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A Comparative History of AIDS in Latin America: Brazil and Cuba

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According to a joint report of the World Health Organization and the Pan American Health Organization in September 2002 there were approximately 1.4 million HIV+ people in Latin America, and a further 420,000 HIV+ people in the Caribbean. The number of infections had increased by nearly 10% from the previous year in Latin America, and 16% in the Caribbean.¹ While striking, these figures may obscure the diversity of the HIV epidemic in the region. Latin America has a varied pattern of infections, which means that the experience of Bolivia, Ecuador and Mexico is quite different from that of Honduras, Haiti and the Dominican Republic.² Still, during the 1990s much of Latin America witnessed a trend that saw the ratio of men to women with the disease decline, while HIV made increasing inroads amongst the poorest segments of the population. While men having sex with men remained a group at risk, unprotected heterosexual sex became increasingly important in the transmission of HIV, and commentators began to refer to the “feminization” of the epidemic.³ AIDS has devastated the gay community, but it has also spread widely amongst women and young adults, and from major urban centers to the most remote and culturally isolated regions.⁴

Given this fact, one would expect to find a wide and rich range of scholarship in English on AIDS in Latin America. Yet scholarly attention to this topic came late in North America and there is surprisingly little comparative writing in the field.⁵ Only Cuba and Brazil have received considerable attention from North American scholars because of their HIV/AIDS policies. These countries adopted opposing approaches to dealing with the epidemic, but their policies did share two characteristics: they both successfully contained HIV, and they both generated international controversy. This paper will examine how an international context shaped the development of both countries’ policies on HIV/AIDS.

International Context

This emphasis on international relationships is somewhat unusual. Public health scholars have a standard series of questions to understand the spread of HIV in different countries: what is the epidemiology of the disease in each nation, the underlying health infrastructure, the approaches taken to prevention, the obstacles to success, and the underlying factors that have affected the response to the disease. But the contradiction of AIDS is that this biological disorder

¹ Pan American Health Organization/World Health Organization, “Acquired Immunodeficiency Syndrome in the Americas, 54th Session, 23-27 September, 2002,” Washington, D.C., PAHO/WHO, 2002, 3.

² C.W. Henderson, “Diversity of AIDS Epidemic is a Risk Factor in the Americas,” *AIDS Weekly* (July 9, 2001), 6.

³ According to a recent study by the Pan American Health Organization, less than a third of the total cumulative AIDS cases in the southern cone (Argentina, Chile, Paraguay and Uruguay) have been among men having sex with men. In Central America, 78.8% of all people with AIDS became HIV+ through heterosexual sex. The figures for the Caribbean are similar (76.1% for the Latin Caribbean, 79.5% for the English, Dutch and French Caribbean). Pan American Health Organization/World Health Organization, *AIDS Surveillance in the Americas: Biannual Report, December 2001*. (Washington, D.C: PAHO/WHO, 2001), 6, 8, 9, 10. A similar pattern holds true in Brazil as the work of Brazilian epidemiologists such as Celia Landmann Szwarcwald has demonstrated. Indeed, men who have sex with men have not made up the majority of notified infections in *any* region of Brazil since the mid-1990s, and in some regions less than a fifth of new infections are among this group. Celia Landmann Szwarcwald, Francisco Inácio Bastos, Maria Angela Pires Estves, Carla L. Tavares de Andrade, “A disseminação da epidemia da AIDS no Brasil, no período de 1987-1996: uma análise especial,” *Cadernos de Saúde Pública*, 16:1 (2000), 14.

⁴ Sandra W. Key and Daniel J. DeNoon, “AIDS May Become Biggest Killer of Latin America’s Youth,” *AIDS Weekly Plus* (11/24/97), 12-13.

⁵ Most Latin Americanists rely on the *Handbook of Latin American Studies* as a reference. This annual publication provides an annotated bibliography of important works on Latin America published during preceding years. In an average year, it will provide reviews of 8,000-10,000 books and articles in English, Spanish, Portuguese, and French. Yet during the late 1980s and early 1990s for many years there was no listing for HIV/AIDS in each volume’s very comprehensive subject index. Of course, important work was being done on this topic in Latin America, but it did not attract much attention outside of the region.

spread by personal behaviors is shaped by a wide variety of societal and cultural issues. One cannot understand the spread of HIV/AIDS without considering international forces, as Paul Farmer's work has stressed for the Caribbean:

The Caribbean nations with high attack rates of AIDS are all part of the West Atlantic system. A relation between the degree of "insertion" in this network and prevalence of AIDS is suggested by the following exercise. Excluding Puerto Rico, which is not an independent country, the five Caribbean basin nations with the largest number of cases by 1986 were as follows: the Dominican Republic, the Bahamas, Trinidad/Tobago, Mexico, and Haiti. In terms of trade, which are the five countries most dependent on the United States? Export indices offer a convenient marker of involvement in the West Atlantic system. In both 1983 and 1977, the years for which such data are available, the same five countries were most linked to the United States economically- and they are precisely those countries with the largest number of AIDS cases.⁶

This argument can be taken too far, and early in the epidemic exaggerated perceptions about the "foreignness" of AIDS in many countries impeded an effective response to the epidemic. At the same time, however, international forces have shaped the epidemic throughout the region and may help to explain the fractured nature of the Latin American epidemic.

One cannot understand the Cuban government's response to the epidemic without addressing that country's relationship to the United States. Brazil's program to provide free medications to all AIDS patients was funded by the World Bank, but Brazilian AIDS policies led to an international controversy that drew in the U.S. government, multinational drug companies, NGO's and the World Health Organization. Latin American institutions, sexual practices, cultural barriers, religious beliefs, and social mores have all influenced the spread of HIV/AIDS, but they have done so within a particular international context.

The Early Perception of AIDS in Latin America

Throughout Latin America, HIV/AIDS initially was viewed as a U.S. and gay disease in the early 1980s. While it served as a symbol for both the strengths and failings of U.S. society, AIDS was not seen as a disorder likely to spread in Latin America, as the comments of the Mexican medical establishment made clear. In 1985 one doctor, Ruiz Palacios, said that it didn't make sense to "expend great economic and human resources to investigate and fight this malady, as in the United States, when there are other disorders."⁷ Dr. Cipriano Borges Cordero, the academic chief of gastric medicine at UNAM spoke of the divine punishment of the city of Sodom in the bible and said that this was perhaps the antecedent for what was happening in "New York, San Francisco, Los Angeles, Miami and Newark, where 70 percent of the AIDS cases in the United States have been reported."⁸ AIDS was not a disease that would spread out from the United States, as the comments of Dr. Manuel Cervantes Reyes the president of the Mexican Association of Doctors (AMM) made clear: "Acquired Immune Deficiency Syndrome will cause less damage in Mexico than in developed countries like the United States, given that our population has greater natural defenses from being in contact from an early age with a wide range

⁶ Paul Farmer, *AIDS and Accusation: Haiti and the Geography of Blame*. (Berkeley: University of California Press, 1992).

