidence

The first recorded case of AIDS in South Africa was diagnosed in 1982, and although initially HIV infections seemed mainly to be occurring amongst gay men, by 1985 it was clear that other sectors of society were also affected (Pembrey 2006).

In 1990 the first national antenatal survey to test for HIV found that 0.8 percent of pregnant women were HIV positive. It was estimated that there were between 74,000 and 120,000 people in South Africa living with HIV (Whiteside and Cross 2001).

In 1991 number of heterosexually transmitted HIV infections equalled the number transmitted through sex between. Since this point, heterosexually acquired infections dominated the epidemic (Pembrey 2006).

The most rapid increase in South Africa's HIV prevalence took place between 1993 and 2000, during which time the country was distracted by major political challenges. As a result the HIV didn't gain the deserved attention instead more the attention of the South African people and world was more focused on the political changes.

In 1993 the number of HIV infections doubled and the HIV prevalence among pregnant women was 4.3 percent, which further than rose up to 12.2 percent in 1996, 17.0 percent in 1997, 22.4 percent in 1999, 24.8 percent in 2001, 27.9 percent in 2003 and 30.2 percent in 2005 (Pembrey 2006).

The magnitude and growth of the prevalence rates of HIV infection differ by provinces. In 2002, KwaZulu-Natal recorded the highest HIV prevalence among all provinces; the lowest recorded prevalence was in the Western Cape, Mpumalanga and Free State (Garbus 2003:5).

Current Status

According to the estimated figure of the UNAIDS (United Nations Programme on HIV/AIDS) and WHO (World Health Organization), the number of people living with HIV and AIDS by the year 2006 is projected at 46 million. An estimated 4.1 million became newly infected with HIV and an estimated 2.8 million lost their lives to AIDS. Out of this 46 million, it has estimated that South Africa alone has 5.5 million (UNAIDS 2006).

The report also says that 320,000 deaths are reported due to AIDS during 2005. Further, the report estimates that by the end of 2005, only 18.8 percent of adults (ages 15-49) were living with HIV and AIDS. The number of women (ages 15-49) living

with HIV and AIDS by the end of 2005 as per the study of UNAIDS is 3,100,000 (UNAIDS 2006).

The report (UNAIDS 2006) further states that national infection rate among pregnant women in antenatal clinics has shown dramatic growth: from less than 1 percent in 1990 to 37.9 percent in 2005. Prevalence rates are increasing in all age groups and there has been no indication of a decline in the epidemic. Estimates indicated that between 204000 and 297000 women living with HIV and AIDS give birth annually, which resulted in an estimated 61000 and 89000 cases of mother to child HIV infection.

The HIV prevalence among sex workers is estimated at 70 percent followed by 56 percent in mobile groups. Since its inception, the HIV and AIDS epidemic has had a profound impact on life expectancy. Adult deaths in South Africa are estimated to have increased by more than 40 percent over the past six years. HIV and AIDS has now become the single largest cause of death in South Africa and has cause a dramatic shift in the pattern of mortality from the old to the young, especially among young women (UNAIDS 2006).

Transmission Pattern

The prominent pattern of transmission of HIV in South Africa is both biological and behavioural, such as, heterosexual, homosexual or bisexual men, and mother-to-child transmission.

In southern Africa as a whole, 88 percent of new HIV infections are transmitted heterosexually, 10 percent are MTCT, and 2 percent through infected blood transfusions (Garbus 2003)

A sizeable proportion of soldiers have been the basic vectors and presently the truck drivers and commercial sex workers are in the race. The intravenous drug users and

contaminated blood transfusion are also becoming a major cause and vectors of HIV transmission in South Africa (Lobsang 2005:142-143).

Knowledge and Awareness Regarding HIV and AIDS

Generally, the oldest age group (50 and older) had the highest levels of incorrect knowledge and less awareness regarding HIV and AIDS, followed by the 12-14 age groups (Johnson and Budlender 2002 quoted in Garbus 2003:50).

The younger, more educated, lived in urban rather than rural areas had better HIV and AIDS knowledge. Whites had the most correct HIV and AIDS knowledge, followed by Indians, Africans, and coloureds. Those with no education believed that HIV transmission is not possible by touching an HIV-infected person (Johnson and Budlender 2002 quoted in Garbus 2003:50).

Further a survey by Kaiser Family Foundation reveals that, 76 percent of South Africans received at least some information on HIV and AIDS in the past year. There were substantial differences, however, among racial groups. Whereas 80 percent of Africans had received HIV information, only 55 percent of whites had. In general, urban Africans and urban coloureds were more likely than their rural counterparts to have received HIV information.

The survey reports that a significant minority of young South African (9 percent) remained unaware of HIV and AIDS. Awareness also varied by age group, province, and locale. As per the survey among 12- to 13-year-olds, 20 percent indicated they have not heard of HIV and AIDS, compared to only 7 percent of 14 to 15 year olds and 2 percent of 16-17 year olds. About one in ten (11 percent) Africans and one in four (26 percent) young people from the Northern Province responded that they had never heard of HIV and AIDS. Other groups less likely to have heard of HIV and AIDS were those from the North West Province (18 percent), those who live in informal settlements (12 percent), and those from rural areas (14 percent). Of youth

who had heard of HIV and AIDS, 39 percent believed that one could contract HIV from condoms. Fifty percent of those who had heard of HIV and AIDS did not know that men could be infected with HIV through sex with other men. Many young people were also unaware of nonsexual modes of transmission (Johnson and Budlender 2002 quoted in Garbus 2003:50).

Discourse Around HIV and AIDS

In South Africa, the discourse around HIV and AIDS is heavily racial, where blacks insist that AIDS is a disease of the white gay population and whites insist that AIDS is mainly a disease of blacks. As a result, only 13 percent of South Africans say that addressing the AIDS problem should be a priority for the government (Gauri and Lieberman 2004).

Further the discourse around HIV and AIDS in South Africa transformed into various definitions at different periods. There was a first period in which the infection was associated with the high-risk behaviour of homosexual men. Gay (white) men were seen as a small, deviant and closed group, which made unlikely the transmission of the virus to the heterosexual population. The government early on made it very clear that it considered HIV and AIDS to be a "gay" problem, and considered it the gay community's own responsibility (Patterson 2005:128).

In the second phase, the focus shifted to migrant workers. AIDS was associated with foreign, black workers. This period coincided with the total onslaught phase of the apartheid state's policy when the regime sought to strengthen white solidarity by identifying a threat around which the group could unite. Measures taken to deal with the supposed problem were administrative, punitive and discriminatory. Legislation was passed which allowed HIV antibody testing of foreign workers entering the country. Those found to be HIV-positive could be sent back home (Patterson 2005:128).

During the third phase, it was alleged that ANC guerrillas were carriers of the virus. At a time when the mass struggle was gaining momentum, there was an attempt to create an association between liberation politics and what was portrayed as an unknown but "killer" disease (Patterson 2005:129-130).

Until about 1991, when a shift in policy took place and a fourth phase opened, there was what amounted to an official silence about the implications of the spread of HIV and AIDS. Because the infection was not seen as a threat to the majority of whites (and in particular the supporters of the National Party), there was not a problem. Such an attitude, of course, displayed a cynical disregard for South Africa's black population. Hence, resources devoted to public information and education campaigns were negligible (Head 1993 quoted in Patterson 2005:23).

The post apartheid period saw a drastic change in the perception of HIV and AIDS. It is now seen more than a health problem. Initially the state leadership was more hesitant to come out with concrete policies to combat the most disease of the decade, the later years witnessed increased state initiatives in scaling down the menace.

State Response

In response to the increased international pressure and apparent rise in HIV amongst South Africans, after three years of the report of first HIV case (1982), in 1985 the country set up the first AIDS Advisory Group. Later towards the end of the decade, as the abolition of Apartheid began, an increasing amount of attention was paid (Pembrey 2006).

South Africa's first democratic elections were held in 1994, and the African National Congress (ANC) is since in power, first led by President Nelson Mandela and then by President Thabo Mbeki. The ANC began to address the growing problem of HIV and AIDS in South Africa even before the end of Apartheid, collaborating with the state to organise the first South African AIDS conference in 1992. This conference led to the

creation of the National AIDS Committee of South Africa (NACOSA) during the same year, with a committed strategy to prevent further transmission of HIV and AIDS, reduction of personal and social impact of HIV and AIDS and to mobilise the provincial, local and international resources in the battle against HIV and AIDS has yielded some results. (Narain 2003:3).

