Boundary Institutions and HIV/AIDS Policy in Brazil and South Africa[*]

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Why have some national governments acted more aggressively to address the HIV/AIDS pandemic than others? More specifically, what explains widely varied responses across Brazil and South Africa—two countries where one might have expected more similarity than difference? We argue that *boundary institutions*—those sets of rules and practices that give social and political meaning to group identities—help explain this puzzle. Institutions interact with other pressures to structure the dissemination of information, the construction of risk, and priorities within society. Where institutions divide groups deeply, elites and ordinary citizens are less likely to feel vulnerable, and more likely to blame other groups, making aggresive government action far less likely.

Introduction

Given the magnitude and implications of the crisis, the devastating global AIDS pandemic must begin to figure more prominently in theoretical and empirical scholarship on the politics of development policy.[1] In this article, we take up the specific question of explaining divergent policy responses. Brazil and South Africa are both recently democratized, upper-middle income countries that have faced significant AIDS epidemics. Yet Brazil stands out as a world leader on AIDS prevention and care, while South Africa, for most of the epidemic, has been criticized as a laggard. What accounts for these differences? Our initial motivation is the substantive importance of the question, yet our explanation has broader theoretical implications for understanding the relationship between institutions, identities, and policymaking.

Our explanation highlights the role of boundary institutions—the rules and procedures, especially those implemented by the state, which involve monitoring or regulating citizens according to particular group identities. When boundary

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institutions consistently reinforce racial or ethnic group identities, this is likely to impede the political mobilization of a generalized threat and to facilitate patterns of denial and blame across group lines, ultimately leading to less aggressive national responses. Whereas a country's level of development and health capacity, the extent of its epidemic, the nature of the political regime, and its place in the international political economy all affect politics and decisionmaking, these factors are insufficient for understanding cross-country patterns. Our findings are based upon analyses of government documents, newspaper articles, secondary accounts, websites of various actors and international organizations, and semi-structured interviews conducted out by the authors with approximately 90 individuals from the two countries, carried out in Brazil (May 2003), South Africa (June/July 2003), and in Bangkok, Thailand, during the Fifteenth International AIDS Conference (11-16 July 2004).[2]

Theory: Boundary Institutions, Information, and Risk

By now, few political scientists doubt the relevance of institutions as determining factors in the organization of politics and on substantive outcomes. More contentious is the nature of the relationship between institutions and outcomes, and *which* institutions matter for politics. Our central aspiration in this article is to develop a "mid-level" theory that explains how a particular set of institutions affects a particular policy area, with its own distinctive properties (Thelen and Steinmo, 1992: 10-11). Following Frederik Barth's (1969) classic statement, we focus on the role of boundaries within societies as potential sources of intergroup division and conflict, which in turn structures how information is disseminated and how citizens and elites are likely to understand their own risks of being affected by social processes and policy interventions.

It is somewhat understandable, if truly lamentable, that governments have not always responded to AIDS aggressively. The human immunodeficiency virus (HIV), which causes AIDS, is largely transmitted through sexual contact; symptoms are slow to appear; and most related policies promise uncertain, long-term benefits, not immediate material gains. Moreover, HIV/AIDS is associated with taboo subjects, such as sex, sexual orientation, sexual (in)fidelity, and drugs. Prevention policies involve inducements and sanctions to motivate individuals to do things that they might not otherwise do (wear condoms, abstain from sexual relations, use clean needles, get tested for HIV); and the disease itself has been associated with social deviance. In these ways, it is a policy area that demands sacrifice, more akin to taxation or conscription (Levi, 1988; 1997) and less like "typical" distributive social policies, such as health insurance or pension benefits.[3] To gain widespread demand for or acceptance of such policies, citizens and elites must perceive a real threat of infection. In the early stages, only a very small portion of a population will be infected, and the political challenge for proponents of aggressive policy is to persuade elites and ordinary citizens that the presence of the virus within society is *generally* threatening, and potentially avoidable through deliberate action. Because the efficacy of policy interventions are almost always uncertain (Grindle and Thomas, 1991: 4-5), and because disease risks are always interpreted and usually manipulated, the task for political analysis is to identify the variables that facilitate the social construction of a generalized threat and a plausible response.[4]

In our model of policy responsiveness, boundary institutions play a critical role in the politics of policymaking. Boundary institutions are those sets of rules that regulate racial and ethnic group categories and intergroup behavior. Examples of boundary institutions include the census and other protocols for gathering and disseminating information in terms of group identities; policies granting access to jobs, political offices, schools, and certain rights of citizenship on the basis of group membership; and group-differentiated personal law. In our investigation of the politics of AIDS policies, we are particularly interested in the regulation of racial and ethnic group boundaries because membership *may be* presumed to be given at birth and to be unalterable; and intimate contacts between sexual partners and between mothers and infants—the two leading pathways for spread of infection in the countries we analyze—*may be* presumed to be contained within such groups. As we will discuss, these properties are particularly consequential for assessing risks of infection to oneself, one's family, and other intimate relations over the long term.

Boundary institutions are created because states, in their efforts to monitor and to regulate large and diverse populations, often require information about group identities to allocate rights and responsibilities according to prevailing policy and strategy. Such information may be used for a range of purposes—to deny privileges to certain groups of citizens (i.e., race-based slavery), to rectify past injustices, or merely to keep track of the cultural and socioeconomic composition of the larger society. While national states in the modern state system attempt to control large territories by building a sense of political unity, such aspirations often conflict with claims to difference originating from the forced and voluntary mixing of people with different cultural and physical traits, international norms about the recognition of group difference and human rights, as well as patterns of mobilization and de-mographic change within societies. In the face of such contradictions, there may be pressures to create or modify boundary institutions to further emphasize or diminish the recognition and salience of groups. We do not propose a theory of the origins of such boundary institutions, or the specific determinants of institutional change. Instead, we attempt to tease out the implications of institutional variation.

We can say that boundary institutions are "strong" when the same group labels and categories are repeatedly and consistently used across institutional forms, and when those state-sanctioned labels and categories correspond with the everyday racial or ethnic divisions that people employ in society. Boundary institutions are "weak" when group labels are not used; or when they are used inconsistently or very flexibly, and these inconsistent or flexible uses by the state correspond with a fluid use of the labels in society. When states and societies are out-of-sync in the consistency and rigidity of usage of group labels, we would describe such boundary institutions as "mixed." While emphasizing the role of formal boundary institutions controlled by the state, we realize that these are likely to shape and be shaped by more informal and unwritten rules of group contact, such as prevailing norms of intermarriage and social contact.[5] Because of the important role state institutions play in collecting and disseminating public health information, and the likelihood of correspondence between states and societies in their use of group labels, we emphasize the role of formal, state institutions.

We depart from strict rational-choice perspectives that specify what voters or consumers prefer *ex ante* (Weingast, 2002: 661), including much recent scholarship

on the impact of ethnic politics, which has also tended to assume that policy preferences in ethnically diverse societies are intrinsically heterogeneous across group lines (e.g., Easterly and Levine, 1997; Alesina et al., 1999). By contrast, we build on the work of those who claim that institutions can structure both cognitions (Knight, 2002) and policy priorities (Steinmo et al., 1995: 27), refracting and interacting with other social, political, and economic pressures.

