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Pharmaceuticalization: AIDS Treatment and Global Health Politics

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Abstract

This article examines the political economy of pharmaceuticals that lies behind global AIDS treatment initiatives, revealing the possibilities and inequalities that come with a magic bullet approach to health care. It tells how Brazil, against all odds, became the first developing country to universalize access to antiretroviral drugs—a breakthrough made possible by an unexpected alliance of activists, government reformers, development agencies, and the pharmaceutical industry. The article moves between a social analysis of the institutional practices shaping the Brazilian response to AIDS and the stories and lives of people affected by it. It draws from interviews with activists, policy makers, and corporate actors and from longitudinal ethnographic work among grassroots AIDS care services.

Pharmaceutical innovations allow unlikely coalitions that both expose the inadequacies of reigning public health paradigms and act to reform, if to a limited extent, global values and mechanisms (of drug pricing and of types of medical and philanthropic interventions, for example). Treatment rollouts are matters of intense negotiation; their local realizations are shaped by contingency and uncertainty. Such realizations encode diverse economic and *political interests, as well as the needs and desires of citizens. These therapeutic coalitions also expose the deficiencies of national and local infrastructures and consolidate novel state-civil society relations.*

A pharmaceutically-centered model of public health has emerged as a byproduct of AIDS treatment scale-up and the sustainability of the Brazilian AIDS policy has to be constantly renegotiated in light of global drug markets. A multitude of networks and variations in AIDS care have emerged on-the-ground, and the article explores why AIDS treatment has been so difficult to put into practice among poor Brazilians, who are often stigmatized as noncompliant or untreatable, becoming invisible to the public. Poor AIDS patients live in a state of flux, simultaneously acknowledging and disguising their condition while they participate in local economies of salvation. At both the macro and micro levels, we see a state of triage and a politics of survival crystallizing. [Keywords: AIDS Treatment; Global Health; Pharmaceuticalization; Market-Based Biopolitics; Contemporary Brazil; Political Subjectivity]

The Right to a Nonprojected Future

In his book *A Bias for Hope*, economist Albert O. Hirschman challenges social scientists to move beyond categorical prejudgments, beyond the sole search for general laws and orderly sequences of what is required for wider social and political transformation. Having in mind the Latin American countries in which he worked (including Brazil), Hirschman challenges us, instead, to engage the *unexpected*. The study of how beliefs, attitudes, and values are refashioned and molded by "more or less accidentally undertaken practices," Hirschman argues, "widens the limits of what is or is perceived to be possible, be it at the cost of lowering our ability, real or imaginary, to discern the probable."[1] At stake is helping "to defend the right to a nonprojected future as one of the truly inalienable rights of every person and nation; and to set the stage for conceptions of change to which the inventiveness of history and a 'passion for the possible' are admitted as vital actors."[2]

This article addresses the crucial question of what happens when such luminous prospects of social science are politically and technologically operationalized. Against all odds, Brazil invented a public way of treating AIDS.[3] In 1996, it became the first developing country to adopt an official policy that provided universal access to antiretroviral drugs (ARVs), about five years before global policy discussions moved from a framework that focused solely on prevention to one that incorporated universal treatment. About 200,000 Brazilians are currently taking ARVs that are paid for by the government, and this policy is widely touted as a model for stemming the AIDS crisis in the developing world.[4] Throughout the article, I identify the global political economy of pharmaceuticals that lies behind the Brazilian response to AIDS, revealing the possibilities as well as the inequalities that accompany a magic bullet approach to health care.