⁷ *Excelsior*, August 30, 1985, quoted in Max Mejía, "Economía Política y control epidemiológico del sida en México," in *El SIDA en México: Los Efectos Sociales*, ed. Francisco Galván Díaz (Mexico City: Ediciones de Cultura Popular, 1988), 31. See also Paula Anderson, "AIDS in Mexico as an opportunity for Compassion and Growth through Dialogue," (M.A. thesis: Portland State University, 2003), 4-5.

⁸ *Revista Siempre*, No. 1674, August 24, 1985 and *El Sol de México*, 1st ed. August 1985, quoted in Mejía, 31.

of germs. . .”⁹ While Cordera Campos made a video about AIDS in Mexico in 1989, AIDS still appeared to be a predominantly American, as opposed to Latin American, disease.¹⁰

The early imagery associated with AIDS revealed a great deal about how American nations viewed their neighbors. As Paul Farmer’s work on Haiti has made clear, in the United States AIDS became associated with images of voodoo and savagery. The Center for Disease Control identified Haitians as a separate risk group on weak epidemiological grounds. At the same time, some Haitians believed that the United States might have deliberately created the epidemic as a means to stop the immigration of Haitians.¹¹ In Brazil, the association of AIDS with the United States meant that it was seen as a disease of the rich, and the media asked if Brazil was “sophisticated” enough to be vulnerable. From this perspective, its arrival was taken as a sign that Brazil was “civilized.”¹² This perception changed rapidly after 1986 as it became clear that there was a significant heterosexual epidemic in Africa. AIDS then quickly came to be associated with poverty and blackness, so that the depiction of the disease was influenced by ideas about race. But the original perception of AIDS may help to explain the initially slow response of Brazilian authorities to the disease.

In Cuba as well ideas about AIDS were shaped largely by the perception that this was an American (U.S.) disease. Cuba had an exoticized image of the disease that may have legitimated sweeping public health measures. Fidel Castro himself blamed the United States for the existence of the AIDS:

Fidel Castro himself followed this tradition in a September 1988 speech: “Who brought AIDS to Latin America? Who was the great AIDS vector in the Third World? Why are there countries like the Dominican Republic, with 40,000 carriers of the virus, and Haiti, and other countries of South and Central America- high rates in Mexico and Brazil and other countries? Who brought it? The United States, that’s a fact.” The foreign power that had militarily invaded Cuba in the past, that had made numerous assassination attempts on his life, that maintained hostile policies, could now be blamed for introducing the plague.¹³

While it is true that the early history of the epidemic likely was shaped by population flows to and from the United States, this rhetoric of blame ignored the complexity of the epidemic. It also provided a framework for the Cuban response to this health issue.

The Cuban Response to the Epidemic

Unlike some other Latin American nations, Cuba began an aggressive program to control HIV from the earliest stage of the epidemic. This program has had remarkable successes. According to UNAIDS by 2001 there had been 3200 reported cases of HIV/AIDS in Cuba, a country with over eleven million people. This equated with a seropositive rate of less than 0.1%, a figure lower than that for the state of Minnesota.¹⁴ This low rate is surprising for a country in

⁹ *El dictámen de Veracruz*, August 25, 1985, *Excelsior*, August 24, 1985, quoted in Mejía, 32.

¹⁰ Cordero Campos, *El SIDA en México*, Video Recording (Mexico City: Nexos TV, 1989). Videotape obtained from Biblioteca Daniel Casío Villeca, Mexico.

¹¹ See Farmer, *AIDS and Accusation*, 208-243.

¹² Cristiana Bastos, *Global Responses to AIDS: Science in Emergency* (Bloomington, Indiana: Indiana University Press, 1999), 70-71. See also Claudia Moraes and Sérgio Carrara, “AIDS: Um vírus só não faz a doença,” *Comunicações do ISEER*, vol. 17, 5-19.

¹³ Leiner, 131. It would be wrong to describe Fidel Castro’s attitude as being unusual. Early in the epidemic a wide range of nations blamed the epidemic upon U.S. decadence. Ibid, 136-137.

¹⁴ UNAIDS, “Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections, 2002 update, Cuba,” accessed on-line on Feb. 5, 2003, <http://www.unaids.org/hivaidsinfo/statistics/factsheets/pdfs/Cuba-en.pdf>. For the fact that Minnesota has a higher rate of HIV infection see Tasya Rosenfield and Kira Herbrand’s report, “Part One: the AIDS colony” at www.kfai.org/programs/

which the epidemic was dominated by heterosexual transmission from the start.¹⁵ Fifty-six of the early cases were among soldiers returning from service in Africa.¹⁶ To some extent Cuba may have been shielded from early infection by its isolation from the U.S., because of that country's economic blockade of the island. But Cuba also had significant exchange programs with other countries, and welcomed large numbers of students from African nations where the virus was present early in the pandemic: "Of primary concern were the more than 380,000 Cubans who had traveled abroad, as soldiers in Africa, or as advisers, diplomats, or participants in cultural exchange programs."¹⁷ Thus it is likely that the low rate of HIV in that country is more a result of the government's efforts to control the epidemic than its separation from the world community, and in particular the United States.

Early in the epidemic Cuba began an extensive program to control the spread of HIV. It banned the importation of blood from Europe, and destroyed 22,000 containers of foreign blood.¹⁸ Not all government measures may have helped to fight the virus. For example, as Marvin Leiner has stressed the Cuban government did not initially place great emphasis on mass education as a way to prevent the disease, which is surprising in a country with excellent literacy rates and a good health infrastructure.¹⁹ Instead, the Cuban government began the mass testing of the population for HIV beginning in 1986. Those who tested HIV positive were isolated in sanatoria, and their sexual contacts were traced. By 1989 the government tested over seventy-five percent of the population over the age of fifteen for HIV.²⁰ This figure continued to increase: "By April 1991, 9,771,691 people, almost the entire population had been tested."²¹ Every Cuban province had its own sanitarium.

[locnews/aids.htm](#) Accessed on February 14, 2003. It is true that there are some questions about the reliability of Cuban government statistics. For a debate on this issue, see the correspondence concerning "Controlling AIDS in Cuba," and Bayer and Heaton's response, *New England Journal of Medicine*, 321:12 (Sept. 21, 1989): 829-830. Some Cuban assertions do seem dubious. For example, according to the Cuban Ministry of Public Health "illicit drug use does not exist in Cuba and thus is not a risk factor for HIV infection." Pérez-Stable, 563. But when Vladimir Ceballos released a documentary on AIDS in Cuba in 1994 entitled *Maldito se tu nombre libertad*, it included interviews with HIV+ Cubans who were injecting drug users. For the government's denial that IDU use is spreading the disease see Tasya Rosenfield and Kira Herbrand's report, "Part Three: the Cure" at www.kfai.org/programs/locnews/aids.htm Accessed on February 14, 2003. Still, in general Cuban figures do seem reliable. Pérez-Stable, "Cuba's Response," 564.