Particularly for policies in which risks, costs, and benefits are unclear, boundary institutions provide "convenient" labels and reference points for processing information about "hidden" risks. When boundary institutions are strong, preferences and strategies are more likely to be shaped along such lines, and political entrepreneurs are likely to seize on these labels. Our understanding of the impact of identity politics on policy comes closer to Edward Miguel's (2004), who emphasizes the value of nation-building strategies for achieving cooperation, with positive effects for the provision of public goods. We highlight the particular implications of "nation-dividing" institutions (internal boundaries) on preferences and policymaking.

When boundary institutions reinforce subnational identities, they can reduce intergroup contacts and exchanges, but more important, they promote the widespread *perception* of low cross-boundary contact. To the extent that the state asks questions about group identity and reports information or frames policies in terms of such groups, citizens soon believe that social conditions and associated policies will affect them *as members of those groups*, potentially in conflict with the fortunes of other groups. In the case of health problems, this includes reporting on epidemiological and behavioral patterns in group terms. When boundary institutions are weak or permeable (Lamont and Molnár, 2002: 186), members of society are more likely to believe that interethnic contact is standard practice, and it becomes easier to imagine that risks are shared across groups.

Turning to the problems of infectious disease, we argue that in societies with strong boundary institutions, individuals located in groups not yet identified with the pathogen are more likely to believe their families, partners, and regular social contacts are unlikely to mingle with infected individuals because the latter are supposedly located in stigmatized groups on the other side of the boundary. Because social boundaries often have real or imagined bodily correlates, and because epidemics tend to inspire metaphors of physical difference (Sontag, 2001), groups with initially lower rates of disease tend to believe that their bodies and physical habits, such as hygiene, drug use, or promiscuity, are distinctive, and therefore impervious to infection. Conversely, when boundary institutions are weak, information about group infection may not be available, implying weak prospects for political entrepreneurs and citizens to mobilize ideas about insulation from risk.

Beyond their impact on perceptions of risk, strong boundaries institutions increase the likelihood that competitions concerning group status will inform policy debates about important and sensitive topics. Following social identity theory (e.g., Tajfel and Turner, 1986: 16), group members strive to achieve or to maintain a positive social identity and to reduce negative images whenever possible. Because social boundaries inevitably concern not only group differences, but also intergroup moral hierarchies in which groups occupy spaces of relative virtue or cleanliness, a dynamic of blame and shame about the pathogenesis of AIDS ensues. This results in a tendency to deny known risks because of the shame entailed in recognizing it. In

a bitter irony, even among groups for which infection is known to be higher, such moral competition may lead those groups to downplay the problem in anticipation of the costs of self-stigmatization. This has been found to be the case for the AIDS epidemic among African Americans in the United States (Cohen, 1999).

Our central hypothesis is that when state institutions consistently reinforce group boundaries that can be plausibly linked to differential risks for HIV infection, this is likely to impede the roll-out of AIDS policies, irrespective of which group holds political power.

Government Responses to HIV/AIDS in Brazil and South Africa

In this section, we turn to a paired comparative-historical analysis of government HIV/AIDS responses and attempt to explain the Brazilian government's much more aggressive response when compared with South Africa's. Since our general model was largely derived through an empirical investigation of AIDS politics and policy in Brazil and South Africa, our analysis cannot be considered, strictly speaking, a "test" of our argument. No single case or pair of cases can be said to be "representative" of a larger sample in any meaningful way, and we leave it to future research to assess the generalizabilty of our propositions. The strength of our research design is the analysis of generally similar cases[6] with highly varied scores on the central explanatory variable (King et al., 1994: 137-142). Both are middle-income countries: and per capita income in 2002, in international dollars adjusted for purchasing power parity, was $9,810 in South Africa and $7,450 in Brazil. Income inequality is high in both countries: South Africa had a GINI index of .59 in 1995, and Brazil's GINI was .58 in 2001 (World Bank, 2005). Both are characterized by a high degree of ethnic and racial heterogeneity—a critical similarity because our argument is not about demographics *per se*, but about the impact of institutions that mediate the social and political meaning of such heterogeneity.

Similar Threats

It is true that South Africa's epidemic, measured by HIV prevalence, is *today* orders of magnitude larger than Brazil's, but this may partly be explained by the very differences in government policy that we investigate here. However, the epidemic followed a similar initial trajectory in both countries. The first case of AIDS was reported in Brazil in 1982 and in South Africa in 1985. In the first decade, HIV/AIDS most visibly affected urban, white, educated gay men in *both* countries. Commercial sex workers, the poor, and heterosexuals more generally were visibly affected only 7-10 years later. From 1982 to 1990, 43 percent of reported AIDS cases in South Africa were transmitted through men having sex with men (Hamilton, 1991); the corresponding figure for Brazil in mid-1993 was 56 percent (World Bank, 1993). By the early 1990s, there was widespread concern in both countries that the epidemic was poised to become "generalized" or "explosive" (Grundligh, 2001; Galvão, 2000: 192; Brooke, 1993). In the early 1990s, the absolute number of cumulative cases of *diagnosed* AIDS was more than an order of magnitude higher in Brazil than in South Africa, but a retrospective UNAIDS prevalence map (2004) indicates that by 1993, infection rates were already slightly higher in South Africa

than in Brazil. Nonetheless, national HIV prevalence of less than 1 percent was interpreted as generally threatening in Brazil, but even after South Africa began to report double-digit HIV prevalence levels, there was significant delay in political and policy responses.

Different Policy Responses

We consider four broad areas of government responses to HIV/AIDS: the construction of bureaucratic capacity, the broadcasting of prevention strategies, the provision of treatment and support to people who are HIV positive, and human rights/nondiscrimination protections. We are interested in comparing the aggressiveness of government response in these areas, measured in terms of *speed* and *scope*. Overall, we find that in South Africa the response was substantially more delayed and less robust than in Brazil. Table 1 summarizes the differences.

Brazil established an AIDS bureaucracy earlier than South Africa, and it created a much larger agency that assumed significant authority in formulating policy by the end of the 1980s.[7] By contrast, there is still no truly autonomous AIDS policy-making unit in South Africa: although the South African National AIDS Council (SANAC) was established in 2000 (RSA, 2000: 12), this body is not widely recognized as the authoritative source of decisionmaking on AIDS policy.

Although the South African AIDS budget increased dramatically in recent years, reflecting increasing attention to the HIV/AIDS problem, the Brazilian state dedicated more resources to HIV/AIDS sooner, and by our calculation, spent more than eight times what the South African government spent from the start of the epidemic until 2003. (Brazil's GDP and population are approximately four times the size of South Africa's, but the cumulative number of infected individuals is just a fraction of South Africa's.) Brazil's national budget included a reference to AIDS control as early as 1988, when it was included in the program to control sexually transmitted diseases (*Orçamento da União, Projeto da Lei*, Vol. 1, 1988); but it was not until the 1997 budget speech in South Africa that AIDS was even mentioned in the formal presentation of that country's budget, and it was not until 2000 that the expenditure estimates of the budget would reveal specific line items dedicated to expenditure on HIV/AIDS.

Most major prevention policies and programs generally occurred a decade or so sooner in Brazil (Gauri, Beyrer, and Vaillancourt, 2006) than in South Africa. Though the South African government has a long history of rolling out minor and pilot HIV/AIDS prevention programs, many were misguided or poorly implemented (Schneider, 2002: 147; Grundligh, 2001: 137-144). Major national campaigns to respond to the key drivers of the epidemic were not launched until the epidemic was generalized throughout the country. The South African government also famously resisted the use of antiretroviral (ARV) drug monotherapy for the prevention of mother-to-child transmission (PMTCT)—an inexpensive and effective strategy for reducing pediatric AIDS (Nattrass, 2004). A notable exception involved blood safety, where South Africa was actually more aggressive than Brazil—an important exception that we attribute to the less contentious nature of regulating blood supply as compared with the behavior of individuals.