To understand AIDS treatment in Brazil, I undertook a twofold investigation on how therapeutics are affected by politics (both nationally and globally) and on the paths of care that AIDS patients pursue to survive amid poverty and disintegrating public health care institutions. My article draws from interviews with people working in state, corporate, scientific and non-governmental institutions, and from longitudinal ethnographic fieldwork among marginalized AIDS patients and grassroots care services in the northeastern city of Salvador. Fieldwork allows us to see these various actors and forces at work, reminding us that there is no shortcut to understanding the ways pharmaceuticals move from the laboratory to professional medicine and public health policy, and how they affect the intimate realms of bodily experience. The anthropological approach of ethnography remains, in my view, a vital social scientific antidote to what Hirschman identifies as "compulsive and mindless theorizing." As he writes, the "quick theoretical fix has taken its place in our culture alongside the quick technical fix."[5] Brazil's response to AIDS thus provides a unique opportunity both to apprehend shifting public-private involvements amid pharmaceutical globalization and to assess their immediate and long-term effects.

The article moves between a social analysis of the institutional practices shaping the Brazilian response to AIDS and the stories and lives of people affected by it. I show that this AIDS breakthrough was made possible by an unexpected alliance of activists, government reformers, development agencies, and the pharmaceutical industry. The politics of treatment access were fueled by market forces and not solely by social mobilization or an ethical principle of universal health care. Some of the unintended consequences of AIDS treatment scale up have been the weakening of prevention efforts and the consolidation of a model of public health centered on pharmaceutical distribution. The sustainability of the AIDS policy has to be constantly renegotiated in light of global drug markets. Amidst a striking decrease in AIDS mortality, this *pharmaceuti-*

calization of public health also promotes models of treatment inclusion that redefine some segments of the population as disposable.

A multitude of networks and variations in AIDS care have emerged on-the-ground, and the article illuminates the modes of life that were created around ARV access in impoverished urban settings where AIDS is spreading most rapidly. My ethnography shows that poor AIDS patients live in a state of flux, simultaneously acknowledging and disguising their condition while they participate in what I call local economies of salvation. Through sporadic and hard-won circuits of care, their subjectivities are refigured as a will to live. At both the macro and micro levels, we see a state of triage and a politics of survival crystallizing.

Universal Access to Lifesaving Therapies

Amidst denial, stigma, and inaction, AIDS became the first major epidemic of present-day globalization. Of more than 40 million people estimated to be HIV-infected worldwide, 95 percent live in middle- or low-income countries, causing life expectancy to drop dramatically in those countries worst hit. In late 2003, with only about 400,000 people receiving treatment, the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) announced their goal of having 3 million HIV-positive people on antiretroviral therapy by 2005. The results have been mixed, but by any account Brazil has been a leader in the effort to universalize access to treatment. By the end of 2004, the number of people on ARVs had increased to 700,000 globally—in the developing world, this figure stood at 300,000, of which half lived in Brazil. And when the deadline arrived at the end of 2005, with an estimated 6.5 million people requiring treatment, 1.2 million were on ARVs—encouraging, but still short of the target. Brazil, with less than 3 percent of the world's HIV/AIDS cases, still accounted for nearly 15 percent of people on ARVs.

Brazil is the epicenter of the HIV/AIDS epidemic in South America and accounts for 57 percent of all AIDS cases in Latin America and the Caribbean. AIDS was first reported in Brazil in 1980, and through mid-2002, the Ministry of Health had reported nearly 240,000 cumulative cases. HIV prevalence in Brazil is higher than in most of its neighbors, although this is in part due to more accurate reporting. At the end of 2001, an estimated 610,000 individuals were living with HIV/AIDS (an adult prevalence of 0.7

percent, about half of what had been projected).[6] Social epidemiological studies show considerable heterogeneity in HIV infection rates, with large numbers infected among vulnerable populations and a fast-growing number of heterosexual transmissions. In 1998, 18 percent of sex workers tested in São Paulo were HIV-positive, and in certain areas of the country, intravenous drug users contribute to almost 50 percent of all AIDS cases. Since 1998, the death rate from AIDS has steadily declined, an achievement attributed to the country's treatment policy.[7]

In the Brazilian AIDS world, the vital actors with a passion for the possible were not just professional politicians. Throughout the 1990s, a range of different groups and institutions—activists and local nongovernmental organizations (NGOs), central and regional governments, and grassroots organizations, along with development agencies such as the World Bank—came together, helping to address what was earlier perceived to be a hopeless situation.[8] This combination of social organization and education, political will (at various levels of government), and international cooperation made it possible for Brazil to overcome AIDS denial and to respond to an imminent crisis in a timely and efficient way.