After the ANC was elected in 1994, President Nelson Mandela prioritised AIDS as an important public health and security issue. The ANC adopted NACOSA's AIDS plan. Along with 20 other social priorities, AIDS was declared a "Presidential Lead Project," giving it special status and early access to resources set aside for reconstruction and development (Garbus 2000:73).

In 1995 The International Conference on AIDS was held in South Africa for the first time. The then Deputy President, Thabo Mbeki, acknowledge the seriousness of the epidemic (Pembrey 2006). Till the end of the decade, state continues to struggle in scaling down the epidemic and no concrete initiative was witnessed from the states' part.

In the continuing years the situation began to changes and the state seems more committed in its fight against HIV and AIDS. The South African state has demonstrated a high degree of political commitment in tackling the HIV and AIDS epidemic and has committed significant financial and institutional resources to reforming the public health services to meet the challenges of HIV and AIDS (Pembrey 2006).

In 2000 the first central authority to deal with the menace was set up. South African National AIDS Council (SANAC) came into being. Further provincial AIDS councils were established as part of national process³.

³ Department of Health (2000), "HIV/AIDS Strategic Plan For south Africa:2000-2005).

In 2001 the state set up the AIDS Communication Team (ACT) to develop and implement a two year media campaign intended to educate people about the dangers HIV, and AIDS (Garbus 2000).

In November 2003 the state has approved an operational plan for comprehensive HIV and AIDS care, management and treatment for South Africa. In 2005 at least one service point for AIDS related care and treatment had been established in all the districts in the country by March, meeting the Government's 2003 target (Furlong and Ball 2004 quoted in Patterson 2005:136).

Despite these commitments the rising rates of HIV infection in South Africa continues, suggesting that the states' response to the crisis has been ineffective leading to a catastrophe situation in the state. In South Africa the states' response to HIV and AIDS has been marred, not by a lack of political leadership, but by pattern of technocratic, authoritarian, and controlling political leadership, which has sought to impose its decision on people, rather than facilitate cooperation among the people to realise society's goals.

In South Africa, centralised institutions of the state have inhibited any policy autonomy on the part of civil society or local levels. Entrepreneurial municipalities and provinces that wish to address the problem of AIDS are branded as renegades by the federal state, and they are paralyzed to implement any effective programs due to fear of repercussions (Gauri and Lieberman 2004).

During 2000, President Thabo Mbeki, who had succeeded Nelson Mandela as South Africa's president in 1999, had begun to publicly question the link between HIV and AIDS. In May 2000, he convened a panel of international AIDS experts including AIDS dissidents charged with re-examining the causes of AIDS and determining African solutions to the pandemic (Patterson 2005).

Indeed, AIDS policy has also been the victim of power struggles between different spheres of government. Local responses to HIV and AIDS in South Africa differ strikingly from central policy in some regions. KwaZulu-Natal province, the region hardest hit by HIV and AIDS and also one of the poorest provinces in the state, choose to override the states' policy against providing ART. Western Cape province took the same step, leaving seven provinces without public support for mother to child transmission province. Despite of the new democratic, federal constitution, the pre-1994 tendency to centralise AIDS programs at the central level remained (Patterson 2005:195).

Although the production of generic AIDS drug was in large scale, yet problems of drug distribution remains. A study by the Institute for Democracy in South Africa (IDSA) in 2003 concluded that the biggest challenge facing by the state in its response to HIV and AIDS is not the lack of financial resources, but the capacity to spend (IDSA 2003 quoted in Pembrey 2006). Thus all these factors lead to the severity of epidemic in the region making the country highly HIV infested country worldwide.

Conclusion

In sum, early denial, lack of funding, absence, ineffective initiatives and endless delays in implementation of policies, absence of autonomous central authority to combat HIV and AIDS are responsible for where South Africa is today. Further increasing population, conservative societal culture, highly unstable politics and economy, deteriorating education and health system and the low HDI ranking itself makes the point of decreasing state commitment towards the issues of human security threat like HIV and AIDS. At the same time to be fair, there were some promising efforts, yet the state has miles to go.

The state should adopt and act in accordance to a more comprehensive strategy, which includes; prevention, treatment for sexually transmitted infections (STI's), and HIV

and AIDS therapy. Last but not the least the battle against HIV and AIDS should be linked to a wider national battle and not merely a battle of a particular group.

"There are times when I need to remind myself why and how I got involved with HIV/Aids. These moments are stimulated by the political quagmire around Aids, and always leave me wondering at the gap between intentions and result..."

(Source: Aids Analysis Africa, June/July 1998)

CHAPTER V

Comparing State Responses to the AID Epidemic: Brazil, India and South Africa

The AIDS epidemic has created a devastating human tragedy through out the world and especially in developing nation states. The disease is also crippling progress at the personal, familial, community, and national level. In severely affected nations it poses a big threat to economic growth, political stability as well as security of the state (Lemptey et al 2002). Despite concerted efforts to curb the epidemic, HIV continues to spread as in case of India and South Africa. However, some states like Brazil, Uganda and Thailand emerge as global leaders in terms of successful state response. This dichotomy in success rates in combating the epidemic raises several questions- What explains these differences? Is there is any divergence in nature of state responses between the two classes? What are the strategies or pillars of the successful state responses? Can it be replicated in other countries facing growing AIDS crisis? This chapter will elaborate more on these questions by comparing the state responses to the AIDS epidemic in Brazil, India and South Africa.

The study so far broadly discussed the epidemics of AIDS and the state response in Brazil, India and South Africa as well as socio-economic and political features of the three states. It draws a picture that the success rate of the state responses in bringing down the epidemic in the three cases is far different with India and South Africa topping the list as comparative failed state responses and Brazil as successful state response. Thus it stresses to study the elements that can clearly explain the variation in state responses. This can be achieved by drawing a comparison of the state responses to the epidemic.

The comparative study of the state responses to the AIDS epidemic in Brazil, India and South Africa becomes vital to address the question of whether there is any difference in the nature of state responses in these states (Brazil, India and South Africa). Moreover it becomes imperative because no substantial work has been done on the same so far. But one can find enough literature on the socio-economic and security implications of HIV and AIDS in Brazil, India and South Africa as well as the role of respective governments in addressing this epidemic. These studies lack a

comparative dimension on the three most interesting and important cases of comparatively of different state responses.

As discussed in the introductory chapter many scholars in the recent past did made an important contribution in order to describe the nature of state response to the AIDS epidemic and among them were also some comparative studies, case in point are; regime type (Sen 2000); bureaucratic capacity (Boone and Batesell 2001); the quality of leadership (Whiteside 1999); nature of political institutions and strength of national community (Gauri and Lieberman 2004); historical institutionalism and cultural analysis (Gomez 2005); state-society relationship and strengthened health bureaucracy (Huang 2006); international influence (Richard Parker 1990). The arguments put forth by these scholars do not clearly define the variance in state responses. The same set of variables fails to explain the variation in state responses when considered in cases other than the studied one. In the context of Brazil, India and South Africa, however, these explanations are not immediately satisfying. The three case studies share many similarities in the proposed variables still one can find different state responses.

Thus this chapter will make an attempt to answer the question that why in some states like Brazil, India and South Africa where one might have expected similar state responses, but in which substantially different outcomes are observed. The chapter will emphasize on three important variables- primacy of states to human security, socio-cultural norms, activism of civil society groups, and rapidly changing strategic environment, which provide a better specified model of cross-country variation in state response to the AIDS epidemic. Before elaborating on the above stated variables the chapter will discuss the pattern of state action in Brazil, India and South Africa in context of three broad areas; establishment of autonomous authority for combating the AIDS epidemic, broadcasting of prevention strategies and the provision of treatment and support to HIV positive people. This will help in distinguishing the aggressiveness of the state responses and also in the better understanding of the various dimensions of state's response.

Establishment of AIDS Combating Authority

Scholars from various disciplines writing on AIDS have hypothesized that establishment of AIDS authority in combating AIDS is a must for an effective state response. As, such institution influences the political decision-making bodies, thus initiating an aggressive and timely response (Steinmo et al 1995 quoted in Gauri and Lieberman 2004:11). However in the context of some case studies the argument failed to explain that why in some states where despite the presence of such institutions, the countries experience different rates of responses. This raises questions on the extend of autonomy of these institutions and priority assigned by those in power.

Gauri and Lieberman (2004) in their study of state response to the AIDS epidemic made a vital argument raising the importance of decentralisation of political institutions in successful state response. Thus the present study makes a step ahead attempt and builds its argument on the lines as put forth by these authors that countries characterized by decentralized political institutions are likely to be associated with more timely national response which further ensures the establishment of AIDS authority. Thus the study argues that guarantee of autonomy and authority of the AIDS policy units becomes imperative as par with the decentralized political environment.