Table 1
Timing and Scope of State Responses to HIV/AIDS

Bureaucracy	SOUTH AFRICA	BRAZIL
National AIDS program established	1988	1985
Interministerial AIDS Council established	1998	1988
Appearance of HIV/AIDS as budget line item	2000	1988
Number of HIV/AIDS program staff	100 (2004)	476 (2002)
Partnerships with NGOs	Mixed/Conflictual: NGOs challenge, sue government	Collaborative: Direct budgetary support to NGOs since 1993
Monitoring and evaluation	Systematic antenatal clinic surveillance since 1990, little surveillance among risk groups	Ad hoc monitoring among risk groups since 1989, systematic population based monitoring since 1998

Prevention

	SOUTH AFRICA	BRAZIL
Education and outreach	Epidemic already generalized before significant campaigns initiated	TV spots and workplace by 1988; School-based by 1992; Targeted outreach programs (e.g. with MSM* 1985, sex workers 1990, harm reduction/needle exchange 1996)
Condom distribution	More muted program with less outreach. Government distributes approximately 540 million in 2004 (12 units per capita)	Extensive, high visibility government programs. Government announces distribution of 3 billion in 2004 (17 units per capita)
Prevention of Mother-to-Child Transmission (PMTCT)	2001 Nevirapine provided only following legal battle	1994 Launch of AZT 076 protocol
Safety of blood supply	Deemed safe in 1985	Mostly safe in 1988, clandestine blood market eliminated in 1998

Treatment

	SOUTH AFRICA	BRAZIL
Monotherapy	-- Never implemented	1991 Universal and free AZT
Initiation of public Highly Active Anti-Retroviral Therapy (HAART)	2004 (21,000 on HAART in 2003, of which 1,500 funded by government)	1996 (175,000 on ART or follow up in 2003; virtually all funded by government)

Human Rights

	SOUTH AFRICA	BRAZIL
Workplace non-discrimination	1995 Employment equity law	1988 Law extends disability protection to HIV-positive citizens

More aggressive actions are shaded.
*MSM: Men who have sex with men

Table 2
Central Government Expenditures on HIV/AIDS (1987-2003)

	ARV expenditures ($US millions)		Non-ARV expenditures ($US millions)		Total ($US per capita)		Total ($US per HIV+)	
	So. Africa	**Brazil**	**So. Africa**	**Brazil**	**So. Africa**	**Brazil**	**So. Africa**	**Brazil**
1987			0.5		0.01			
1988								
1989								
1990			2.1	0.3	0.06	0.00		
1991				14.2		0.09		
1992				7.8		0.05		
1993				26.9		0.17		
1994				36.9		0.23		
1995			10.7	49.7	0.27	0.31		
1996	0	34	16.3	75.2	0.41	0.68		
1997	0	224	15.2	36.2	0.37	1.59		
1998	0	305		55.9		2.18		
1999	0	336		85.9		2.51		
2000	0	303	10.8	73.5	0.25	2.21		
2001	0	232	40.0	54.5	0.89	1.66	4.44	
2002	0	179	61.4	30.0	1.35	1.20		184.28
2003	12	181	116.6	80.0	2.84	1.48	13.20	

Sources: Ministerio da Saúde, 2005; World Bank, 2004; World Bank, 2005; Hickey, 2004; Van der Vliet, 2001; Bennett, 1990; Schneider and Stein 2001. Empty cells indicate lack of available data

Brazil has forged much deeper and cooperative partnerships with NGOs than South Africa. Although there were notable conflicts between Brazil and NGOs in the mid- to late 1980s, after the return of the previous director of the National AIDS Program in 1992 and the beginning of the first major World Bank loan in 1993, the state began to transfer significant resources to NGOs for HIV/AIDS prevention, outreach, treatment, and support projects (Teixeira, 1997; Galvão, 2000; World Bank, 2004). While there have been important instances of cooperation, relations between South African NGOs and the national government have developed with more conflict. A series of disputes concerning the use of prevention funds for a high-priced musical production, commitment toward the National AIDS Plan, and government support of a domestically developed AIDS drug damaged state-NGO relations, resulting in hostility, protests, international condemnations, and lawsuits (Gumede, 2005: 153; Van der Vliet, 2001: 170).

Brazil's public health system began to provide free AZT to all patients with clinical AIDS in 1991. In 1996, its Congress passed a law requiring the public system to provide all medically necessary pharmaceuticals for AIDS patients, and Brazil began to provide highly active antiretroviral therapy (HAART) and the requisite laboratory monitoring support for patients with clinical AIDS late that year. But the South African government resisted the public provision of such drugs for treatment until recently, introducing a "comprehensive plan" for care and treatment only in 2003.[8]

In 1988, Brazil passed a law guaranteeing workers with HIV/AIDS the same rights afforded to those with other incapacitating illnesses and, in 1992, the government disallowed HIV testing before school admission and made it illegal to dismiss HIV-positive students, teachers, or school staff. In South Africa, a law regarding employment equity protection was not passed until 1995 (Garbus, 2003: 75). In fact, the South African state initially reacted to the HIV/AIDS threat not by protecting the rights of HIV positive individuals but with coercive measures. In 1987, the government announced that it would deport all HIV-positive migrant workers, and it added HIV/AIDS to the list of "notifiable" diseases, which would require medical practitioners to report HIV positive individual names to the public health authorities (Ngwena, 1998: 119). Although both of these acts were eventually repealed, they demonstrated the government's initial intent to be more repressive, using control and force, rather than engaging in a strategy that supported the rights of the infected.

Partial and Alternative Explanations

Before turning to our central explanation, we highlight the limits of several alternative accounts. Although these factors have clearly influenced policymaking in the two countries, we conclude that they were not *sufficient* to produce the divergent responses described above.

State Capacity and Public Health

One prominent analysis of the responses of the advanced industrialized epidemic to HIV/AIDS highlights the impact of longstanding approaches to other public health problems (Baldwin, 2005: 1). Common sense compels us to inquire about relative

differences in public health capacities and strategies as a possible answer to our puzzle. Although state capacity in Brazil is strong compared to many developing countries, and was certainly important for the development of Brazil's aggressive response to AIDS, it is difficult to conclude that the Brazilian state is generally more efficacious than the South African state. Whether we use overall levels of central state taxation, direct collections of income tax (Lieberman, 2003), percentage of paved road, or ICRG country risk ratings as proxies for overall state capacity (World Bank, Development Data Platform, 2005), South Africa meets or exceeds Brazil for most years between 1980 and 2002.

With respect to capacity in public health, both countries have mixed records, which would have made it difficult to predict *ex ante* if either country would have responded aggressively. Brazil's Oswaldo Cruz Foundation, which was founded in 1900 to address growing epidemic threats such as yellow fever and bubonic plague, has been a leading institution in public health; but Brazil has struggled with many other public health crises in the decades preceding the AIDS crisis, including historically high rates of child and maternal mortality, endemic malaria, and periodic outbreaks of dengue and cholera. The South African government established a policy guaranteeing free care to all pregnant women and children aged six and under—which made the specific failure to initiate a PMTCT program particularly surprising. In the past 20 years, both countries launched reforms that made their general health care system accessible to poor and excluded groups: Brazil in 1990, with the inclusion of informal sector workers into the system that was formerly available only to those contributing payroll deductions; and South Africa in 1989-1990, with the desegregation of the public system. An expert-based assessment of maternal and neonatal health services rated Brazil's program "weak" while South Africa's was "moderate" (Bulatao and Ross, 2002). Total expenditures for health have been comparable for the two countries in recent decades, and when different, they have been higher in South Africa. Public sector health expenditures as a share of GDP were close to 4 percent in South Africa and close to 3 percent in Brazil between 1997 and 2001 (World Bank, Development Data Platform, 2005).