AIDS activists and progressive health professionals migrated into state institutions and actively participated in policy making. They showed creativity in the design of prevention work and audacity in solving the problem of access to AIDS treatment. In their view, the prices pharmaceutical companies had set for ARVs and the protection they received from intellectual property rights laws and the World Trade Organization (WTO) had artificially put these drugs out of reach of the global poor. After framing the demand for access to ARVs as a human right, in accordance with the country's constitutional right to health, activists lobbied for specific legislation to make the drugs universally available.

The Brazilian government was able to reduce treatment costs by reverse engineering antiretroviral drugs and promoting the production of generics in both public- and private-sector laboratories.[9] Had an infrastructure for the production of generics not been in place, the story being told today would probably be different. For its part, the Health Ministry also negotiated substantial drug price reductions from pharmaceutical companies by threatening to issue compulsory licenses for patented drugs. Media campaigns publicized these actions, generating strong national and international support.[10]

The result—a policy of biotechnology for the people—has dramatically improved the quality of life of the patients covered. AIDS treatment has been incorporated into the country's ailing unified health care system (Sistema Único de Saúde, or SUS) and, according to the Health Ministry, both AIDS mortality and the use of AIDS-related hospital services have subsequently fallen by 70 percent.[11] Brazil's treatment rollout has become an inspiration for international activism and a challenge for the governments of other poor countries devastated by the AIDS pandemic. This policy challenges the perception that treating AIDS in resource-poor settings is economically unfeasible, and it calls our attention to the possible ways in which lifesaving drugs can be integrated into public policy even in the absence of an optimal health infrastructure.

By 2000, the Brazilian AIDS Program had been named by UNAIDS as the best in the developing world, and in 2003 it received the Gates Award for Global Health. Brazil is now sharing its know-how in a range of ways. It has taken on a leadership role in the WHO's AIDS program and it is supporting international networks aimed at facilitating treatment access and technological cooperation on HIV/AIDS. In the past years, the Brazilian government has also been leading developing nations in WTO deliberations over a flexible balance between patent rights and public health needs. We are still far from achieving international justice in the realm of AIDS, but the Brazilian response has at least helped to expose the failures of reigning paradigms which promote public-private partnerships for the resolution of social problems. Brazil's national response has also shown the limits of international development agencies when confronted with the need to act directly on behalf of the poorest. Practically speaking, Brazil opened channels for horizontal south-south collaborations and devised political mechanisms (as fleeting and fragile as they may be) for poor countries to level out some of the pervasive structural inequalities that place their populations at increased risk and continued ill health.

Persistent Inequalities and Grassroots Health Services

The medical accountability at stake in this innovative policy has drastic implications for Brazil's 50 million urban poor, either indigent or making their living through informal and marginal economies. By and large, they gain some public attention during political elections—even then only in the most general terms—and through the limited aid of international agencies. Through AIDS, however, new fields of exchange and possibility have emerged.

I was in the coastal city of Salvador (the capital of the northeastern state of Bahia) conducting fieldwork when AIDS therapies began to be widely available in early 1997. Considered by many "the African heart of Brazil," Salvador was the country's capital until 1763. A center of international tourism, today Salvador has an estimated population of 2.5 million, with more than 40 percent of families living below the country's poverty line. At the time of my fieldwork, local health officials claimed that AIDS incidence was on the decline in both the city and the region, ostensibly in line with the country's successful control policy. But the AIDS reality one could readily see in the streets of Salvador contradicted this profile. A large number of AIDS sufferers remained epidemiologically and medically unaccounted for, thereafter dying in abandonment.[12] Meanwhile, community-run initiatives triaged care for some of the poorest and the sickest.