In terms of establishment of AIDS authority Brazil has been more aggressive than India and South Africa. Brazil established an AIDS bureaucracy in 1985, when a National AIDS Program (NAP) was created within the Ministry of Health (Pembrey 2006). In 1988, the inter-ministerial National Commission to Control AIDS was established. Thus since 1992 the NAP has been responsible for the formulation of AIDS policy (Brazilian Ministry of Health 2001 quoted in Pembrey 2006).

In India it took nearly six years for the state to establish a full-fledged autonomous AIDS policy unit since the inception of the disease in 1986 (Pembrey 2006). It was only since 1992 that here has been a serious effort to put into place an infrastructure at Central and State levels for tackling the problem of AIDS. In 1992 the National AIDS

Control Organisation (NACO) was set up and the Control Programme expanded into a National AIDS Prevention and Control Programme. The same year that NACO was established the state launched National AIDS Control Project under which State AIDS Control Societies were set up. The purpose of the setting up of State AIDS bodies was to carry out the NACO's AIDS control programmes (WHO 2005).

In contrast South Africa took almost ten years to establish an AIDS institutional body in the state. There was no truly autonomous AIDS policy-making unit in South Africa. In 1988 ten years later than Brazil an inter-ministerial unit was established (Schneider 2002). In 2000 the first central authority to deal with the menace was set up. South African National AIDS Council (SANAC) came into being. Further provincial AIDS councils were established as part of national process. Gauri and Lieberman (2004) notes that throughout the history of the AIDS epidemic, there has not been a clear centre of power for the direction of AIDS policy, as the various AIDS policy-making structures have been granted limited autonomy, and have often been contradicted by various national executives.

AIDS Prevention Strategies

In order to curb the spread of new infections, states have, to varying degrees, tried to convince citizens to get their blood tested, and to alter their sexual practices-including the use of condoms, the numbers and types of partners they have, and the age of sexual debut; how and where they deliver babies; and how they use injecting drugs. A strong prevention effort by the state in this realm increases the knowledge and awareness about HIV and AIDS among its populations and thus decreases the vulnerability. In this regard, early and most effective prevention policies and programmes occurred in Brazil than in India and South Africa.

A World Bank report says that in variety of ways, the Brazilian state has been aggressive in the area of prevention. It states that right from the very early years of the disease inception, Brazilian state launched a mass scale prevention campaign targeted

at high risk population that included commercial sex workers, gay men, injecting drug users. Brazil also implemented national prevention programmes targeted at general population as early as 1987 (World Bank 2004). Further the report adds that HIV prevention messages like promotion of condom have been promoted through a variety of media, including television, newspapers and public spaces such as billboards and bus shelters. Even famous celebrities and popular television soap operas are used to educate people and free condoms were distributed on large scales (Singhal and Rogers 2003). As a result a dramatic increase in condom use has been witnessed. In 1986 it was estimated that only 4 percent of the Brazilian population used condoms, by 1999 it increases to 48 percent and 35 percent in 2005 compared to 24 percent in 1998 (Okie 2006).

In contrast both India and South Africa were at snails pace in this regard during the early days of disease outbreak. Even the later years saw an increased intervention from both the states in HIV prevention programmes but those initiatives have been poorly planned and implemented. Pembrey (2006) attributed this delay and poor prevention intervention in India to ideological barriers, low status accorded to the scientific speciality and bureaucratic apathy. Though later years saw a massive increase in prevention efforts in India through various media but still its rate of success in increasing knowledge and awareness among high-risk groups and general population is in question. The much-needed treatment, healthcare and infrastructural development has taken a back seat in the current strategies and policies of NACO, the author added. Peter Piot, Director of UNAIDS in an interview with Associated Press said, 'At the recent meetings in India, I heard great speeches, but as for action, zero' (Pembrey 2006).

Moreover, prevention efforts directed by the South African state, both during and after apartheid rule have been variously characterized as misplaced and misguided, disconnected from the social realities in which people live (Schneider 2002).

AIDS Treatment and Support to HIV Positive People

The provision of treatment and support to people living with HIV and AIDS is important to improve the quality of life of infected individuals and it also reflects the extent of seriousness of the state response. Again the three states i.e. Brazil, India and South Africa acted at varying degrees in this regard. Brazil was seen more aggressive in financing or providing medications to treat opportunistic infections and anti-retroviral drug therapies to slow the progression of AIDS as compared to India and South Africa (Gauri and Lieberman 2004:8). Though at later stages some degree of aggressiveness was shown by India and South Africa.

Brazil has been noteworthy among developing nations for the scale of its commitment to AIDS treatment. Even before the advent of highly active anti-retroviral therapy (HAART) Brazil makes effective initiatives in treating the opportunistic infections associated with the disease. In 1996 HAART was developed, revolutionising HIV treatment and the drugs were made available for free throughout the public sector. In following years the national AIDS mortality rate began to decline due to the effectiveness of the treatment (Pembrey 2006).

Another major factor in Brazil's success has been its ability to produce several AIDS drugs locally. Brazil has a large pharmaceutical industry and around 40 percent of ARVs currently purchased by the state are manufactured domestically (Pembrey 2006). However, some of the ARVs required for the Brazilian treatment program have to be obtained internationally. To ensure that these drugs are not too expensive, the state has continually put pressure on international pharmaceutical companies to lower their prices (Okie 2006).

The Indian and the South African state, on the other hand, have been slower to enact treatment programmes and also there was a huge gap in expenditure on treatment between Brazil and the rest two. In India the provision of drugs for treatment started in 1999 but was limited in its reach and many people living with HIV and AIDS have not

any access to these drugs (Fredrickson et al 2006). India being a major producer and exporter of cheap generic HIV and AIDS drugs but for millions of Indians access to these medicines was a distant dream (Lancaster 2003 quoted in Fredrickson 2006). India's ART treatment rate at the present stage is also dismal. The UNAIDS (2006) report says that only 7 percent of Indians who needed antiretroviral drug therapy actually received it. Even human rights advocates fear India does not have the health infrastructure in place to treat and care for the thousands who will test HIV positive (HT, 02/02/2007).

In South Africa these drugs were only available to a small minority of population who afford to pay. It was only in 2003 when the state approved plans to provide public access to ARV drugs but many in power raise questions regarding the cost and effectiveness of ARVs (Pembrey 2006). The state's apathy in providing proper treatment and care to people living with HIV and AIDS is also evident from the fact, when in 2006 more than 130 HIV positive South African women sought asylum in Canada after attending Toronto AIDS conference, apparently claiming that they cannot get adequate treatment at home. At its worst South African Health Minister Manto Tshabalala-Msimang goes on record advocating a diet of garlic, lemons, beetroot and the African potato as an alternative to antiretroviral drugs (Hindu, 05/09/2006).

In terms of support and care of HIV positive people, Brazil has again acted more seriously providing legal protections against non-discrimination, enacting legislations guaranteeing treatment and various insurance schemes to HIV positive people. By contrast, in India and South Africa no such provisions were made for the support and care of HIV positive people. In fact initially the South African state acted in a more repressive manner against people living with HIV and AIDS, using force and control (Gauri and Lieberman 2004).

The above discussion on some important dimensions of state's actions gives a clear picture that the state response to the AIDS epidemic from all the three cases vis-à-vis

Brazil, India and South Africa shows a high degree of variation. The following section will make an attempt to explain this dichotomy in state's action in the light of the following four important variables.

State's Primacy to Human Security

This section will explore how state's level of primacy to human security defines its response to the human security threats. Although there is high degree of disparity between scholars regarding the appropriate definition of human security. This study will rely on the definition put forth by Kanti Bajpai (2000). According to him human security constitutes protection from direct and indirect threats to the personal safety and well being of the individual (Bajpai 2000 quoted in Jacob 2005:130).

When we talk about the threats to human security, Jacob (2005) writes that HIV and AIDS constitutes biggest human security threat because as per the author HIV and AIDS related suffering and consequent untimely death constitute undeniable suffering and loss of dignity for a person. The author further adds that HIV and AIDS also contribute to death and suffering of large numbers number of infected populations, thus becoming a human security threat of national proportions.

Thus going by Kanti Bajpai's (2000) definition, two important strategies emerge; protection and empowerment as an elements of human security against the HIV and AIDS threat. Protection shields people from dangers or protects them from HIV and AIDS. In the context of HIV and AIDS, empowerment means creating an enabling environment in which people can obtain the necessary information and have the means and choices to make decisions in their lives and to protect themselves from HIV and AIDS.