Political Regimes and Civil Society

Social scientists have long been concerned with the impact of democracy on development (e.g., Sen, 1999). In the specific area of public health, theory has been mixed. In his examination of government responses to epidemics in Europe between 1830 and 1930, Peter Baldwin (1999: 24-36) identifies the Ackernacht thesis, which posits that public health threats are often addressed more forcefully under authoritarian regimes. Varun Gauri and Peyvand Khaleghian (2002) discuss the potentially ambiguous effect of democracy on public health outcomes. Goran Hyden and Kim Lanegran (1993); Catherine Boone and Jake Batsell (2001); and Evan Lieberman (2004) raise this question about HIV/AIDS, recognizing that the impact might be ambiguous. We cannot derive any general conclusions from our paired comparison, but we find similar regime dynamics driving contrasting patterns of politics and policy, suggesting the limits of any strong conclusions about the impact of regime type.

The Brazilian response to AIDS must be seen in the context of the movement to restore democracy after a long period of military rule, which spun off a move-

ment to provide health care to underserved groups and regions, the *moviemiento sanitaria* (Weyland, 1995). That movement also informed and motivated activism about AIDS policies. Several influential former exiles and opponents of the military regime contracted AIDS themselves and played significant roles in the mobilization of Brazilian civil society to fight AIDS in 1987-1988 (Biehl, 2004; Parker, 1994a; Galvão 2000). The number of registered NGOs working on HIV/AIDS increased from 120 to 480 between 1993 and 1997 (Galvão, 2000), and a review conducted for the World Bank in 2003 found 798 different NGOs working on HIV/AIDS in Brazil. The influence of Brazilian NGOs was visible in their opposition to national AIDS policies under President Fernando Collor de Mello, which led to the return of the previous HIV/AIDS program director (Teixeira, 1997; Galvão, 2000), in their efforts to secure additional AIDS treatment funding in 1999, despite the recent devaluation and financial crisis, and in the routine movement of AIDS activists into government positions in recent years.

These organizations were important for mobilizing general perceptions of risk in Brazil, and ultimately for policy outcomes; but the South African case demonstrates that the presence of a strong and robust civil society is not a sufficient condition for aggressive policy. The weak South African response in most other aspects of AIDS policy has persisted well after significant political openings, including the completion of three free and fair multiparty national elections. As in Brazil, South African civil society was vocal and organized as a collective actor in the establishment of democracy (Seidman, 1994). Similarly, civil society organizations have been long present in the HIV/AIDS sector. Mary Crewe observed in 1992, "much of the successful work in AIDS prevention is being taken on by NGOs and other important groups such as unions and the ANC" (Crewe, 1992: 71).[9] As of 2000, there were over 600 NGOs working in the HIV/AIDS field, and by 2004 (Van der Vliet, 2001: 170), the AIDS consortium website claimed more than 1,000 organizational members, including the Treatment Action Campaign (TAC), which has mobilized a series of campaigns, including court litigation, public relations campaigns, and civil disobedience. Although the generally strong AIDS civil society is at least partly responsible for some of the more recent policy developments in South Africa, including public provision of PMTCT and HAART, we are struck by the *insensitivity* of government decisionmakers to the strong South African civil society organizations that have mobilized on this issue. This vocal but concentrated group of activists did not manage to capture the national imagination about the threat of HIV/AIDS because their claims have repeatedly the abyss fallen into strong group boundaries, as we discuss below.

In terms of comparing the timing of policies, the historical records *do* suggest that democratic transitions in both countries directly facilitated the protection of human rights for HIV-positive individuals. In the South African case, far more coercive measures, which *restricted* the rights of many HIV-positive individuals and "high risk" groups were in place *before* the democratic transition, and rights-oriented protective legislation was drafted almost immediately after 1994. Overall, although democratic regime change provided an opening for the development of human rights protections, its impact on the other aspects of AIDS policy, particularly the ones requiring the greatest sacrifices and the most recognition of personal risk, was not consistent.

International Influences

Because AIDS has been the first major epidemic during globalization (Altman, 1999; Barnett and Whiteside, 2002), international actors have attempted to establish global governance regimes to prevent the further spread of HIV infection, offering assistance, and applying pressure directly to national governments. We call the portfolio of best practice ideas—which have been articulated and advocated by major international organizations such as the World Health Organization (WHO), the Global Program on AIDS, and UNAIDS since early in the epidemic—the "Geneva Consensus." Pressures to adopt the Geneva Consensus can help explain *similar* patterns of *over-time change* across countries, but on its own, this influence cannot account for important differences in the specific trajectory of country responses.

Some observers have argued that that in the first years of the epidemic, AIDS-related policy in Brazil was a "prisoner" of the broader political process, and that international influences were particularly important for the effort of AIDS NGOs to adopt a national network that resembled related efforts on the global level (Parker, 1994). For example, from 1993 to 2003, the World Bank lent Brazil US$325 million to respond to the HIV/AIDS epidemic. At the same time, South Africa was an international pariah because of its apartheid government, and had little direct contact with international organizations until after the political transition in 1994.

But the argument that international influences explained Brazil's greater aggressiveness has several problems. First, both governments have pursued aggressive strategies against pharmaceutical MNCs. The threat of compulsory licenses motivated Brazil to negotiate lower prices on imported drugs, and South Africa fought a suit by 39 pharmaceutical manufacturers challenging the country's right to import generic drugs. Second, even before the World Bank loan was signed in 1993, Brazil had established a national program; its president had mentioned AIDS in a public speech; the government had begun to purchase and to distribute some AIDS drugs, including AZT monotherapy free of charge; the government had issued several human rights protections; and at the state and municipal levels, at least 67 laws and resolutions regarding HIV/AIDS were on the books by the end of 1992 (*Ministerio da Saúde*, 2000). Third, like the South African government, which after 1994 steadfastly rebuffed offers of aid and assistance, and which in more recent years has been noncooperative and even combative with both the U.S. government and the Global Fund, the Brazilian government has defied international actors at key moments when domestic political concerns were at stake. Declaring that "Brazil will not be a guinea pig" and impugning the expertise of the WHO, the minister of health refused to participate in WHO-led HIV vaccine trials, which resulted in the temporary isolation of the Brazilian AIDS program from the international community (Parker, 1990; Teixeira, 1997). Both countries have been able to maintain substantial policy autonomy in their response to the epidemic, but only in Brazil has this produced policy aggressiveness.

Leadership

Explanations about the role of leadership are rarely given much attention in theoretical accounts of politics and policymaking, yet we cannot avoid discussion

of the now infamous statements of South Africa's President, Thabo Mbeki, who publicly expressed his sympathies for the scientific views of a small number of dissident scientists questioning the link between HIV and AIDS. Between 2000 and 2001, he began to publicly question the mainstream scientific wisdom, and in a country with a staggering AIDS epidemic, he seemed to pay little attention to the problem, rarely making HIV or AIDS a significant point of discussion in general policy addresses. His most recent health minister, Manto Tshabalala-Msimang has continued to emphasize a set of heterodox policies on HIV/AIDS, such as an emphasis on diet and vitamins, and skepticism about antiretroviral drugs, which has been widely interpreted as merely a continuation of a "dissident" approach, leading many to blame South Africa's blazing epidemic, and its government's failure to respond, on the personal idiosyncrasies of Mbeki and his inner circle.