¹⁵ For the fact that the epidemic was initially mainly spread through heterosexual sex see Sarah Santana, Lily Faas, and Karen Wald, "Chapter *: Human Immunodeficiency Virus in Cuba: the Public Health Response of a Third World Country," in *Aids: the Politics of Survival*. Ed. Nancy Krieger (Amityville, NY: Baywood Publishing Inc., 1994), 174.

¹⁶ Rosenfield and Herbrand, "AIDS colony." For the fact that many of the early cases of HIV were among returning soldiers and their partners see Marvin Leiner, *Sexual Politics in Cuba: Machismo, Homosexuality, and AIDS* (Boulder: Westview Press, 1994), 122 and Ian Lumsden, *Machos, Maricones, and Gays: Cuba and Homosexuality* (Philadelphia: Temple University Press, 1996), 161; R. Bazell, "Happy Campers," *New Republic*, 206:10 (1992), 14.

¹⁷ Cheryl Heaton and Ronald Bayer, "Special Report: Controlling AIDS in Cuba: the Logic of Quarantine," *The New England Journal of Medicine* 320:15 (April 1989): 1022.

¹⁸ Tasya Rosenfield and Kira Herbrand's report, "Part three: the cure" at www.kfai.org/programs/locnews/aids.htm Accessed on February 14, 2003.

¹⁹ Marvin Leiner, *Sexual Politics in Cuba: Machismo, Homosexuality and AIDS*. (San Francisco: Westview Press, 1994), 133-134. See also Cheryl Heaton and Ronald Bayer, "Special Report: Controlling AIDS in Cuba: the Logic of Quarantine," *The New England Journal of Medicine* 320:15 (April 1989): 1022. Helena Hansen and N.E. Groce, "From Quarantine to Condoms," 261.

²⁰ Eliseo J. Pérez-Stable, "Cuba's Response to the Epidemic," *American Journal of Public Health*, 81:5 (1991): 563. Cheryl Heaton and Ronald Bayer provided a lower figure of three million Cubans having been tested by 1989 in their work. Heaton and Bayer, "Controlling AIDS in Cuba," 1023

²¹ See also Leiner, 117.

The sanatoria attracted international attention, because of human rights concerns. On the one hand patients in the sanatoria received free medical care, access to medications, additional rations, their salaries and better living conditions than were available to Cubans living outside. On the other hand, this policy stigmatized HIV positive Cubans. In practice many HIV+ Cubans found it to be impossible to say “no” when asked to go to the sanatoria, at least during the early years of the program.²² And while these facilities with their small cabanas and manicured lawns appeared attractive, they initially had guards, gates, and in some cases fences topped by barbed wire.²³ Moreover, families were separated by this policy. One woman commented that the most difficult part of being in a sanitarium had been being removed from her nine year old son.²⁴ Cuba was nearly unique internationally in adopting this policy, which reflected a number of distinct aspects of Cuban society, and Cuba’s perception of itself.

Cuba had an international reputation in the field of public health, from which the nation had drawn considerable legitimacy internationally since the revolution. Cuba had invested both energy and capital in its public health infrastructure, and it was probably the only country in Latin America that had the public health institutions to carry out this program of mass testing. Cuba’s policy was also possible because of the character of its government. There were no independent NGOs or gay rights organizations with the power to oppose government policy, nor was there an independent news media. The long-standing hostility with the United States also had undermined the legitimacy of institutions that the government did not control: “Organizations such as gay rights groups are seen in terms of their potential for facilitating CIA infiltration.”²⁵ There was a long government tradition of intolerance towards homosexuality, as demonstrated by the forced induction of gays into the Military Units to Aid Production (UMAP) from 1965-1967 and Cuban legislation of the 1970s.²⁶ All these factors, but in particular the equation of political organization with pro-U.S. sympathies served to bolster the Cuban government’s quarantine policy.

This does not deny, however, that the policy had considerable public support, and even many homosexuals backed mandatory testing and confinement.²⁷ Cuba has traditionally placed more emphasis on social than individual rights. The Cuban government argued that its policy was more humane than that of the United States, where the government did not guarantee the health care, medications, jobs, or housing of people with AIDS. From this point of view, it was better to be living in a Cuban sanatorium than to be homeless on the American streets.²⁸ The international respect for Cuba’s health programs may have initially muted the critiques of this policy, particularly on the part of academics and health professionals. The striking Cuban success in

²² This point was stressed by a health care worker who contracted HIV through sexual contact with his partner and was informed of his HIV status in 1988. This man said that any refusal to enter the sanatoria would have led to a conflict with the health authorities, who would have taken him to court. Rosenfield and Herbrand, “The AIDS colony.” Leiner discusses the psychological factors that made resistance difficult. Leiner, 122, 125. For a further discussion of this issue see also Heaton and Bayrer, “Controlling AIDS in Cuba,” 1024

²³ See the footage of the sanatoria in the following video: John Marshall Law School, “Aspects of Criminalization: Cuba’s HIV-AIDS Quarantine,” VHS tape. Chicago: John Marshall Law School, 1993.

²⁴ Rosenfield and Herbrand, “The AIDS colony.” For a further description of the sanatoria see Leiner 117-121.

²⁵ Leiner, 2. See also *ibid.*, 27. Leiner listed five reasons why Cuba maintained its policy of quarantine. *Ibid.*, 123.

²⁶ Leiner, 28. The last of the camps was not closed until 1969. For Cuban legislation on homosexuality see Leiner 35, 43.

²⁷ Ian Lumsden, *Machos, Maricones, and Gays: Cuba and Homosexuality*. (Philadelphia: Temple University Press, 1996), 163. R. Bazell, “Happy Campers,” *New Republic*, 206:10 (1992), 12.

²⁸ See the comments of Rev. Charles Carnahan in the following video: John Marshall Law School, “Aspects of Criminalization: Cuba’s HIV-AIDS Quarantine.”

controlling the virus, and the high human toll that HIV took in other Caribbean nations such as Haiti, also served to legitimate the policy.

By the early 1990s, however, the Cuban government's AIDS program became problematic. With the collapse of the Soviet Union in 1991 the Cuban government lost its major international sponsor and entered into economically difficult times. Although the health sector was privileged, it too was hurt by the economic crisis: "The dissemination of any research findings related to HIV/AIDS and other medical, nursing, and/or public health issues is limited, however, as nearly all medical and nursing journals ceased publication in 1992, due to the shortage of paper."²⁹ Tourism became increasingly important to providing the government foreign exchange, and with the tourists came prostitution.³⁰ The Cuban government politically could not afford to offend visiting tourists by mandating HIV tests.³¹ This made education increasingly important to fight the disease. At the same time, the sanatorium program was relatively expensive (\$24,000 U.S. a year) on a per capita basis.³² In 1993, therefore, the Cuban government began to relax its sanatorium policy, at first allowing people to leave the clinic without chaperons, and ultimately even allowing some people to return to their communities.³³

This policy was especially important as Cuba's quarantine policy attracted increasing international attention. Some scholars worried about the possibility that mistaken test results might lead to the incarceration of HIV- people, despite a careful system of checks that made this unlikely.³⁴ Political activists, some of whom had long sympathized with the Cuban revolution, argued against the Cuban policy of quarantine.³⁵ A number of academics and health care professionals wrote articles that questioned the rationale of the program, although some writers also defended Cuban policy.³⁶