Therefore, the study argues that the extend of primacy and guarantee of this security by the states results in a more effective and timely state response against the AIDS

epidemic. This is one of the reasons we can relate with the dichotomy in states action against the AIDS epidemic.

Looking at Brazil's response to the epidemic both in terms of prevention strategies and treatment and care of HIV positive people, it gives an impression that the state was more concerned in this regard. The Brazilian initiatives of guaranteeing the human rights of people living with HIV and AIDS and universal and free access to HIV and AIDS treatment, including antiretroviral drugs are more prominent in this direction (Okie 2006:1978). Thus resulting in a more successful response as compared to the other states responses like India and South, where the concept of human security was always at receiving end. This fact is also evident in the interventions made by them in prevention and treatment of HIV and AIDS as discussed above. Further the presence of legislations like section 377 of Indian Penal Code which criminalise sexual orientation which is a great human right concern strongly supports the point of argument that the state accorded low priority to issues of human security in India (Sharma 2006).

State and Socio-Cultural Norms

Social and cultural norms are orders and expressions that do not describe how the world is, they rather prescribe how the world should be (McElreath et al. 2003). In general terms these are the values that govern the socio-political affairs of societies and cultures and in most cases these values defines the priority areas for the state functioning. Also there are certain behaviours and issues which are often considered unacceptable and against these norms and thus are highly contested and ignored. As a result of this ignorance, the threat posed by such socially and culturally unacceptable issues are always neglected.

The HIV and AIDS because of its association with behaviours that may be considered socially and culturally unacceptable by many societies and cultures, the subject is widely stigmatised. This stigma associated with HIV and AIDS has made it extremely

difficult for the most effective prevention methods to be employed. They discourage states from acknowledging or taking timely action against AIDS (Altman 2006:260-261). Thus the study argues that the fundamental barriers to timely and effective state response to the AIDS epidemic are social and cultural norms, and that many states place more emphasis on preserving traditional norms and social arrangements than on saving lives. However the states which discuss these issues more openly rising above social and cultural constraints makes aggressive and successful state response to the AIDS epidemic, Brazil and Uganda stands as interesting cases studies here.

As a result of HIV and AIDS related discrimination, appropriate policies and models of good practice remain underdeveloped. People living with HIV and AIDS continue to be burdened by poor care and inadequate services, whilst those with the power to help do little to make the situation better. And neither the state nor civil society have as yet been able to overcome the ideological barriers, to be able to come up with wide-ranging interventionist tools to deal with this sensitive area of behavioural change. Thus this results in failure to develop the necessary technical and administrative skills in the direction of raising awareness about the disease, high risk behaviours and primary prevention among these groups and in the larger society or, to develop support structures for those suffering from the disease (Rosenbrock 1998:28-30).

Brazil makes a very interesting case study in this context, which can be attributed to its successful state response to the AIDS, epidemic. The denial and the stigma that one finds attached to sexual health issues in so many places are not prevalent in Brazil. Sexuality and sexual expression are integral to Brazilian culture and are discussed openly. While some cultures associate sex with shame and corruption, however Brazilians see it as something that should be celebrated, and this social climate has made it much easier for the state to carry out prevention work (Pembrey 2006). Even practices like prostitution and homosexuality are not illegal in Brazil, which is not in the case of other states where such practices are always seen as unethical and against social and cultural norms. The state also funds many events and projects such as gay pride marches in order to encourage people to respect sexual diversity (Pembrey

2006). Thus it can be argued that Brazil's response to the AIDS epidemic also includes the development of sexuality and sexual discourse. This initiative can also be regarded as a special nature of state response that makes it different and unique when compared with the state responses of India and South Africa.

In India due to the traditional socio-cultural norms of monogamy, universal marriage and, therefore, heterosexual relations and virtual non-existence of homosexual behaviour, and societal proscriptions against an explicit focus on sex and sexuality in public social interactions and discourse, the social reactions to people with AIDS have been overwhelmingly negative. For example, in one study 36 percent of people felt it would be better if infected people killed themselves, and the same percentage believed that infected people deserved their fate. Also, 34 percent said they would not associate with people with AIDS, and one fifth stated that AIDS was a punishment from God (UNAIDS 2001 quoted in Pembrey 2006). Even the Union Health Minister in an interview makes the point that the traditional attitudes towards sex makes it difficult for the state intervention to be effective (Sharma 2006).

The failure of state in combating the AIDS epidemic in South Africa can also be attributed to the socio-cultural constraints as discussed above in the case of India. Lemptey et al (2002) in their article notes that most of the African states including South Africa usually avoid public debates on topics related to sexuality because of the fear of inviting a conservative societal backlash and also to secure their political interest, while the cases like Uganda stand in stark contrast in this regard (Lemptey et al 2002:18). Thus these societal and cultural norms against sex and sexuality have led to the AIDS denialism in the political circle. As a result the state distracts itself from the AIDS crisis, making the situation worst in the state.

State and Civil Society Activism

From the onset of the AIDS epidemic, civil society groups like non-governmental organizations (NGOs), community based organizations (CBOs), faith based

organizations and many adhoc groups have been at the forefront of promoting prevention, care and treatment. The presence of these civil society groups is a key to the medium and long-term success of AIDS prevention. As a document of World Bank (1999) points out that these groups pressurise the state to be more responsive to the AIDS crisis. Further the document argues that prevention initiatives by states could not succeed without active participation of these groups as these groups help the state to increase the capacity and coverage of its prevention and treatment efforts (World Bank 1999). Recently the 2004 Noble Peace Price winner Wangari Muta Maathai in an interview to an Indian daily stressed on the importance of active civil society groups in good governance (Hindu, 22/03/2007). But several scholars like Gauri and Liberman (2004) in their paper maintain that civil society groups have a limited scope in influencing the state responses though they attribute it as a necessary factor in successful state responses but not a sufficient one.

In order to remove this dichotomy the study looks at the state of activism of civil societies and argues that the degree of activism on the part of civil society groups influences and shapes the state response. Thus, greater the degree of activism shown by these groups, greater it will influence the decision makers in prioritizing the epidemic on the agenda. This can be best illustrated and explained in the context of state responses to the AIDS epidemic in Brazil, India and South Africa. In Brazil the extent of activism shown by these groups and most importantly by faith based groups like Catholic Church in the fight against the AIDS epidemic also provides a lesson for the rest of the world. This unique activism have ensured that stigma and discrimination have been reduced, human rights have been taken into account, moral and religious views have not impeded prevention campaigns and ensures an effective state response (Pembrey 2006). Homosexual activists in Sao Paulo created the first NGO to fight AIDS in 1985, three years after the first case of AIDS was reported. The following year, activists in Rio de Janeiro created the first national NGO to fight AIDS in Brazil. This activism by such groups complemented state's efforts in stemming the rapid spread of HIV and AIDS (Huang 2006:110).

In contrast both India and South Africa harbours thousands of civil society groups and the number is much more than in Brazil, still the two states are witnessing high rates of HIV infection and thus a situation of a failed state response. In these cases, civil society numbers are strong but achieved little due to the insufficient level of activism and huge discrepancies in AIDS allocations by these groups (Dickson 2006). Even the argument of activism holds relevance when one can look at the initial degree of activism and concern shown by civil society groups in South Africa that led to the apartheid regime to acknowledge the growing threat which then later in 1992 led to the formation of first AIDS policy body, NACOSA (Gauri and Lieberman 2004). Though with the passage of time this zeal disappeared thus resulting in a catastrophe like situation in South Africa.

State and Rapidly Changing Strategic Environment

Often states are seemed to address and respond to the changing strategic environment of state politics on priority basis. The aftermath of cold war results in a more volatile world politics as well as state politics in different parts of the globe, this result in decrease in state's intervention in matters of human security concerns like HIV and AIDS and they began to priorities those issues which are of great strategic importance in relation to the rapidly changing state and international political system. As a result states deny or minimize the presence and the threats of HIV and AIDS (Singer 2002:154-155). Thus the study argues that AIDS competes with these other issues for priority on the agenda of states, as a result leading to late and unsuccessful state response. And the states, which do not, witnessed such strategic changes on the state political sphere show timely as well as more aggressive state response. In brief, human security threats like AIDS always went ignored when the state is grappling with change on so many fronts and is faced with a multitude of more visible priorities. HIV and AIDS prevention in a society and state undergoing changes on many fronts becomes especially difficult.