While recognizing that the public opinions and positions of Mbeki and his advisers were individual acts that can only be understood as having a proximate, negative influence on the speed and scope of the policy response, we think it is problematic to argue that the South African outcome we have described is solely or even largely the product of Thabo Mbeki's idiosyncrasies. First, AIDS was largely neglected under the presidencies of two Nobel Peace Prize winners—Nelson Mandela and F.W. de Klerk. Second, Mbeki's record before becoming president was as a champion of HIV/AIDS prevention (*Mail and Guardian* online, 4 December 1998). Third, setting aside the issues of HIV/AIDS, it would be difficult to describe Mbeki, the second president of post-apartheid South Africa, as less than a widely respected leader who generally commands broad respect within his own society (Jacobs and Calland, 2002) and on the international stage, where he has been seen as a visionary leader in advancing African integration.

Moreover, the leadership factor cannot be sustained as a positive explanation for the Brazilian case. Most of the Brazilian presidents who were in power during the outbreak of the AIDS epidemic—José Sarney, Fernando Collor, and Itamar Franco—must be described as weak and unremarkable leaders. Of the presidents who came to power during the recent democratic era, only Fernando Henrique Cardoso and Luiz Inácio Lula da Silva ("Lula") could possibly be described as having broad popular support and possessing strong leadership styles, but their presidencies both postdate national records of aggressive action on HIV/AIDS. Moreover, the lead actors in the Brazilian health ministry were hardly visionaries. Early in the epidemic, within the Ministry of Health in Brasília, some officials argued that AIDS did not satisfy the epidemiological criteria of "transcendence," "magnitude," and "vulnerability" necessary to warrant a response from public institutions. As late as 1985, INAMPS (Instituto Nacional de Assistência Médica da Previdência Social—the medical care division of the social security institute) argued that AIDS was a "public health problem," not a medical concern, and therefore an issue for the state health secretariats (quoted in Teixeira, 1997). Although Brazil has become a world leader on AIDS, and impressive Brazilian public officials working in the field have emerged, we attribute more causal weight to broad sociopolitical inducements and constraints rather than to isolated individuals.

Federalism and Decentralization

Finally, we consider the implications of hypotheses about the influence of *varying* levels of effective decentralization across the two countries.[10] As Constance Nathanson (1996) points out, one can advance theoretically plausible hypotheses about the positive and negative effects of centralization on the aggressiveness of public health policies. There is much greater policy autonomy at the subnational *estado* level in Brazil than in South Africa's provinces because of a deeper legacy of federalism and because of the single-party domination of the polity in South Africa (by the National Party until 1994, and by the African National Congress since). One can argue that decentralization facilitated the Brazilian response, whose origins lay in the early political entrepreneurship of activists and state-level public health officials from the Southeastern states, but we cannot sustain the counterfactual claim that the South African *national government's* response would have been significantly different with greater provincial autonomy. As in Brazil, the AIDS epidemic first hit South Africa's wealthiest cities, Cape Town and Johannesburg, and there has been space, albeit more limited, for more aggressive provincial action in the Western Cape and in KwaZulu-Natal. In South Africa, provinces have had significant, concurrently shared responsibility for health since the mid-1990s. We might expect in a country with a large and widespread epidemic that its national government should have been able to respond even *more* effectively and decisively than a more fragmented state power such as Brazil (Kohli, 2004). Nonetheless, throughout the history of the epidemic, we find evidence of rebukes and refusals from the national government. It is not that the South African provinces lacked information or aggressive actors to help push for a national policy. Particularly because they were from the same party, there should have been strong and clear information channels. The more problematic issue has been the resistance of the national government to advance a policy agenda that it viewed as untenable and undesirable from the perspective of the politics of intergroup competition. Especially interesting in the Brazilian case is that the national government has been so aggressive, even when the problem was so clearly concentrated in a particular region.

The Impact of Boundary Institutions

The Brazilian government's aggressive response can be linked partly to its relatively competent state, a strong civil society, and foreign pressure to adopt the Geneva Consensus, as discussed above. Yet South Africa scores similarly on these factors, which demonstrates that such factors are not sufficient to explain the different responses. We argue that strong boundary institutions impeded AIDS policy formulation and implementation in South Africa when judged against Brazil's response. Information about the spread of the virus, the perceived risk of infection, and policy approaches have all been structured by strong boundary institutions in South Africa.

Both countries contain sizeable "black-," "white-," and "mixed-" race groups, and in both countries, blackness is a strong predictor of low socioeconomic status, which has increased susceptibility to the disease, even though the virus was initially concentrated among more affluent whites.

However, the social and political signification of race is distinctive across the two contexts. Before the turn of the twentieth century, both countries experienced long histories of European immigration, the subjugation of people of color through various legalized institutions, including chattel slavery, and sufficient "miscegenation" across European- and African-descended peoples to produce a significant "mixed" population group. As documented elsewhere, different political strategies and bargains associated with the resolution of major political conflicts in the late nineteenth and early twentieth centuries produced different state policies and eventually contrasting societal norms regarding the permeability and sociopolitical relevance of the color line (Lieberman, 2003; Marx, 1998; Skidmore, 1995; Telles, 2004). The history of South Africa, marked by institutionalized white supremacy for most of the twentieth century, created increasingly rigid categories of "White/European," "Black/African," "Coloured," and "Indian." Eventually, the South African state would enforce policies of *apartheid* or apartness, banning sexual relations across the color-bar. Beginning in the early 1980s, as the apartheid system of government began to crack from a combination of internal and external pressure, it became increasingly clear that South Africa would need to extend citizenship to people from all race groups, even as strong tensions and animosities existed between those groups. The end of apartheid and the first truly racially inclusive national election in 1994 marked an opportunity for creating a "non-racial South Africa," but centuries of separation, which helped to reinforce overlapping economic, territorial, cultural, and linguistic distinctions, have meant that South African citizens have continued to experience the effects of such boundaries for the entire history of the AIDS pandemic. In its attempts to redress a history of racial injustice, the post-apartheid state has persisted in collecting almost all household and epidemiological data along racial lines, using the same categories as the apartheid state. Strong preference policies (affirmative action) and official multilingualism continue to reinforce commonsense notions of group difference within society and polity. Official speeches and policies routinely identify race, and race continues to be a clear predictor of preferences and attitudes (Gibson, 2003).