In October 1992, for example, Timothy Martin, a student at John Marshall Law School, and Mark Woods, a faculty member at the same university, traveled to Cuba to take part in the First International Conference on AIDS. They produced a video in which Timothy Martins strove to appear balanced, even though he clearly had serious reservations about Cuban policy. In the video interviews with sanitarium residents included statements by several people who criticized their internment: "I would give up one year of my life to have my liberty again," said one speaker. Another person said "We shouldn't be here. We haven't broken any laws. We aren't criminals. We should be with our families. We should be in our homes."³⁷ At the same time, some interviewees defended the sanitarium system. And in his narration, Timothy Martins noted a division within those interned within the sanitarium. People interned for less than a year generally resented the loss of their liberty, while those confined for three years or more seemed

²⁹ Janice M. Swanson, Ayesha E. Gill, Karen Wald and Karen A. Swanson, "Comprehensive Care and the Sanatoria: Cuba's Response to HIV/AIDS," *The Journal of the Association of Nurses in AIDS Care* 6:1 (January-February 1995), 40.

³⁰ Keith K. Key and Daniel J. DeNoon, "Cuba Sees AIDS Rise Linked to Tourism Growth," *AIDS Weekly Plus* (Dec. 23, 1996): 12.

³¹ Pérez-Stable, "Cuba's Response," 565.

³² Helena Hansen and N.E. Groce, "From Quarantine to Condoms," 271.

³³ It is true that there were tight restrictions on who could be released from the sanatoria. See Leiner, 120-121.

³⁴ Leiner, 129. Heaton and Bayrer, "Controlling AIDS in Cuba," 1023. Thomas C. Quinn, Fernando R.K. Zacarias, Ronald K. St John, "AIDS in the Americas," *The New England Journal of Medicine* 320:15 (April 1989): 1007.

³⁵ *Ibid.*, 143-144.

³⁶ For a defense of the mass internment of HIV+ Cubans, based on cultural relativism, see Santana, Faas, and Wald, "Human Immunodeficiency Virus in Cuba," 193.

³⁷ John Marshall Law School, "Aspects of Criminalization: Cuba's HIV-AIDS Quarantine."

resigned to their fate.³⁸ But such materials increased the pressure on the Cuban government, which badly wished to defend its progressive international image.

This image would be especially challenged because of surprising developments within Cuba. A small sub-culture rock music fans (called roqueros) had entered into frequent conflict with government authorities and the police over issues such as military service and work. Beginning in 1989 some of these young people began deliberately to inject themselves with HIV+ blood as an act of political protest unique to Cuba. In the Cuban city of Pinar del Rio this strange movement spread and by 1992 perhaps a hundred people had deliberately infected themselves with AIDS. At first most of these people were young men, but in many cases their wives and girlfriends also chose to infect themselves in order to be able to join their partners in the sanitarium. Many of these people at first concealed from the authorities that they had injected HIV+ blood, for fear of being sent to prison rather than the sanitarium.³⁹ Others did not, however, and this issue became a serious political embarrassment for the Cuban government when Vladimir Ceballos produced a documentary *Maldita sea tu nombre, libertad* in 1994.⁴⁰

This was not the only documentary on the Cuban roquero movement, but it represented the initial discovery of this movement by the American media. Both *Newsweek* and the *New York Times Magazine* quickly published articles by reporters who interviewed some of these people.⁴¹ Vladimir Ceballos was a rocker from Pinar del Rio who had many friends who had chosen to commit suicide by this means. He and a friend, Carlos Zequeira, shot a video with some of their HIV+ friends, who had been released from the sanitarium “over a long weekend when the rockers had passes to attend a local baseball game. . .”⁴² When they could not show the film in Cuba, Ceballos and his friend sought political asylum in the United States.

The film itself was often shot outdoors, and at times the sound quality is poor. It consists of a series of interviews with the roqueros, in which they describe how they injected themselves with HIV, and their subsequent thoughts on their decision. With its descriptions of police brutality and reflections about impending death, the video is emotionally devastating. The roqueros described the rise of this phenomenon, which they seemed to understand would confuse any-one from outside their world: “Look Vladi, the problem we had with this AIDS thing was more than anything the rise of a fever that we had among us in the years of ’90 and ’91. But all that is due to the repression that existed against us. . .”⁴³ It was particularly convincing because the sanitarium patients gave names, and described their life histories in detail:

I went to Santa Clara for the first festival of rock. When we were coming back, we went by Los Cocos Sanitarium. And there myself and Ramon Perez, who’s now dead, el “Bruja,” as we called him, injected ourselves with Juan Miguel Garcia’s blood, the son of the director of education, who’s now also dead. Orlirio was also with us. That’s how it all went. Until today there still continue to appear new people who injected themselves. Almost all the patient population

³⁸ Such divisions among the sanatorium residents have been found by others. See Santana, Faas, and Wald, *Human Immunodeficiency Virus in Cuba*, 188.

³⁹ For the fact that Cuban’s concealed how they acquired the infection see Scott Malcomson, “Socialism or Death?” *New York Times Magazine*, September 25, 1994, 48. See also Vladimir Ceballos, *Maldita sea tu nombre libertad*, VHS documentary, 1994.

⁴⁰ I wish to thank Vladimir Ceballos for providing me a copy of his film.

⁴¹ Paul Katel, “Cuba: did some youths get AIDS on purpose?” *Newsweek*, 123:20 (May 16, 1994): 42. Scott Malcomson, “Socialism or Death?” *New York Times Magazine*, September 25, 1994, 45-49. See also Frank Baker, “Filmmaker tells stories of Cubans who injected themselves with HIV,” Associated Press, January 17, 1995. Accessed on-line on September 9, 2002 at <http://www.geocities.com/lavola01/English1.html>.

⁴² For a discussion of the film’s origins see Malcomson, 48.

⁴³ *Maldita sea tu nombre libertad*. Translation by Luis Rivera.

here infected themselves with a syringe through direct contact. Since we injected ourselves the sale of syringes in pharmacies has been prohibited. And then Vladi, like me many get HIV. Now almost all of them are dead.”⁴⁴

Other rockers described the emotional impact upon them that having tens of their friends infected and dying had taken.

Some of the women described how they had decided to infect themselves so that they could be with their partners. Raysa Valdes described her partners’ response to her decision: “Then I chose to get HIV. He is already dead. He never wanted to involve me but I wanted to do it. I went to where he was so that he would inject me in October 1991.”⁴⁵ Most of these women, including Raysa Valdes who had a nine-year old son, regretted their actions. Raysa Valdes herself died at the age of 24. The video ended with the names of some of those who died, together with their age at death, which was usually in the early twenties.