This argument can be best illustrated in the context of Brazilian, Indian and South African state responses to the AIDS epidemic. In case of Brazil, when HIV and AIDS marks its existence on the map of Brazil, there were not any drastic changes going on the political sphere of the state nor the state was facing any external threat of great concern that calls for immediate response. At that time HIV and AIDS was a big threat for the state, as a result the state made a timely and aggressive intervention as evident in the above discussion of state action.

In contrast the situation in India and South Africa was completely different. The decade when the AIDS epidemic was looming on the map of India and South Africa, both the states were also witnessing a rapidly changing strategic environment on the political sphere both domestically as well as on the international sphere. In India infrastructural development, military security and economic development was on the priority of the state agenda. India was facing many burning problems such as the ongoing dispute with Pakistan over Kashmir, terrorism, massive overpopulation, environmental degradation, extensive poverty, and ethnic and religious conflict. These issues prioritized the state agenda, as a result the threat posed by HIV and AIDS remained unnoticed. Though at later stages interventions were made in this regard but were not of that intensity as required or call for by the situation. As a result in the ensuing years the disease attained an epidemic stage posing a biggest threat to the society, economy, politics and security of the state.

In South Africa, politics has always loomed large. South Africa was in a transitional period with restructuring of just about every aspect of the state. During that time it also has a serious HIV epidemic. The most rapid increase in South Africa's HIV prevalence took place between 1993 and 2000, during which time the country was distracted by major political challenges. While the attention of the society and the state was focused on the political and social changes occurring in the country, HIV was silently gaining a foothold. The AIDS epidemic rarely figured on the priority expression of citizens as well as the state. Among the priorities expressed for public policies by citizens, AIDS rarely ranks high. Other issues such as development,

poverty, crime, employment and education tend to rank higher. As Gevisser (1999) writes, 'The tragedy of South Africa and the AIDS epidemic is that the time at which something could be done was also the time of the transition. So, despite the warnings and the incredible research contained in the 1994 document, the AIDS Plan effectively went onto the backburner (Gevisser 1999 quoted in Johnston 2006:115). Thus the spread of the virus was not given the attention that it deserved, and the state did not realise the impact of the epidemic in South Africa until prevalence rates had begun to accelerate rapidly. Pembrey (2006) in his article states that it was likely that the severity of the epidemic could have been lessened by prompt action at that time.

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<u>POLICY AREAS</u>	<u>BRAZIL</u>		<u>INDIA</u>		<u>SOUTH AFRICA</u>	
	Less Aggressive	More Aggressive	Less Aggressive	More Aggressive	Less Aggressive	More Aggressive
1. Bureaucratic Development						
• Timing and authority of national programme		X	X		X	
• Level of expenditure		X	X		X	
• Coordination with civil society		X	X		X	
2. Prevention strategies						
• Condom promotion		X	X		X	
• Programmes targeted at high risk groups		X	X		X	
• Knowledge and awareness programmes		X	X		X	
3. Treatment and care						
• HAART to PLHA		X	X		X	
• Human rights legislation		X	X		X	

Table 1: Aggressiveness of State Responses to the AIDS Epidemic (1982-2004)
(HAART: Highly Active Anti-retroviral Therapy; PLHA: People living with HIV and AIDS)

Conclusion: Lessons learnt so far

Given the detailed understanding of the virus, the knowledge about the natural history of HIV and AIDS, and the global epidemic state, its socio-economic and security threats, the failure to mount successful interventions on the spread of the disease particularly in India and South Africa is one of the greatest failures in the history of public health. HIV and AIDS has now become the single most formidable challenge to the nation states. Already, over 2.8 million people have died of AIDS worldwide and an estimated 38.6 million people are presently living with HIV and AIDS. Some 4.3 million people across the globe became infected with the HIV virus in 2006 alone. Almost every country of the world except few like Brazil, Uganda and Thailand has shown an alarming increase in the HIV infection and the situation is even worse in countries of South Africa and India. Both these countries have seen a sharp increase in the number of HIV infections from a few thousands in the early 1990s to around 5.5 million and 5.7 million respectively in 2006.

The mention of the HIV and AIDS statistics is important because these numbers itself questions the commitment of worst affected states in dealing with HIV and AIDS. Although responses against the epidemic were made by all the states but still leaving few many failed in combating the epidemic. This divergence caught the eyes of many scholars but none came up with a concrete hypothesis explaining the variation in state responses as well as success rates in scaling down the number of infections. Thus the present study after the appraisal of the works of many scholarships on the subject attempted to give a more reliable explanation of this puzzling difference in states response to the epidemic. The study emphasises the power of findings with an eye on state responses of Brazil, India and South Africa. These states share many similarities in terms of discovery of the epidemic, territory, politics and economy, which make them an important comparative case study. More interestingly, despite the fact that the state responses of Brazil, India and South Africa were similar to an extent but still the success rate in these states are far different. Brazil has emerged as a successful state in

scaling down the number of HIV infection while India and South Africa make a case of comparatively failed states in combating HIV and AIDS.

In this study, I have submitted an alternative approach to understand the politics of state responses to the AIDS epidemic. In contrast to present literatures focusing more on role of leadership, regime type, bureaucratic capacity, civil society, nature of political institutions, historical institutionalism and cultural analysis, and international influence to explain the nature of state responses, it has addressed a new set of variables like primacy to human security, socio-cultural norms, civil society activism, and rapidly changing strategic environment to explain the state commitment to combat the AIDS epidemic.

The study demonstrates that if the Indian as well as South African state would have given more primacy to human security threats like HIV and AIDS than other issues of state interest, the epidemic would not have attained this stage in both the states. Further it argues that the level of civil society activism found in case of Brazil was missing in India and South Africa, which further worsened the situation. The study also demonstrates that the socio and political conditions do impact the state response. Prominent among them as per the study are the rapidly changing strategic environment and socio-cultural norms. The study reveals that the political sphere in both the states India vis-à-vis South Africa was very volatile as a result the AIDS competes with these other issues for priority on the agenda of states, while Brazil didn't experience any such changes in the strategic environment that's why HIV and AIDS was always a priority for the state. Lastly the study does found socio-cultural norms as the fundamental barriers to timely and effective state response to the AIDS epidemic. Thus many states place more emphasis on preserving these traditional norms for their political interest, India and South Africa's case fits within this hypothesis. While as in Brazil the more open society led to an effective and successful intervention of HIV and AIDS programmes.

Thus in India and South Africa the main factors inhibiting the state response have been the socio-cultural norms and stereotypes. These have combined with the fall of issues of human security in the state's priority agenda due to rapidly changing strategic environment, organisational inefficiencies and weaknesses, and the lack of political will, particularly at the level of the state, to undertake major public health and educational reforms.

Both the states require increased state commitment and more effective response, in the sense that in spite of states interventions at all level, the HIV and AIDS epidemic has is in its full-blown stage and there in no any sign of decrease in the rate of epidemic. Thus it is high time that both the states should initiate the measures to overcome the weakness and should draw lessons from Brazil's successful state response. Some major elements learned from Brazil's success that could possibly be encouraged in India and South Africa are;

- Focus on cost-effective programmes especially those that affect the core transmission groups such as participants in transactional sex, intravenous drug use, and men who have sex with men.
- Provision of free treatment to all, and aggressive efforts to minimize the cost of antiretroviral drugs should be priority of the state. The state should also ensure the adequate supply of condoms and STD drugs to the population.
- More focus should also be made on the innovation and mass broadcasting of prevention strategies.
- Greater concentration should be on increasing the efficiency of the undergoing intervention programmes rather than organizing large number of national and international meetings. They simply waste resources.

- Trade-off in the allocation of resources for prevention and highly active antiretroviral therapy should be confronted and the epidemic should not be measured on priority scale on the state agenda as par to other issues.
- Increase national budgets for health sector generally and that for HIV and AIDS particularly. Large investments in these sectors will have a greater impact on slowing its progress.
- State should establish a strong relationship with civil society groups including religious institutions. Simultaneously the civil society groups should show the level of activism, as did by the Brazilian civil society groups.
- Concrete efforts should be made on minimising stigma and discrimination and encouraging a culture where people living with HIV are not looked down upon.
- Legislations criminalising sex orientations should be scrapped at the earliest because in both India and South Africa these Acts have proven as hurdles in successful implementation of HIV and AIDS programmes.
- Update AIDS policies and program efficiently from time to time.

Thus the study believes that by applying these lessons, the two states may be able to stem the tide of this deadly epidemic. It may be difficult to achieve a complete success. But failure to apply the lessons learned to the situation could lead to an utter tragedy.