Every Wednesday at noon, Dona Conceição, a fifty-year-old nurse, cooked large pans of food and, with the help of her religious friends, distributed it to dozens of poor people and families who lived with AIDS and very little else in the abandoned corners of the city's historical compound known as the *Pelourinho*—once a place where African captives were auctioned and rebellious slaves punished. Today it is a lively cultural heritage center.[13] She provided free meals and some care (medication, clothing, and rent aid) to a total of 110 adults, most of them involved in prostitution and drug dealing, and to their children. As Dona Conceição put it: "These people have no protection. They are at the margins of law and life. Medical services never meet the demands and civil society has abandoned them. They need to know that at least someone cares, that they are not just left to themselves. I give them a little comfort and help alleviate things a bit. I am tied to them in spirit."

I talked to the group on several occasions. Soft-spoken Jorge Antonio Santos Araújo said that he was born on January 1, 1963. "I will not lie to you; I injected drugs, and I have AIDS," he told me without hesitation. "I abused drugs and myself. I had to amputate my left leg. When I got to the hospital it was too late. And on top of losing the leg they told me I had AIDS." Jorge had lived by himself and on the streets since the age of fourteen: "I left home because of my stepfather; we didn't get along. I did little jobs, here and there, sold drugs. I think it is a thing of destiny, right?" At some point, he lived with a woman and had a child, but he eventually left them. “If I kept thinking about AIDS, I would already be dead. I don’t live for the disease. I make as if nothing were happening. I am not taking any special medication. When the time comes and if necessary I will take it though. Meanwhile, I roll my life as God wants it. One must forget. One cannot put in one’s mind that one is the disease. If we dwell on the disease, then one starts to say ‘Maybe I should not do this or eat that for it will harm me,’ and then one is left with even less. To be a patient one needs things. What is there here to have?”

The scarcity and violence these street patients navigate day after day are overwhelming. I have always been disturbed and puzzled by the sense of impossibility they voiced, the sense that they had no real references to guide another kind of lifework. Jorge praised Dona Conceição, saying that she played a crucial role in the larger network that he and his friends had to engage to guarantee daily food and drugs. “Besides her help, we do all kinds of things together—we have a few houses and businesses that we visit periodically in the afternoon and get the leftover food. Sometimes we have to sweep the floor or carry things. I will not lie to you, sometimes when the need is just too great we rob things and sell them. The overall situation of AIDS care is pretty bad, that’s what I have to say.” However, through this circuitry—begging, working for food, petty robberies, and AIDS charity—a sense of belonging also takes shape, eliciting a new constellation in which inner life is reframed and social death endured. “People here are all my friends; we have little or nothing, but we give each other strength. Of course, nobody will do anything for the other for free. But they talk to me. They make me laugh. This gives me a bit of extra life.”

One should not expect these patients to adhere to medical treatments, says Dona Conceição, because “they just use medication until they recover.” And she did not blame them: “How can they comply if they live on the streets? Until they have a home, no treatment will work.” Dona Conceição did not judge her street patients and their actions in terms of right or wrong, in terms of normality or pathology; she understood that structural violence compounded substance- and self-abuse. In doing so, she implicitly made their condition a public affair, a Brazilian social symptom, I thought. But to complicate things further, she refused to treat them as a collective, and that’s what drew them to her. She helped them singularize, and she literally struggled in their place: “Each one has a history, a life left behind. Jorge suffers emotionally—all the discrimination he goes through, and he is unable to overcome his personal failures. He does not struggle for health; I struggle for him." How, I wondered, would the antiretroviral rollout fare in this context of multiple scarcities and spurious regional politics? How would the most vulnerable transform a death sentence into a chronic disease? Which social experimentation could make such medical transformation possible?