In Brazil, following the abolition of slavery and the dawn of republican government in the last decades of the nineteenth century, the state began to promote "non-racialism" and a strategy of "whitening" (Skidmore, 1995), which explicitly called for sexual relations between individuals from different race groups as Brazilian society continued to value whiteness with higher levels of social acceptability. A longstanding policy of promoting Portuguese as a single language has helped to unite people across race groups, minimizing a sense of difference. The Brazilian census of 1970 contained no questions about race or color, and the 1960 census data were never fully released (Nobles, 2000), suggesting that by the onset of the AIDS epidemic there would be little information about even the size of different race groups in Brazil, let alone any agreement about relevant and meaningful categories. According to Melissa Nobles, the IBGE (the government's central statistical and demographic agency), "has been reluctant to cross-tabulate color categories with socioeconomic variables or to release color data in a timely fashion" (Nobles, 2000: 1744). Even the widespread use of the concept "color," as opposed to "race," in official Brazilian discourse suggests that group identity is understood less as an essential trait and more like a superficial attribute, which can take a variety of shades

and forms and can differ from parent to child, or even within one's own lifetime depending on circumstances. Although previously outlawed, the gathering of racial identity along with health outcomes data is a recent phenomenon, and racial data are often gathered in an open-ended format, making it harder for political entrepreneurs to identify sharp racial boundaries. Open-ended survey questions that ask Brazilian citizens about their "color" often result in the reporting of dozens, and often more than a hundred different responses (Turra and Venturi, 1995), epitomizing the characterization of weak or fluid boundaries. Different sources within and outside of Brazil report widely different categories and population size distributions (e.g., the Central Intelligence Agency's *The World Factbook* reports the "black" population as 6.2 percent of the population while the Minorities at Risk database reports the "Afro-Brazilian" population as 48.2 percent of the population). There is enormous *potential* to invoke race in ordinary debates over policy, but strong norms against such mobilization have weighed against framing social phenomena in racial terms within most political debates (as distinguished from scholarly discussions within and about Brazil, which are increasingly concerned with the causes and consequences of race).

We do not suggest that Brazil is a completely harmonious and infinitely tolerant society. There is important regional variation in racial relations; and policies and norms are clearly becoming more race conscious in Brazil. Brazilians have begun to politicize the increasingly obvious correspondence between skin color, wealth, and status, but racial politics are orders of magnitude less central and less conflictual than in South Africa,[11] particularly because permeable boundaries impede the formation of strong and recognizable *groups*. The Brazilian AIDS epidemic evolved at a time when the myth of racial tolerance persisted, and the invocation of racial claims into more general policy debates (AIDS, health, and otherwise) has been largely absent. Racial intermingling and generalized tolerance have been longstanding components of public life in Brazil in a manner that would be completely unrecognizable in the South African context, or in most other developing countries for that matter. Given weak boundary institutions, race and color are not good predictors of preferences or cognitions in Brazil.

The varied strength of boundary institutions closely corresponds to group-based attitudes and patterns of behavior in these two countries. Although state institutions may not account entirely for these differences, they have certainly played an important role (Marx, 1998; Lieberman, 2003). Using four waves of data from the World Values Survey, as reported in Table 3, we find striking differences in the degree of negative attitudes expressed towards racial "others." Comparable data for the two countries exist for the 1995-1997 wave and 1999-2000 waves. In the most recent wave, eight times as many South Africans expressed the view that they did not want people of a different race as a neighbor. Negative views toward people of a different race have worsened in South Africa since the 1995-1997 "honeymoon period" of national reconciliation following the election of Nelson Mandela. In both countries, such statistics probably underestimate true national sentiments because people recognize it is not socially acceptable to express prejudice, but there is no reason to believe that underreporting accounts for such large differences between the countries.

Table 3
Attitudes about Race, People with AIDS in Brazil and South Africa

Question: "SHOW CARD G; On this list are various groups of people. Could you please sort out any that you would not like to have as neighbors?" (Figures represent percent of respondents mentioning a given group.).

Identify who "you would not like to have as a neighbor"	WVS Wave	Brazil	South Africa
People of a different race	*1981*		**17 %** N=1,529
	1990	**5%** N=1,502	
	1995-1997	**3%** N=1,494	**11%** N=1,493
	1999-2000	**3%** N=1,149	**24%** N=3,000
People who have AIDS	*1990*	**24%** N=1,502	
	1995-1997	**14%** N=1,494	**44%** N=1,494
	1999-2000	**14%** N=1,149	**27%** N=3,001

Source: Inglehart et al., (2004) World Values Survey (Four waves: 1981; 1990; 1995-7; 1999-2000).

Demographically, these differences are manifest in national rates of interracial marriage. While more than 99 percent of white South Africans had white spouses according to analysis of the 1996 census, a full 23 percent of Brazilians reported being married to persons of a different color in 1991 (Telles, 2004: 176-177). Such dramatic differences highlight the plausibility that there is much greater real and perceived intimate contact across the racial line in Brazil when compared with South Africa. Though racial boundaries in South Africa are today more fluid than under legal segregation, they remain much stronger than in Brazil. Even South Africa's "mixed" race group—"Coloured"—has developed as a largely self-contained and socially and politically separate social group, not an intermediate or fluid category as is the case in Brazil.

The Impact on Politics and Policy

These differences have led to different political responses to the threat of the AIDS epidemic. Even while South African prevalence rates soared past Brazil's peak, actors in South Africa argued that the epidemic was "contained," weakening the resolve of the central government and sowing confusion within society about the need for private and public action. In Brazil, until very recently, there has been an almost complete absence of racial discourse around HIV/AIDS.

Mobilizing various facts and fictions, South African political actors—high-level government leaders, church leaders, ordinary citizens—have portrayed HIV/AIDS as a problem for "them," not "us." Many other observers (e.g., Crewe, 1992; Van der Vliet, 2001; Grundligh, 2001) have similarly linked various forms of race-based intolerance to the proliferation of HIV within the country, as well as to the specific question considered here, of the weak South African government response. The Brazilian comparison provides illuminating evidence that the issue is not racial diversity *per se*, but the boundaries between race groups that ultimately influences the politics of policy response.

In the two countries, the political discourses concerning *who* is afflicted with AIDS, and who is at risk, have been sharply different. In more recent years, a much greater proportion of black South Africans have been HIV-positive than white South Africans, but as discussed above, the epidemic was initially concentrated in both countries among people with white skin. A 2002 survey reported that HIV prevalence among black adult South Africans was 18.4 percent and 6.2 percent among whites (Shisana et al., 2002: 8); but even the white prevalence is high by any standard—higher than in Brazil, all industrialized countries, and many African countries.[12] Observers have argued that the political response to the epidemic in Brazil can be understood in terms of its effects on an affluent middle-class segment of the population—but in South Africa, a much larger share of that country's socioeconomic strata has been infected, suggesting that risk of infection among the economically privileged is not determinative of government response.

More critical for policymaking has been the social and political signification of such epidemiological patterns as the basis for politicizing risk and response. It is the *idea* of concentration within particular race groups that has been so influential on policy in South Africa. Such ideas are made concrete through various actions on the part of state actors and others within society: most important, virtually every survey or projection of HIV prevalence is conducted and reported in terms of the four racial groups. It was not until 2004 that the state discontinued the practice of registering the racial identity of blood donations. Yet, in Brazil, it is rare to find epidemiological data with racial breakdowns in any government report.[13] Despite racial differences in Brazil, and an increasingly open discussion about general socioeconomic inequalities along skin color lines in recent years, particularly as researchers demonstrate the association between race and economic position in that society, strong historical legacies continue to prevent race from becoming a "politicizable" dimension of the political conflict over policy. This may change with the shifting nature of race politics in Brazil, but for the crucial early decades of the epidemic, such identity-based conflict has not been evident.