FIGURES

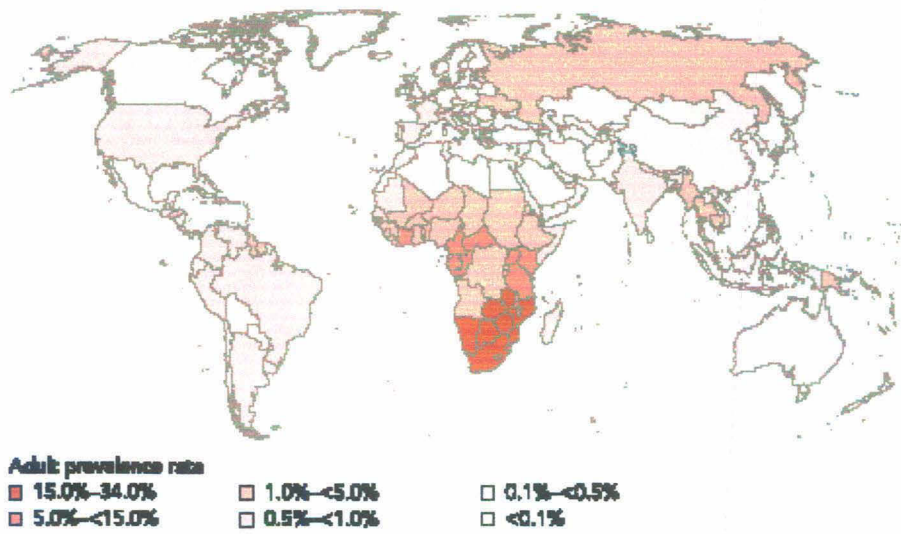


Figure I: A Global Overview of HIV Infection

(Source: UNAIDS 2006)

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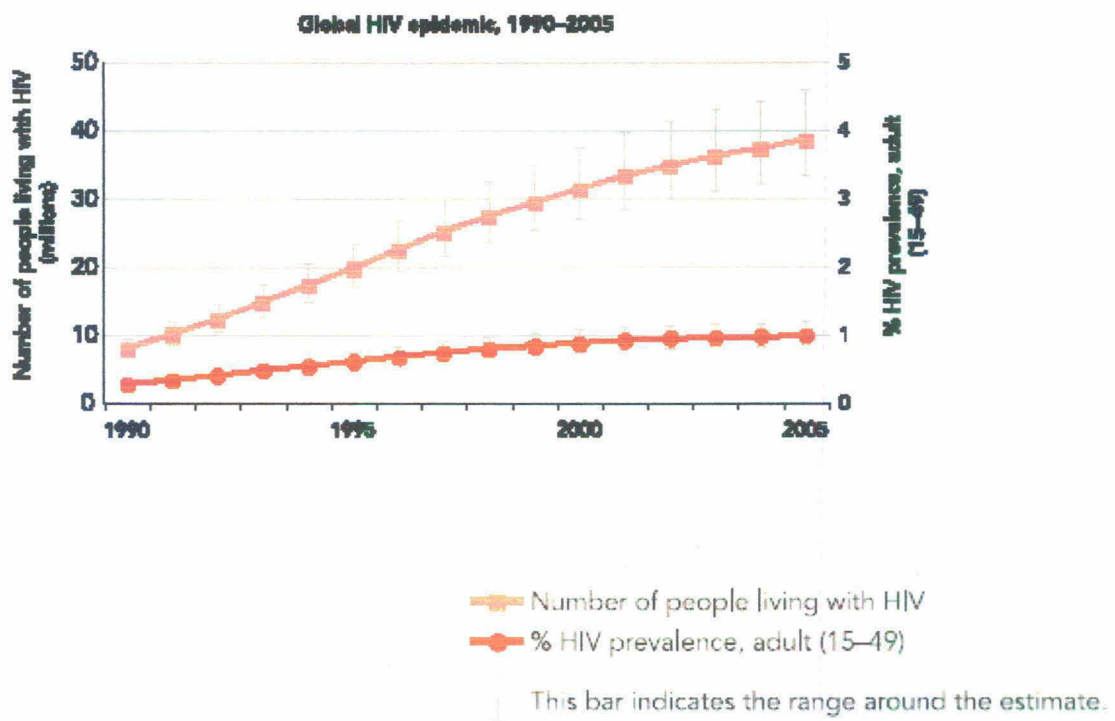


Figure II: Global HIV Epidemic

(Source: UNAIDS 2006)

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Country	Adults (15+) and children living with HIV	Adults (15+) and children newly infected with HIV	Adult (15-49) prevalence (%)	Adult (15+) and child deaths due to AIDS
Sub-Saharan Africa				
2005	24.5 million [21.6-27.4 million]	2.7 million [2.3-3.1 million]	6.1 [5.4-6.8]	2.0 million [1.7-2.3 million]
2003	23.5 million [20.8-26.3 million]	2.6 million [2.3-3.0 million]	6.2 [5.5-7.0]	1.9 million [1.7-2.3 million]
North Africa and Middle East				
2005	440 000 [250 000-720 000]	64 000 [38 000-210 000]	0.2 [0.1-0.4]	37 000 [20 000-62 000]
2003	380 000 [220 000-620 000]	54 000 [31 000-150 000]	0.2 [0.1-0.3]	34 000 [18 000-57 000]
Asia				
2005	8.3 million [5.7-12.5 million]	930 000 [620 000-2.4 million]	0.4 [0.3-0.6]	600 000 [400 000-850 000]
2003	7.6 million [5.2-11.3 million]	860 000 [560 000-2.3 million]	0.4 [0.2-0.6]	500 000 [340 000-710 000]
Oceania				
2005	78 000 [48 000-170 000]	7200 [3500-55 000]	0.3 [0.2-0.8]	3400 [1900-5500]
2003	66 000 [41 000-140 000]	9000 [4300-69 000]	0.3 [0.2-0.7]	2300 [1300-3600]
Latin America				
2005	1.6 million [1.2-2.4 million]	140 000 [100 000-420 000]	0.5 [0.4-1.2]	59 000 [47 000-76 000]
2003	1.4 million [1.1-2.0 million]	130 000 [95 000-310 000]	0.5 [0.4-0.7]	51 000 [40 000-67 000]
Caribbean				
2005	330 000 [240 000-420 000]	37 000 [26 000-54 000]	1.6 [1.1-2.2]	27 000 [19 000-36 000]
2003	310 000 [230 000-400 000]	34 000 [24 000-47 000]	1.5 [1.1-2.0]	28 000 [19 000-38 000]
Eastern Europe and Central Asia				
2005	1.5 million [1.0-2.3 million]	220 000 [150 000-650 000]	0.8 [0.6-1.4]	53 000 [36 000-75 000]
2003	1.1 million [790 000-1.7 million]	160 000 [110 000-440 000]	0.6 [0.4-1.0]	28 000 [19 000-39 000]
North America, Western and Central Europe				
2005	2.0 million [1.4-2.9 million]	65 000 [52 000-98 000]	0.5 [0.4-0.7]	30 000 [24 000-45 000]
2003	1.8 million [1.3-2.7 million]	65 000 [52 000-98 000]	0.5 [0.3-0.6]	30 000 [24 000-45 000]
TOTAL				
2005	38.6 million [33.4-46.0 million]	4.1 million [3.4-6.2 million]	1.0 [0.9-1.2]	2.8 million [2.4-3.3 million]
2003	36.2 million [31.4-42.9 million]	3.9 million [3.3-5.8 million]	1.0 [0.8-1.2]	2.6 million [2.2-3.1 million]

Figure III: Regional HIV/AIDS Statistics

(Source: UNAIDS 2006)

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Figure IV: Map of Brazil

(Source: Govt. of Brazil in Bacon et al 2004)

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Region	States	State Capital
South	Rio Grande do Sul	Porto Alegre
	Santa Catarina	Florianópolis
	Paraná	Curitiba
Southeast	São Paulo	São Paulo
	Rio de Janeiro	Rio de Janeiro
	Minas Gerais	Belo Horizonte
	Espírito Santo	Vitória
Center West	Mato Grosso	Cuiabá
	Mato Grosso do Sul	Campo Grande
	Goiás	Goiânia
	Distrito Federal	Brasília
North	Amazonas	Manaus
	Acre	Rio Branco
	Roraima	Boa Vista
	Rondônia	Porto Velho
	Amapá	Macapá
	Para	Belém
	Tocantins	Palmas
Northeast	Bahia	Salvador
	Alagoas	Maceió
	Sergipe	Aracaju
	Pernambuco	Recife
	Paraíba	João Pessoa
	Rio Grande do Norte	Natal
	Ceará	Fortaleza
	Piauí	Teresina
	Maranhão	São Luis