At first the government itself did not appear to be greatly concerned about the epidemic, as one Cuban doctor working in the sanitariums made clear to Scott Malcomson, who described the conversation in the *New York Times Magazine*: “According to one doctor in Havana’s flagship AIDS sanitarium, the dead and dying rockers are no great loss because they wouldn’t have contributed much to society anyway.”⁴⁶ The government did not see this movement as a serious political challenge, and never denied that people had acquired AIDS by self-injection. But the issue did not go away. During this same time period the Swedish film maker Bengt Norborg released a documentary, *Socialismo o muerte*, which also contained interviews with young Cubans who had decided to commit suicide by HIV. Like the young roqueros of Ceballos’ documentary, these youth also complained about the police oppression that they argued made this step logical: “In any other country this would be a problem of madness; in Cuba it’s a political problem.”⁴⁷ The Cuban AIDS specialist Dr. Jorge Pérez, interviewed by Norborg, argued that the problem was the suicidal attitude of the young roqueros, rather than a larger political issue. Similar statements by senior officials in the AIDS program did not prevent continued negative publicity. In 1996 Leon Ichasa released *Bitter Sugar* (Spanish with English subtitles) which dealt with this subject in a fictionalized manner. By the mid-1990’s the phenomenon of self-injection with HIV in Cuba had stopped.⁴⁸ But the issue of the roqueros would not go away.

The public discussion of the roquero phenomenon made Cuba’s quarantine policy problematic. Still, this was likely less important as a factor leading to the change of the policy than the growing power of the gay movement internationally during the 1990s. The Cuban epidemic was unique in Latin America in that, unlike the trend elsewhere in Latin America, it became increasingly focused in the homosexual community with time. While many other nations in the hemisphere had historically had equally homophobic policies as Cuba, this political trend made the policy of quarantine politically costly. When combined by the growing importance of tourism as a means for the spread of HIV, the Cuban government needed to rethink its policies.⁴⁹

By the late 1990s the Cuban government was placing much greater emphasis on preventing AIDS through education. While the government had never ignored education, it is perhaps fair to say that it was a less important facet of the government’s program than the

⁴⁴ *Maldita sea tu nombre libertad*. Translation by Luis Rivera.

⁴⁵ *Maldita sea tu nombre libertad*. Translation by Luis Rivera.

⁴⁶ Malcomson, 46. For the government’s indifference see also *ibid.*, 47.

⁴⁷ Text from the following website, accessed on November 22, 2002: www.jornada.unam.mx/1996/jun96/960625/carlos.html. Translation by Smallman. For an extensive discussion of the film and the phenomenon of HIV self-injection see Ryan Prout, “Jail-house Rock: Cuba, AIDS, and the Incorporation of Dissent in Bengt Norborg’s *Socialism or Death*,” *Bulletin of Latin American Research*, 18:4 (1999): 423-436.

⁴⁸ Prout, 429.

⁴⁹ Helena Hansen and N.E. Groce, “From Quarantine to Condoms,” 261.

sanatoria. In 1996 Doctors without Borders traveled to Cuba and advised the Ministry of Health on AIDS education programs and supplied education materials. In 1998 Cuba founded the National Center for the prevention of STDs and HIV. This organization had a phone line, ran workshops for youth, and organized a trailer covered with flowers that drove through the countryside giving out AIDS information.⁵⁰ The sanatoria residents themselves began to play a larger role in AIDS education:

One result of the new environment created of the sanatoria created by Dr. Pérez is the Grupo de Prevencion del SIDA (GPSIDA), an informal, officially authorized group of HIV-positive people, health professionals, and social scientists that was formed at the initiative of HIV-positive sanitarium residents. GPSIDA has the mission of supporting HIV-positive people in their daily lives and of educating the community at large about the experience of HIV-positive people as well as about modes of transmission and prevention of HIV infection.⁵¹

It is true that GPSIDA exists in only three provinces.⁵² The lack of similar NGO's in Cuba also remains a serious impediment to the government's efforts to contain the virus through education. But the renewed emphasis on education, and the role that HIV+ people could play in this effort, was a significant alteration in Cuba's AIDS policy.

It is also true that one could overestimate the extent of the change to the sanatorium system. The majority of HIV+ people have decided to remain in the sanatoria. This may be because of the psychological screening that is required to leave the sanatoria, or because of the economic hardships they faced outside.⁵³ Nor has the Cuban government done adequate work to replace the sanatorium system with one based on education and safe sex. Helena Hansen found that "condoms are often unavailable due to chronic shortages of imported goods. . ."⁵⁴ In practice, the government and the media also continue to portray AIDS as a U.S. disease, which may decrease Cuban's desire to practice safe-sex when their partners are Cuban.⁵⁵ Still, there are significant changes taking place in the Cuban AIDS program. Given the excellent education system, strong public health-infrastructure, and government pride in Cuba's public health system, Cuba will continue to have the basis for an effective response to this epidemic.

In summation, from its inception the Cuban policy to control AIDS has been shaped by international factors. The first reported cases were among soldiers returning from Africa. Because of Cuba's pride in its international reputation in the field of public health, its equation of the disease with foreign corruption, and its distrust of NGOs because of their possible links to foreign countries, the government adopted a sanatorium system to control AIDS. With the collapse of the Soviet Union, the dollarization of the Cuban economy, the rising importance of tourism, and the growth of the sex trade, this policy became problematic. At the same time, international publicity around the roquero movement and the growing power of the gay movement in North America and Europe made the policy costly. Cuba needed its international allies in the progressive movement. Still, the program has been altered but not abandoned. Cuba takes great pride that it has avoided the significant HIV+ rates that some other Caribbean countries, such as Haiti and the Dominican Republic, have suffered. As a result, Cuba's AIDS program is currently a hybrid that has embraced mass education without totally abandoning mass

⁵⁰ Rosenfield and Herbrand, "Part Three: The Cure."

⁵¹ Helena Hansen and N.E. Groce, "From Quarantine to Condoms," 266.

⁵² Hansen and Groce, "From Quarantine to Condoms," 267, 274.

⁵³ Hansen and Groce, 270-272.

⁵⁴ Hansen and Groce, 275.

⁵⁵ Hansen and Groce, 277, 284-285.

testing. Despite its successes, however, it is not likely that Cuba's program will serve as a model for other nations, as is now the case with Brazil.⁵⁶

Brazil

The Brazilian media did not report on the first cases of AIDS in Brazil until 1983, although the first case had appeared in 1980.⁵⁷ Initially, the disease was overwhelmingly one of gay, relatively well-to-do men, living in major cities, and in particular in São Paulo. The military still controlled the national government until 1985, so throughout the latter half of the 1980s the nations' attention and energy was given to the question of democratization. The government did create a structure to respond to the appearance of HIV, and it launched an AIDS control program in 1985. Still, funding was minimal, and in many respects the private response to the epidemic in the early years was more significant. The first non-governmental organization, Grupo de Apoio à Prevenção à AIDS (GAPA), also was founded in 1985. ABIA, the Associação Brasileira Interdisciplinar de AIDS, was founded the following year.⁵⁸ These would become the two best known of the perhaps 600 nongovernmental organizations that, according to Paulo Teixeira, now run perhaps 1000 programs to fight AIDS.⁵⁹

This grassroots effort was vital to overcome government response to the epidemic that initially was far weaker than Cuba's, as well as the powerful stigma that surrounded AIDS. The government at first failed to make AIDS a national priority:

The association of AIDS with privilege at the beginning of the epidemic had two repercussions. On one hand, it was used as an excuse for the government's lack of attention to the disease, as the government could claim that AIDS affected a very small minority (the "First World Within"), who could afford their own health care abroad and that it should use its resources for the massive endemic diseases, such as malaria and tuberculosis, that were affecting the deprived in massive numbers. In a page-length article that appeared in the daily *O Globo* on September 8, 1985, Health Minister Carlos Santana declared that even though his office was taking a series of measures against AIDS, this disease could not really be considered a priority.⁶⁰

Herbert Daniel and other AIDS activists argued that the government perceived AIDS as "an epidemic of `minorities,' almost a problem of a few rich and well-provided for homosexuals."⁶¹ For this reason, the government effort appeared to lack energy. By many measures, the Brazilian government's response was far weaker than Cuba's. For example, the Brazilian government failed to take active measures to protect the blood supply, which caused a catastrophe for Brazilian hemophiliacs.⁶²

Brazilian gay organizations had historically been weak, in part because Brazilians perceived sexual identity differently than their North American counterparts. As the epidemic took a heavy toll in young men who had sex with men in major cities this began to change.

⁵⁶ Cuban officials themselves recognize this to be the case. Santana, Faas, and Wald, "Human Immunodeficiency Virus in Cuba," 193.

⁵⁷ For a chronology of events I rely on the following source: Jane Galvão, *1980-2001: uma cronologia da epidemia de HIV/AIDS no Brasil e no mundo* (Rio de Janeiro: ABIA, 2002).

⁵⁸ ABIA was founded in part because Brazilians realized that epidemiological models developed in the first world could not adequately explain the Brazilian epidemic. See Bastos, *Global Responses to AIDS*, 59.

⁵⁹ Bullfrog films, *Brazil: Winning against AIDS* (Olley, PA: Bullfrog Films, 2001).

⁶⁰ Bastos, *Global Responses to AIDS*, 72.

⁶¹ Daniel, "AIDS in Brazil," 201.

⁶² Daniel, "AIDS in Brazil," 202. For similar instances of government negligence regarding AIDS see *ibid.*, 209.

While the statements of AIDS activists such as Daniels (who died of the disease in 1992) about the extent of the government's indifference might be exaggerated, they accurately reflect how his community perceived the government's attitude in the early 1990s:

To this day the government has taken no action on the epidemic, continuing the five-year record of inaction and indifference of the previous administration. There is today absolutely no national program for controlling the epidemic. The service set up by the previous administration in the Ministry of Health in 1986, when there were already more than 1000 reported cases of AIDS, was a symbolic gesture. And so it remains. The idea that AIDS is inevitable, almost a kind of price to be paid for the modernity of our cities, the idea that it is not quite a Brazilian disease but something foreign or strange, has remained almost unchanged from the view that prevailed at that nearly forgotten time when AIDS arrived in Brazil.⁶³

The emerging gay organizations and NGOs devoted to AIDS were emboldened by the climate of political activism that dominated as the country returned to democracy. These groups rallied to ensure a more powerful government response to the epidemic, and dignity for HIV+ people.

Examples of the discrimination that HIV+ people faced were not hard to find. As Herbert Daniel, the Brazilian AIDS activist, has argued, early articles on AIDS in the Brazilian media showed a lack of concern for people with AIDS, or even celebrated the arrival of the disease as a punishment for sinners.⁶⁴ Flávio Braune Wiik has described the story of a Xokleng couple in the state of Santa Catarina who tested positive for HIV in 1988. When the media learned that the first Native American in Brazil had tested positive for HIV, it created a media circus. Dozens of journalists rushed to the couple's village, as did government representatives and doctors.⁶⁵ The Xokleng people faced public ridicule, the woman died, the man faced death threats, his family fell apart, and his parents separated.⁶⁶ Clearly, a great deal of work in AIDS education and community building needed to be done.

Given this history in the 1980s and early 1990s, what is stunning is the speed with which the Brazilian government changed course and began to devote both energy and attention to the epidemic. Two domestic factors help explain this transformation. One is the transformation of the disease from one that largely affected gay males in urban centers, to a disease that also heavily impacted women, and had spread to the most remote areas of the country. The second was the astounding political organization of various communities that rallied together to fight AIDS. In 1989, Brazilian NGOs devoted to fighting AIDS held their first national conference in Belo Horizonte, Minas Gerais.⁶⁷ In the five years that followed, a broad array of organizations appeared representing, women, afro-Brazilians, urban youth, gays, transsexuals, prostitutes and others.⁶⁸

⁶³ Daniel, "AIDS in Brazil," 200.

⁶⁴ Herbert Daniel, "AIDS in Brazil" in *AIDS: the Politics of Survival*. Ed. Nancy Krieger and Glen Margo (Amityville, NY: Baywood Publishing Company, 1994), 199.

⁶⁵ Flávio Braune Wiik, "Contact, epidemics, and the body as agents of change: a study of AIDS among the Xokleng Indians in the State of Santa Catarina, Brazil," *Cadernos de Saúde Pública*, Rio de Janeiro, 17(2): 402.

⁶⁶ Wiik, 403. For similar examples of discrimination see Daniels, "AIDS in Brazil," 208.

⁶⁷ Galvão, "1980-2001," 9.

⁶⁸ See José Marmo da Silva and Marco Antonio Chagas Guimarães, "Odô-Yá Project: HIV/AIDS Prevention in the Context of Brazilian Religion," *Journal of Health Communication*, 5 (2000): 119-122. The breadth of the response to the disease is striking. There is even a literature de cordel poem dedicated to educating the masses about how to avoid AIDS. José Francisco Borges, "Como Evitar a AIDS," Literature de cordel. Date unknown.

In the early 1990s the Brazilian government responded to these pressures by slowly increasing the services available to HIV+. Beginning in 1991 the government began to distribute AZT through the public health system. This represented a major advance, given that in the past health authorities would “say in the press that AZT should not be purchased for patients in public hospitals because `they’re going to die anyway.’”⁶⁹ In 1993 Brazil began to produce AZT in its own laboratories.⁷⁰ But it was in 1996 that something truly remarkable happened. In the summer of 1996 scientists announced that HART (highly active retroviral therapy) had proven to be extremely successful in limiting the replication of HIV. Patients on the so-called “drug cocktail” could have the level of the virus in their blood fall to levels that were not detectable. On November 13, 1996 Law number 9313 came into force, and gave HIV+ people the right to free medications through the public health system.