In the case of South Africa, there is a clear and consistent history of the racialization of the disease, as well as a linking of the disease to "deviant" homosexual lifestyles (which for blacks have been interpreted as *white* homosexual lifestyles), which has contributed to the derailment of the government's response. Even as the virus had been reported by the mid-1980s to be transmitted into the country in a variety of ways, including through several flight attendants who had traveled overseas, and through blood transfusions, the concurrent conflict over the apartheid system of government and race-based citizenship framed the discussion of the disease. In a 1987 interview, Foreign Minister R.F. Botha explained to a public audience that

the "real" threat was from black challengers to the apartheid government, "AIDS gets into this country in ways you wouldn't even think of…. Terrorists cross our borders carrying a more dangerous bomb in their bodies than in their hands. They come from camps where AIDS is rife" (AP, 1987). Notably, many of the HIV-positive AIDS activists in Brazil were also central players in that country's antiauthoritarian movement, but no analogous charges—i.e., linking political dissent, racial identity, or both, to viral infection—were leveled in that country's political history.

As the epidemic progressed in South Africa, policy and media responses reinforced the racial understanding of the epidemic. In 1988, the government propagated separately targeted AIDS programs for white and black audiences (Van der Vliet, 2001: 155), and in turn, race-based accounts of who had the disease in South Africa led to a dynamic of blame and shame rather than a positive action.

As was true in the American case (Cohen, 1999), conspiracy theories have impeded many black leaders and organizations from taking the biological threat seriously. Phillips points oout that an important black magazine, *Drum*, reprinted in 1991 (without comment) an article from an African American journal entitled, "Is AIDS a conspiracy against Blacks?" Within the black community, the disease was nicknamed "Afrikaner Invention to Deprive us of Sex" (Phillips, 2001: 15). In 1994, the *Sowetan*, a newspaper read almost entirely by black South Africans, reported that apartheid-era police deliberately attempted to spread AIDS within the black community (AP, 1994). After 1994, various newspapers carried additional reports of alleged, but largely unconfirmed, reports of various (former white) government plots to infect the black population with AIDS. Such moves reinforced preexisting racial myths in the country as being directly relevant for HIV/AIDS. In turn, racial politics would continue to play an important role in the controversy around AIDS throughout the course of the epidemic.

There is also substantial evidence of racially distinctive interpretations of the risk associated with HIV among the country's white population. As early as 1988, even before a substantial epidemic developed among the country's black population, white inhabitants of a small white resort town argued against the desegregation of South African beaches, citing the risk of AIDS as a reason for barring a visiting black Canadian professor. A town spokesman told a South African newspaper reporter that while the beach was officially open to all races, blacks would need to use nearby bathroom facilities. "We are not prepared to share our toilets with blacks.... What if they have AIDS?" (Boyle, 1988).

One might more easily comprehend the pervasiveness of such discourse during the apartheid era, and during the early stages of the epidemic. But what about under a black-led government? Well into the history of the epidemic—up until the present—when one might have expected such ideas to have been dispelled, charges and countercharges regarding race have remained important within public discourse about the virus. For example, President Mbeki said in a speech at Fort Hare University in 2001:

> Others who consider themselves to be our leaders take to the streets carrying their placards … convinced that we are but natural born, promiscuous carriers of germs, unique in the world, they proclaim that our continent is doomed to an inevitable mortal end because of our unconquerable devotion to the sin of lust (Gumede, 2005: 163).

The conflict over HIV/AIDS in South Africa cannot be understood simply in terms of objective epidemiological factors because political actors across the color line have consistently argued that AIDS was some "other" group's problem, or a fabrication of a larger group conflict. As SA Institute for Medical Research (SAIRM) AIDS center educator Nicolaus Knigge explained in a news report, "SA's sexual taboos posed a challenge to the AIDS educators, and the country's racial attitudes inevitably surfaced. Whites often believed it was a black or gay disease while many blacks believed it was a white disease or a plot to control the black population" (Levy, 1990). In a speech at the 2005 South African AIDS Conference, Mamphela Ramphele, a leading intellectual and former vice chancellor of the University of Cape Town, asked:

> Why did it take so long to have clarity infusing our policy responses? We have the depth of scientific know how and economic resources to have been a front-runner in comprehensive care and treatment to deal a mortal blow to the disease as Brazil did. But the scientists were largely white, male, urban based, and outside the policy making domain of government. Mistrust of the racist system that denied the majority of South Africans scientific literacy and proficiency, constrained evidence based policy-making (Ramphele, 2005).

Even since the South African government came to be run largely by blacks, there has been sufficient suspicion about the nature of the disease (real or imagined; viral or social; indigenous or created in the West), and about who was most vulnerable, that there has been much less public support for aggressive policies than would seem to be warranted by the high prevalence and AIDS-related mortalities. For most South Africans, AIDS has not been seen as a central policy problem: in 2000, only 13 percent of surveyed citizens identified AIDS as a priority problem that the government should address (Whiteside et al., 2004: 137). Also, World Values Survey data (Table 3) show that South Africans in 1999-2000 were about twice as likely as Brazilians to say they did not want someone with AIDS as a neighbor, and the rate of negativism in South Africa toward people with AIDS was still above the level observed in Brazil a decade earlier. We interpret these low levels of AIDS-related support and empathy toward people with AIDS as the product of the political dynamics in a high boundary, or divided society. Since most Geneva Consensus recommendations involve recognition of behaviors among targeted groups that may be viewed as undesirable or immoral, even if widely practiced, political leaders have found it more expedient to deny the problem altogether, place the blame on other factors and groups, or both. Particularly because whites are more closely associated with Western medicine and with the authors of the Geneva Consensus, proposals to incorporate recommended prevention and treatment programs were resisted.

All of this conflict, breeding uncertainty, has allowed Mbeki to promote an alternative view (even while relying on the views of a handful of American dissident scientists) and to incorporate ideas and beliefs that resonate with the black African population, including an emphasis on the notion that disease is associated with poverty, and that traditional medicines and witch doctors can play a useful role in combating the disease. Notions of risk and culpability are structured by preexisting social conflicts. Whereas the politicization of AIDS has exacerbated such divisions in certain places, those cleavages predate the onset of the pandemic.

The foregoing characterizations contrast markedly with the case of Brazil, where social group conflict has been far less evident in battles over HIV/AIDS. As a result, longstanding myths of social mobility across racial lines, as well as high levels of social interaction, particularly in public spaces, meant that a lethal, sexually transmitted virus could easily be interpreted as affecting all of "us"—even when actual rates of infection were fairly low and geographically concentrated within a continental landmass. One can easily find evidence of racism and homophobia in Brazilian society, and a homophobia associated with HIV/AIDS in much of the world was also evident in many of the early reactions to AIDS in Brazil. But given weak boundary institutions, there has been very little opportunity to interpret the epidemic in racial categories. Even researchers *looking* for racial patterns in behavioral and political responses have come up against the legacy of mixing. For example, a 1993 clinical study of AIDS-related behavior in Brazil conducted by the U.S.-based National Institute on Drug Abuse included a cooperative research and intervention program, which, among other things, tried to capture the racial background of individuals. Follow-up interviews revealed that a full 12.5 percent of respondents had actually changed their racial self-identification within just a few months. The authors of a study on the project, while recognizing some of the complexities of race relations in Brazil, ultimately concluded, "Race is of little use in Brazil as a construct for analysis" (Surratt and Inciardi, 1998). A different study investigating the role of ethnicity among registered AIDS patients in São Paulo found that data on ethnicity are, "registered in a subjective and non-standardized manner," and not widely implemented in the disease surveillance system (Jamal et al., 2002).