Figure V: Brazilian Regions and States

(Source: Govt.of Brazil in Bacon et al 2004)

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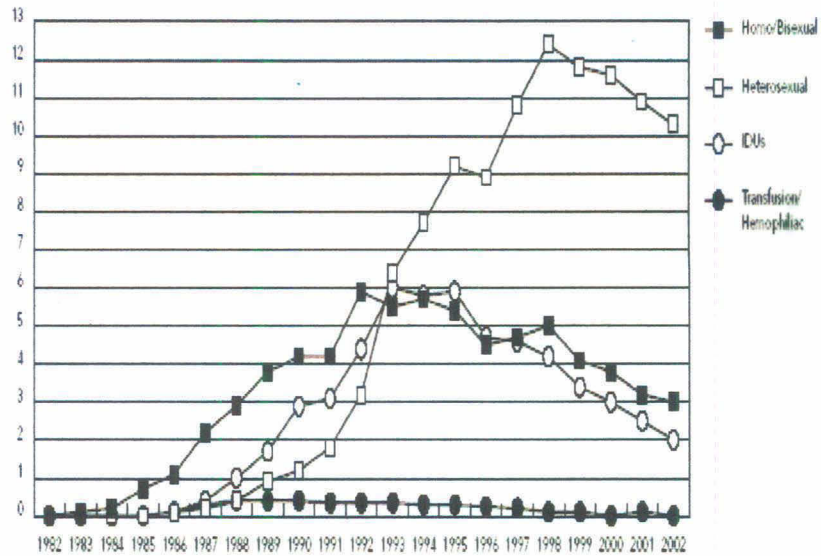


Figure VI: AIDS Incidence Rate in Brazil

(Source: Hacker et al 2006)

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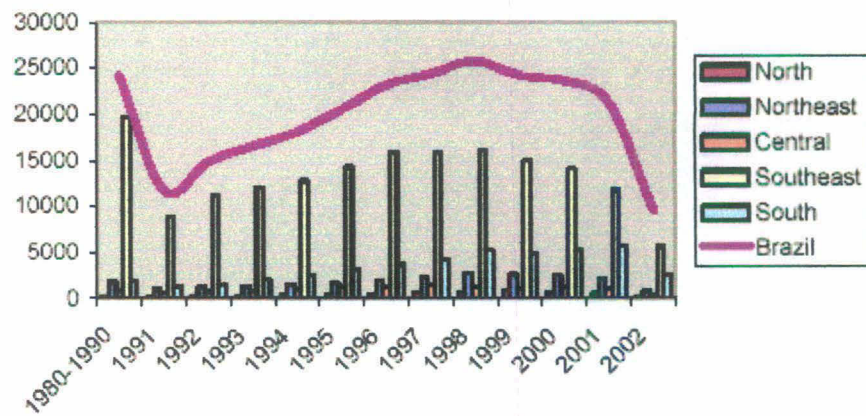


Figure VII: AIDS Case Incidence by Region in Brazil

(Source: Ministry of Health Brazil, 2002 in Bacon e al. 2004)

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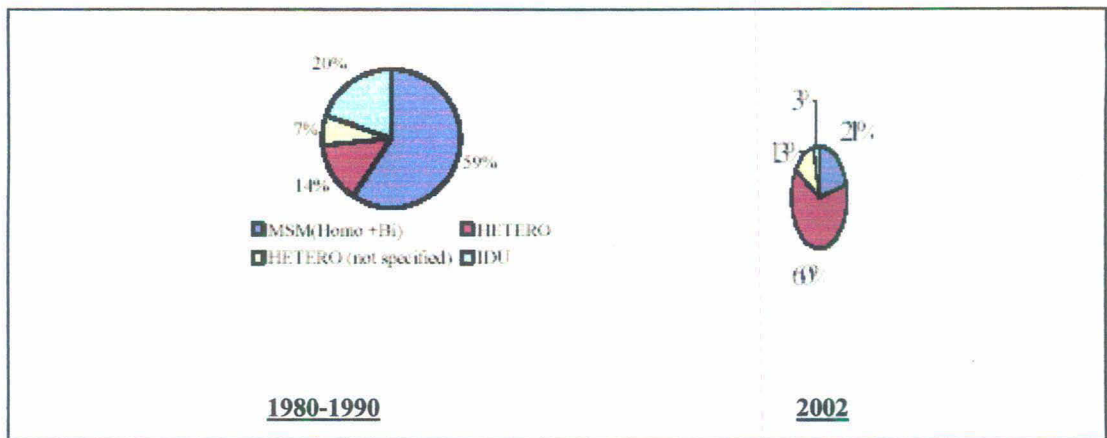


Figure VIII: AIDS Modes of Transmission

(Source: Ministry of Health Brazil, 2002 in Bacon et al. 2004)

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Figure IX: Map of India

(Source: graphicmaps.com)

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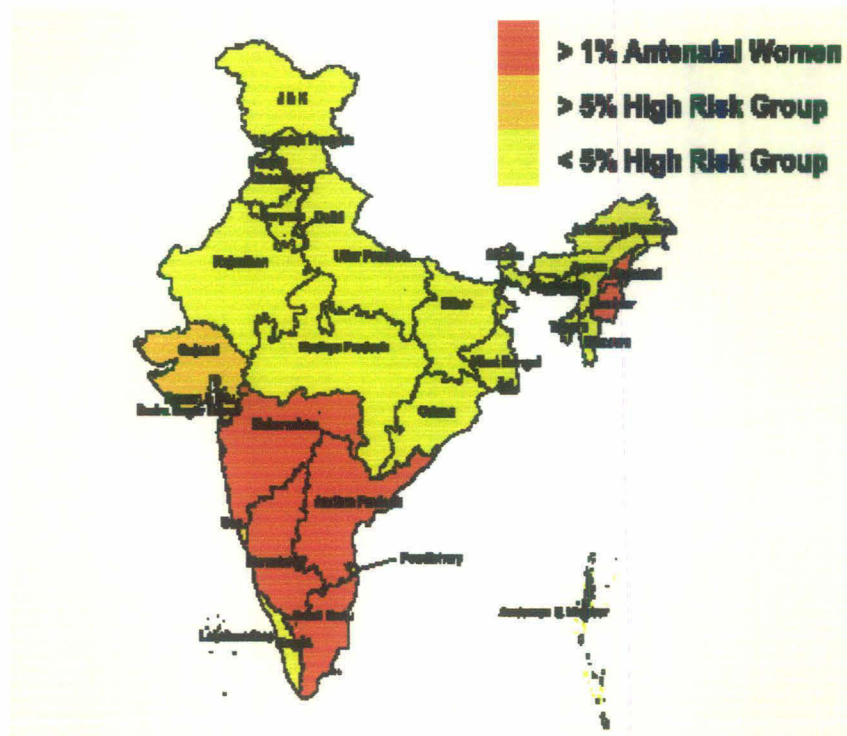


Figure X: Adult HIV prevalence-2003

(Source: NACO 2004)

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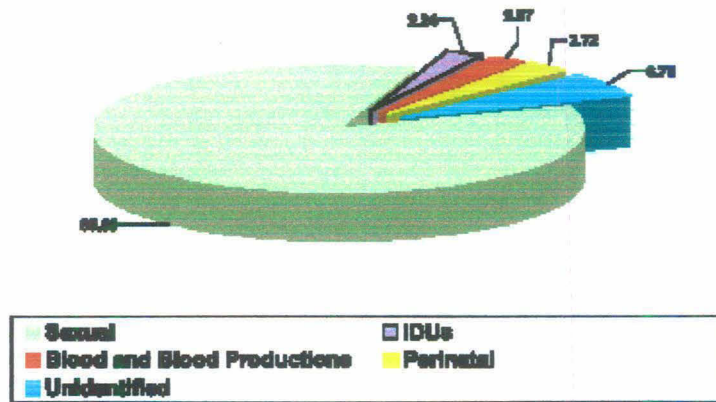


Figure XI: Routes of HIV Transmission, 2003

(Source: NACO 2003)