It is difficult to overstate the extent of the Brazilian achievement in creating the necessary structure to test for HIV viral load, CD4 cell counts, and HIV resistance. A network of dispensaries had to be administered and maintained. Doctors had to supervise patients and ensure their compliance with their regimen, if the virus was not to mutate and develop resistance to the disease. Most of all, the government had to obtain the necessary medications, many of which were extremely expensive. This was a seemingly impossible task for a developing country which already had a significant HIV+ population. Yet Brazil achieved it. Moreover, the program proved to be cost effective because patients with HIV were not entering public hospitals for treatment for opportunistic infections. People now had an incentive to be tested for HIV, because they knew that they would receive care. This increased the number of people who knew their HIV status, and gave the medical system opportunities to educate those who were HIV+. Patients receiving medical treatment proved to be as compliant as their U.S. counterparts, which minimized the spread of viral resistance. Lastly, people on regular treatment are less contagious, which also helped to contain the virus. Together with the aggressive education efforts of both the Brazilian government and NGOs, Brazil has proven to be enormously successful in controlling the spread of HIV.⁷¹

The Brazilian government has also been able to maintain the program through changes in administration and political challenges. According to Pedro Chequer, president of Brazil’s national AIDS commission, a variety of Brazilian actors have proved capable of rallying around this program: “Cooperation agreements with the political opposition have ensured the approval of laws and budgets and have provided continuity to the program despite changes in governments.”⁷² At the same time, the Brazilian government has been able to reach an understanding with the Catholic Church, an achievement that has eluded many other Latin American governments:

In the beginning the Church wanted to control information, but this met with strong resistance from the Ministry of Health and the AIDS Program. Abstinence, fidelity and marriage were just not for everyone; condoms were the

⁶⁹ Daniels, “AIDS in Brazil,” 209.

⁷⁰ For the chronology of the government’s provision of AZT see Galvão, “1980-2001,” 10, 12.

⁷¹ For a description of the Brazilian government’s AIDS policy see José Ricard Pio Marins, “The Brazilian Policy on Free and Universal Access to Antiretroviral Treatment for People Living with HIV and AIDS,” Powerpoint Presentation, Regional Forum of the Latin American and Caribbean Regional Health Sector Reform, held February 20-22, 2002, Ocho Rios, St. Ann, Jamaica. Presentation accessed online on November 2, 2002, www.americas.health-sector-reform.org/english/jam_documpresent_eng.htm. Charo Quesada, “IDB News: Leadership, consensus and technology: With broad support from society, Brazil is improving the life of HIV carriers,” *Unisa Latin America Report* 18,1 (2002), 45-46.

⁷² Charo Quesada, “The Fruits of Foresight,” *Unisa Latin America Report* 18,1 (2002), 47-48.

most sensible option for many. Since 1997, we have been dealing with the chairman of the Bishops Conference and the Church is now our great ally.⁷³

These political successes reflect the powerful domestic forces that have shaped the Brazilian governments' response to the epidemic.

The Brazilian government's successful program, however, also occurred both in spite of, and because of, international pressures. In this sense, the story is almost a cautionary tale about the two faces of globalization. Brazilian policy led it to enter a debate that drew in international pharmaceutical companies, the United States, the World Trade Organization, and international NGOs. In order to be able to provide medications to HIV+ people, Brazil decided to produce generic versions of medications that were not covered by that nation's patent law. This angered pharmaceutical companies, which pressured the U.S. government both to file a complaint with the WTO, and to invoke "the 'Special 301' provision of the country's Trade Act, which allows the United States to impose tariffs unilaterally on a country's exports to the United States if adequate IP standards are not met."⁷⁴

As a result of this stand-off, a lengthy battle ensued between the United States and the pharmaceutical companies, on the one hand, and Brazil and the NGOs, on the other. For Brazil this was a critical issue. The threat that it might break companies' patents proved to be a powerful incentive for corporations to drop the price of their medications.⁷⁵ Without reducing these costs, the Brazilian government did not have sufficient resources to maintain its program. With the support of international NGOs, Brazil brought intense political pressure to bear upon the U.S. government. In the summer of 2001 the United States government "retracted a complaint filed with the World Trade Organization over a law that enabled Brazil to produce cheap generic versions of antiretroviral drugs manufactured by multinational drugs."⁷⁶ Equally important, at the Doha conference in Qatar Brazil saw the wording it desired on compulsory licensing adopted by the WTO.⁷⁷

This did not end the contest. Pharmaceutical companies remained concerned, particularly after Brazil announced in July 2002 that it would "share its generic AIDS drugs and the technology used to produce them with some of the world's poorest countries."⁷⁸ But Brazil

⁷³ Quesada, "The Fruits of Foresight," 48.

⁷⁴ Anonymous, "Brazil fights for affordable drugs against HIV/AIDS" *Revista Panamerica de Salud Pública/ PanAmerican Journal of Public Health* 9 (5) 2001, 333. The best single sources on this issue are: Jane Galvão, "Access to Antiretroviral Drugs in Brazil." *Lancet* 360:9348 (12/7/2002): 1862-1866; Carlos Passarelli and Veriano Terto Jr., "Good Medicine: Brazil's Multifront War on AIDS." *NACLA Report on the Americas* 35:5 (Mar/Apr 2002): 35-41. See also Khabir Ahmad. "Brazil and USA at Loggerheads Over Production of Generic Antiretrovirals." *Lancet* 357:9254 (2001): 453. For an international context for this debate see Elizabeth Becker, "International Business; Trade Talks Fail to Agree On Drugs for Poor Nations." *New York Times* 21 Dec. 2002: C3; P. Boulet; Perriens, J.; Renaud-Thery, F. *Patent Situation of HIV/AIDS-related Drugs in 80 Countries*. Geneva: UNAIDS/WHO publication, Jan. 2000. For a look at the TRIPS provision of the WTO see "Integrating Intellectual Property Rights and Development Policy." *Report of the Commission on Intellectual Property Rights* (Chapter 2). London. Sept. 2002. Accessed on January 28, 2003. <http://www.iprcommission.org>.

⁷⁵ Keith K. Key and Daniel J. DeNoon, "Anti-AIDS Free Distribution Cocktail Begins in Brazil." *AIDS Weekly Plus* 25 Nov. 1996: 15. Jennifer L. Rich, "Roche Reaches Accord on Drug With Brazil." *New York Times* September 1, 2001: C1.

⁷⁶ Haroon Ashraf. "USA and Brazil End Dispute Over Essential Drugs." *Lancet* 357:9274 (2001): 2112; see also Scott Gottlieb, "US Concedes on Cheaper Drug Production in Brazil." *British Medical Journal* 323:7303 (2001): 12.

⁷⁷ Jennifer L. Rich, "Brazil Welcomes Global Move on Drug Patents." *New York Times* 16 Nov. 2001: W1.