When Brazilian AIDS NGOs in the late 1980s emphasized "solidarity" with those infected, and the ministry's media campaigns attempted to avoid stigmatizing portrayals of AIDS victims who also opted for an approach based on solidarity (Galvão, 2000: 85; Teixeira, 1997: 61), there were no obvious political contradictions. Such an approach has a long history in Brazil, where state-sponsored public health policies have been closely linked to broader "whitening" strategies (Stepan, 1991). Brazilians with darker skin often tend to self-identify "whiter," and to seek lighter-skinned mates. Thus, it is perfectly understandable that there would be no outcry or rejection on the part of a darker-skinned majority that the state was "wasting" resources on a disease that initially was most visibly affecting people with lighter skin. Instead, it was easy to promote a politics of empathy and shared risk. We do not find significant evidence in Brazil of the type of "blame" politics that has characterized AIDS policy discourse in South Africa. With few exceptions, "Western" medicine and germ theories of disease are not politicized along race lines.

Because the Brazilian epidemic was initially concentrated in the Southeast Brazilian states of Rio de Janeiro and São Paulo, where state-level resources are significant, the fears and action might have remained localized. However, local level leaders pushed hard for a national response. Dr. Alvaro Matida, an epidemiologist running Rio de Janeiro's AIDS program, explained to the *New York Times*, "At a state level we're still doing far less than we should, but isolated measures are not going to have any impact. This is a national problem that must be faced nationally" (Riding, 1986: 4). From the perspective of technocrats in the national government, the problem remained minor, but the increasing popular and political pressure

became too much to bear. In 1985, Brazil's health minister Carlos Sant'Anna was reported saying that AIDS was not a "priority," particularly when compared with other ailments with much broader impact on Brazilian society. "But in the face of what he called the public's 'massive hypochondria,' the Government is developing a strategy to respond to the problem" (Riding, 1985: 4).

Conclusion

Our central theoretical contribution has been to highlight the important role of boundary institutions. Such institutions affect the salience of identities and the collection and dissemination of information, shaping perceptions and discourses of risk and blame, with important consequences for policymaking. Our comparative analysis of Brazilian and South African responses identified the role of boundary institutions as a key factor explaining cross-country differences in responsiveness to HIV/AIDS. While broader comparative analyses across space, time, and policy are needed to further estimate the magnitude of causal effects and the generalizability of the argument, this type of paired comparative analysis is critical for identifying influences that have been insufficiently theorized or recognized.

We do not claim that boundary institutions will account for cross-country differences in HIV/AIDS policy into perpetuity. Over the long term, other factors such as international and domestic pressures associated with increased mortality and morbidity are likely to weigh heavily on policymakers, and convergence on the Geneva Consensus will be visible. Facing overwhelming infection and mortality rates, the South African government is finally becoming more aggressive. But the costs of delay are large. Average life expectancy was similar between the two countries in the 1980s, reaching 66 in Brazil and 63 in South Africa in 1992. Yet largely because of AIDS-related mortalities, that number dropped to 46 in South Africa by 2003, while in Brazil life expectancy continued to climb, reaching 69 in 2003 (World Bank, 2005).

Regarding the more general quest for institutional "solutions" to underdevelopment, we are struck by the observation that the effects of institutions are likely to vary across time and policy areas. Whereas Lieberman (2003) linked the creation of strong (and exclusionary) boundary institutions in South Africa to the development of more efficient and progressive tax capacities in the early twentieth century, in the context of HIV/AIDS in the late twentieth century, the permeable institutions associated with Brazilian nation building facilitated a more aggressive response. In Brazil, infectious disease in one segment of the population was easily imagined to be threatening for all, and a campaign for solidarity did not break down along racial lines, as was the case in South Africa. Among other things, this suggests the merits of mid-level theorizing, but also the inherent trade-offs of different institutional settings. All "good things" do not necessarily come together. Brazil has an inefficient and regressive tax system, and a good AIDS program; South Africa the opposite.

The legacies of South African apartheid and Brazilian "whitening" are still prominent in these societies, but change is afoot in both countries. In Brazil, social and political actors have begun to mobilize around race and racial identities. The overt racialization of politics is still in its infancy in Brazil, and the independent institutionalization of the Brazilian AIDS program will be less subject to political

influence than was the case at the earlier stages of the epidemic, when the state's course of action was far more uncertain.

Although we have emphasized the role of formal state institutions, we recognize that such institutions may interact with and even be superseded by informal, social norms and habits, particularly when the state is weak. We leave the task of further theorizing and analyzing the role of formal and informal institutions to future research.

It might be tempting to identify HIV/AIDS as a *sui generis* problem with unique properties for the politics of policymaking, but other policy issues share similar dynamics. The policy-making process often begins with actors who identify some undesirable outcome—whether it be poverty, violence, or ill health—prevalent among some segment of the population, and who advocate the need to address the problem for the good of the larger public. Boundary institutions are likely to shape how such problems become understood and discussed in the political arena, and how actors make policy choices, often with enormous consequences for human development.

Notes

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1.   A review of the contents of the leading political science journals identified no published articles on AIDS outside the United States, and only a handful of articles on AIDS in the United States. In African studies journals, Boone and Batsell (2001) and Hyden and Lanegran (1996) called for greater attention to the need for political science research on the issue, but only very recently are scholars beginning to apply theoretical and empirical tools to this problem.

2.   In the article, we make sparing reference to these interviews because in most cases, we agreed to anonymity, and because our sources related to us more general trends and dynamics in politics and policymaking. We have preferred to document more specific outcomes and rhetoric through publicly available sources, but our interview notes support the narratives presented in the text.

3.   This is less true for treatment and care policies, but these have been available only much later in the history of the epidemic, and stigma and discrimination remain obstacles in efforts to locate and support individuals who need treatment.

4.   Like Nathanson (1996), we build on longstanding sociological conclusions that risk is socially constructed (Douglas and Wildavsky, 1983; Clarke and Short, 1993).

5.   See, for example, Varshney (2002) and Lamont and Molnár (2002) for discussions of how non-state and informal institutions may reinforce or break down such boundaries.

6.   Other comparative analyses of Brazil and South Africa include Heller (2001); Seidman (1994); Marx (1998); Lieberman (2003).

7.   See Okie (2006), for a more detailed discussion of the Brazilian policy response from a biomedical perspective.

8.   At the time of writing, some 200,000 to 230,000 South Africans with HIV were receiving AIDS treatment, about half in the public and half in the private sectors. The numbers currently treated are not indicative of the overall government response. Brazil treated more people sooner, and at a

time when treatment costs were much higher; at the same time, more South Africans need treatment than in Brazil partly because prevention efforts were historically less aggressive there.

9. During this period, the African National Congress (ANC) was still a liberation organization, outside of government.
10. In earlier versions of this paper, we emphasized these factors as causal influences on the outcome, but as we discuss here—owing to the urgings of others and our own reanalyses of the comparison—we have become less convinced of their causal weight.
11. For a nuanced discussion of race in Brazil, see Telles (2004).
12. The most recent Human Sciences Research Council survey estimates HIV prevalence among South African whites at 0.6 percent (Human Sciences Research Council 2005). According to the study's authors, it is possible that a relatively high refusal rate among whites might explain the large discrepancy between this number and the estimate from 2002. Another study from 2000 estimated prevalence among South African whites at 2 percent (*Sunday Times*, 30 July 2000). In any case, the data suggest that whites in South Africa have been more likely to be infecte with HIV than the average citizen in Brazil.
13. Until very recently, the Brazilian Ministry of Health did not collect any statistics on HIV or AIDS cases by race. Interviews with Ministry of Health officials at the XV International AIDS Conference, Bangkok, 15 July 2004.

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