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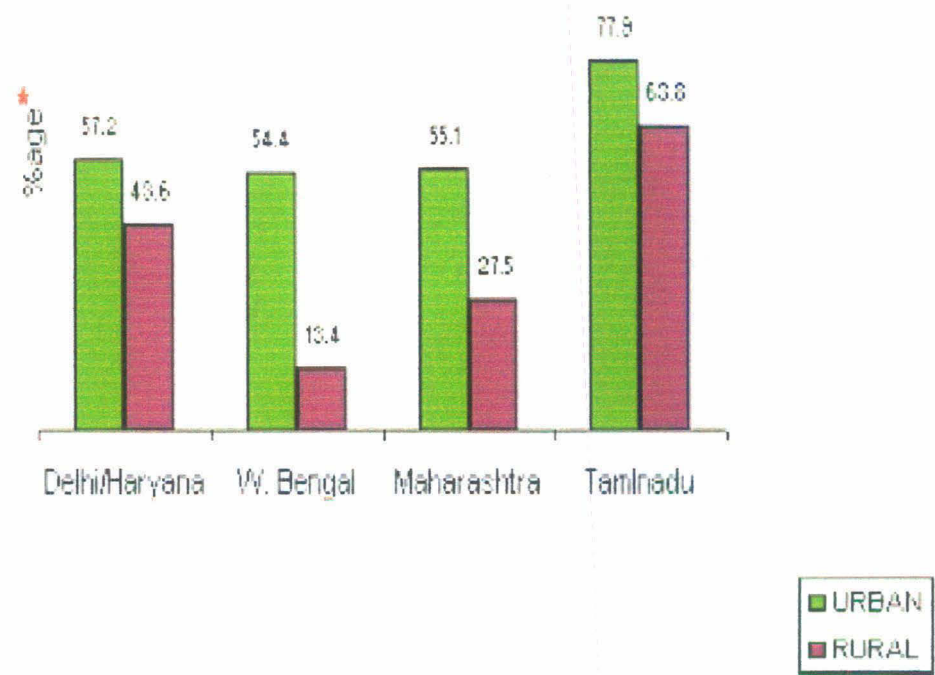


Figure XII: Urban/Rural HIV awareness among various states

(Source: NACO 2003)

The AIDS Epidemic in Brazil, India and South Africa:
a comparative evaluation of state responses

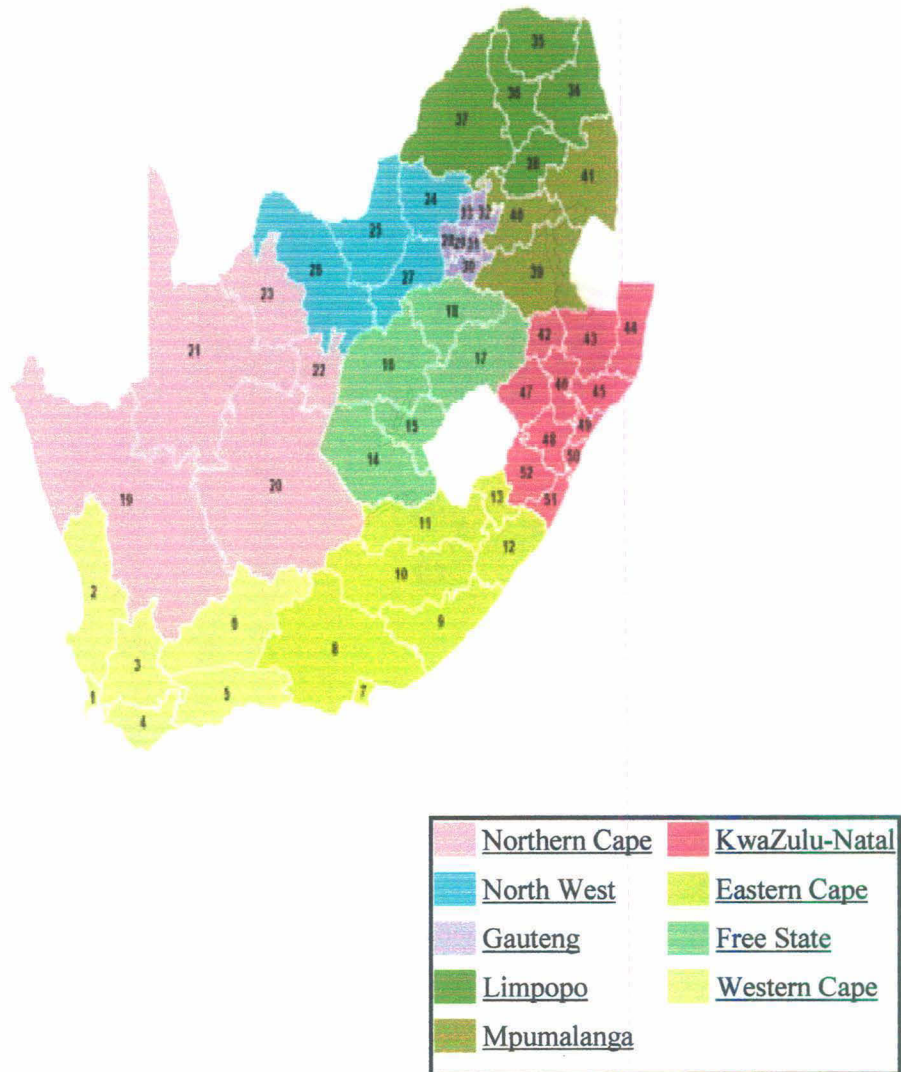


Figure XIII: Map of South Africa showing the provinces and districts (numbered) of South Africa.

(Source: Wikipedia encyclopedia)

**The AIDS Epidemic in Brazil, India and South Africa:
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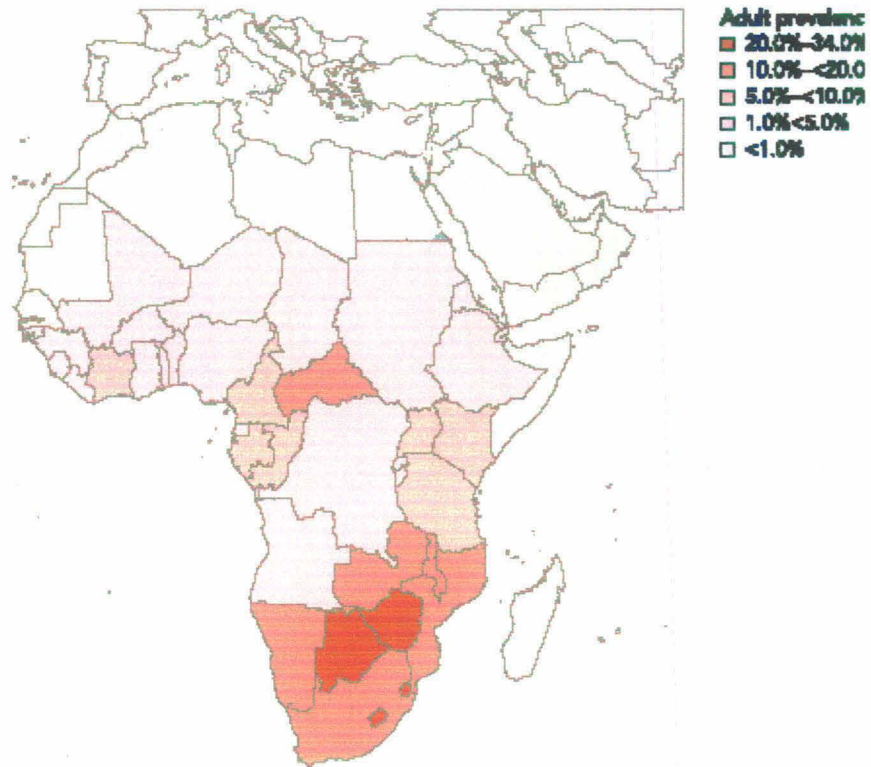


Figure XIV: HIV Prevalence (%) in Africa. South Africa (Red Portion) showing with highest prevalence rate.

(Source: UNAIDS 2006)

**The AIDS Epidemic in Brazil, India and South Africa:
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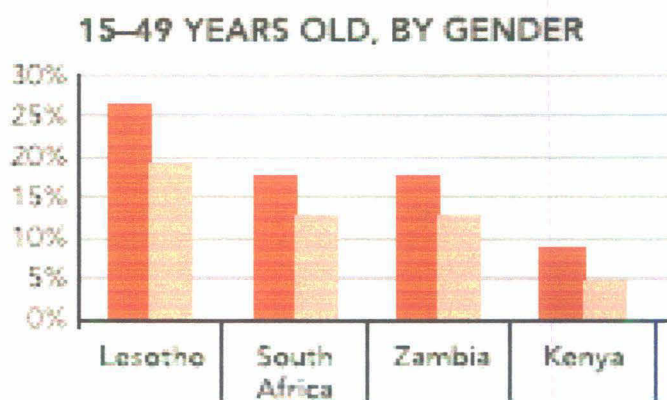


Figure XV: HIV Prevalence (%) by Gender in Selected South African Countries including South Africa

(Source: UNAIDS 2006)

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