⁷⁸ "Brazil to Share AIDS Drugs." *New York Times* 9 July 2002: A10.

continued to enjoy international support. For example, this bilateral problem became a multi-lateral issue in October 2002 when Latin American nations refused to accept any provisions of the Free Trade of the Americas proposal that might limit countries' abilities to produce generic AIDS drugs.⁷⁹ This support, and the consistent efforts of NGOs, has allowed Brazil to continue to follow this policy without paying a significant economic penalty.⁸⁰

It may seem that the story of AIDS in Brazil illustrates the limitations of the Washington consensus and the risks to contemporary globalization. At the same time, however, Brazil's AIDS program has received significant funding from the World Bank.⁸¹ By the early 1990s, the World Bank had begun to make AIDS a major priority, and began to redefine this issue as a developmental question.⁸² In 1994 the World Bank provided \$160 million for Brazil to control AIDS and other STDs. While Brazil had already decided to distribute free medications to AIDS patients, this loan was important in making this program financially possible. A second loan for \$165 million was made in 1998 and helped Brazil to continue its innovative program. This is despite the fact that the World Bank does not support all aspects of the Brazilian program, in particular the free provision of medication to people with AIDS. The World Bank had believed this care to be too expensive, and that the funds would have been better expended on prevention services. Ironically, the World Bank has continued to be unhappy with Brazilian policies, despite their apparent success, even while its funding has helped to make them possible.⁸³ In addition, Brazil has also obtained significant resources from the U.S. government (such as the U.S. Agency for International Development, or USAID) and NGOs, such as the John D. and Catherine T. MacArthur Foundation as well as the Ford Foundation. Both the Brazilian government's response to the epidemic, and the work of a multitude of NGOs, has been funded by the international community.

The HIV/AIDS epidemic has not stopped in Brazil, but as the work of Celia Landmann Szwarcwald and other Brazilian epidemiologists have showed, it is decelerating. This is not to deny the challenge that Brazil faces. The ratio of men to women has continued to decline, while the poor are increasingly affected. The disease is making progress into the most remote areas of Brazil, including the Amazon.⁸⁴ Brazil still has a very high rate of notified AIDS cases.⁸⁵

⁷⁹ Cohen, Jonathan. "FTAA Summit: Reject Tighter Patents on AIDS Drugs." Human Rights Watch 29 Oct. 2002. Accessed on January 15, 2003. <http://www.hrw.org/press/2002/10/ftaa1029.htm> For an outline of the issues concerning intellectual property rights in the draft copy of the FTAA see "FTAA – Free Trade Area of the Americas: Draft Agreement, Chapter on Intellectual Property Rights." Accessed on January 15 2003 at http://www.ftaa-alca.org/ftaadraft/eng/ngipe_1.asp

⁸⁰ NGOs have done a great deal of intellectual work on this issue. See for example "Medical Apartheid: Patents, public health and access to medicines." [Health Gap Global Access Project](http://www.healthgap.org). Accessed on-line on January 27, 2003 at <http://www.healthgap.org>. See also "Meeting Report: Strategy Session on the Free Trade Area of the Americas (FTAA), Intellectual Property Rights & Access to Medicines." Convened by: Health GAP, MSF, Essential Action, and National Council of Churches/World Church Service. October 3, 2002. Accessed on-line on January 27, 2003 at <http://www.healthgap.org>. See also "NGO Letter on Compulsory Licensing and Exports (joint letter to members of the TRIPS Council," January 28, 2002. Accessed on January 27, 2003 at <http://www.globaltreatmentaccess.org>

⁸¹ Daniel J. DeNoon and Sandra W. Key, "World Bank Lends Brazil \$165 Million to Curb AIDS." *AIDS Weekly Plus* (September 28, 1998) 13.

⁸² Ruben Araújo de Mattos, Veriano Terto Júnior, and Richard Parker, "Coleção ABIA: Políticas Públicas e AIDS, no. 1: As Estratégias do Banco Mundial e a Resposta à AIDS no Brasil," (Rio de Janeiro: ABIA, 2001), 5-6.

⁸³ Ruben Araújo de Mattos, "As Estratégias do Banco Mundial" 6-7, 16-18.

⁸⁴ Celia Landmann Szwarcwald, Francisco Inácio Bastos, Maria Angela Pires Esteves, Carla L. Tavares de Andrade, "A disseminação da epidemia da AIDS no Brasil, no período de 1987-1996: uma análise especial." *Cadernos de Saúde Pública*. Rio de Janeiro. 16, Sup. 1 (2000): 7-19. For the situation in the Amazon see also J. Gary Linn, L. Arnelo, B.A. Husaini, C. Brown, A.A. Benzaken and Y.N. Stringfield,

Despite its immense efforts, Brazil has not been able to control the epidemic in the same manner that Cuba has. Nonetheless, the Brazilian achievements are impressive: “Over the last 5 years, has achieved much in the fight against HIV/AIDS, including halving the mortality rate, cutting the HIV/AIDS hospitalization rate by 80%, and sharply reducing mother-to-child transmission.”⁸⁶ This has generated national pride in the program, which Brazil hopes to use as a model for other developing countries.

Brazil is now positioning itself as an international model for how developing countries can effectively fight AIDS. In August 2002 it announced that it signed an agreement with other Lusophone countries to share its technology to produce generic medications. This followed an announcement at the International AIDS conference in Barcelona that summer, where Brazil had pledged a small amount of money (\$100,000 each) for ten pilot projects to promote the Brazilian model in other countries.⁸⁷ NGOs had been pressing Brazil to sell generic anti-HIV medications to other Latin American nations.⁸⁸ Given the scale of the funding, these projects might have a limited impact. They may have been equally significant as a measure of Brazilians’ pride in their national AIDS program, and their wish to draw international attention to their success.

Conclusion

Cuba and Brazil have adopted radically different policies to controlling the HIV epidemic in their countries. While Cuba initially adopted a policy of mass testing and quarantine, Brazil came to rely on mass education, and the free provision of medications to the HIV+. Both national programs reflected Brazil and Cuba’s particular national experiences and political systems. But international factors also shaped the creation and maintenance of both programs. One of most puzzling aspects of the HIV epidemic in the Americas is the wide variety in the dominant mode of HIV transmission. Some public health experts have referred to a “mosaic of infections” in Latin America. It is arguable that the HIV/AIDS epidemic is more heterogeneous in the Americas than anywhere else on the globe at this time. This diversity is surprising given the linguistic unity, shared history, common culture, and religious commonalities that shape this region’s identity. While many factors help to explain the epidemic’s complexity, one variable may be countries’ international relationships. This context may help us to understand questions such as why in Puerto Rico HIV is often spread through IV drug use, while in Colombia it is not, and the international constraints that influence the public health response to the disease in nations as varied as Cuba and Brazil.

“HIV prevention for Indigenous People of the Amazon Basin,” *Cellular and Molecular Biology* 47:6 (2001): 1009-1015.

⁸⁵ Paulo Roberto Tell es Pires Dias and Flavio Fonseca Nobre, “Análise dos padrões de difusão especial dos casos de AIDS por estados brasileiros.” *Cadernos de Saúde Pública* 17:5, (Sept.-Oct. 2001):1174, 1175.

⁸⁶ Anonymous, “Brazil fights for affordable drugs against HIV/AIDS” *Revista Panamerica de Salud Pública/ PanAmerican Journal of Public Health* 9 (5) 2001, 331-337

⁸⁷ Andrew Downie. “Brazil Shares AIDS-Fight Blueprint.” *Christian Science Monitor* 94:179 (2002), p. 6.

⁸⁸ Asia Russell, Letter. *Health Gap Global Access Project*, May 6, 2002. Accessed on-line on January, 27, 2003 at <http://globaltreatmentaccess.org>