Here Hirschman's right to a nonprojected future begs for enactment and institutionalization. Caasah, a focal point of my research, was founded in 1992, when a group of homeless AIDS patients, former prostitutes, transvestites, and drug users squatted in an abandoned hospital formerly run by the Red Cross (Jorge was among them).[14] "Caasah had no government," recalled the president Celeste Gomes. "They did whatever they wanted in here. Everybody had sex with everybody, they were using drugs. There were fights with knives and broken bottles, and police officials were threatening to kick us out."

Soon, Caasah became an NGO and began to receive funding from a World Bank loan disbursed through the Brazilian government. By 1994, eviction threats had ceased, and the service had gathered community support for basic maintenance. Caasah had also formalized partnerships with municipal and provincial Heath Divisions, buttressed by strategic exchanges with hospitals and AIDS NGOs. Throughout the country, other "houses of support" (*casas de apoio*) like Caasah mediate the relationship between AIDS patients and the haphazard, limited public healthcare infrastructure. By 2000, at least one hundred of the country's five hundred registered AIDS NGOs were houses of support. Government officials call these outsourced units of care "social instruments of remediation." In order to belong to these grassroots units, people must break with their old habits, communities, and routines as they forge new biographies.

By the mid-1990s, the unruly patients in Caasah had been ejected. "I couldn't stand being locked in. I like to play around," Jorge told me. "Here I smoke my pot in peace, that's my medication, that's my woman." A smaller version of the group began to undergo an intense process of resocialization mediated by psychologists and nurses. Jorge and about eighty other outpatients remained eligible for monthly food aid. Patients who wanted to stay in the institution had to change their antisocial behaviors and adhere to medical treatments. Caasah now had a reasonably well-equipped infirmary, with a triage room and a pharmacy. Religious groups visited the place on a regular basis and many residents adopted religion as an alternative value system. As Edimilson, a former intravenous drug user and petty thief, put it: “In Caasah we don’t just have AIDS—we have God.” According to Celeste: “With time, we domesticated them. They had no knowledge whatsoever, and we changed this doomed sense of ‘I will die.’ Today they feel normal, like us, they can do any activity, they just have to care not to develop the disease. We showed them the importance of using medication. Now they have this conscience, and they fight for their lives.”

Rose’s left hand was atrophied, and she limped. “It is all from drug use. I was crazy. I went to the street, to a bar, left with a client, did his game, and drugged myself with the money.” Rose and other healthy patients in Caasah repeatedly pointed to the marks on their bodies as images of past misdeeds, as if they were now in another place, seeing and judging their past selves from a photographic distance. “Ah, now I see…. If I only had thought then the way I think now.”

Rose grew up in the interior and was expelled from home at the age of thirteen, after she became pregnant. She moved into Pelourinho’s red-light district. By the end of 1993, Rose learned that she was both pregnant and HIV-positive. A physician who did volunteer work among prostitutes arranged Rose’s move to Caasah. One by one, Rose gave up her children for adoption. The newborn girl was adopted by Naiara, Caasah’s vice-president, and her little boy was adopted by Professor Carlos, the chief nurse. “What else could I have done? I couldn’t give them a house. I also thought that I would not live much longer.”

But Rose has lived longer than she expected. For four years, she had been off illegal substances. She had remained asymptomatic, had become literate, and had learned to make handicrafts. At that time, she was involved with Jorge Ramos, another resident, and was beginning to take antiretroviral drugs. “I take life in here as if it were a family, the family I did not have,” she stated.

Caasah’s residents and administrators constituted a viable public that effectively sustained itself in novel interactions with governmental institutions and local AIDS services. Instead of succumbing to the factors that predisposed them to non-adherence to treatment (such as poverty and drug addiction), residents used their “disadvantages” to create the AIDS-friendly environment that is necessary to accumulate health.[15] In this “proxy-family” people did not have to worry about the stigma that came with having AIDS “on the outside,” and there was a scheduled routine and an infrastructure that made it easier to integrate drug regimens into everyday life.[16] The right to health was group-privatized, and an intense process of individuation—

"salvation from my previous life," as some put it—and a spirit of competition with fellow residents motivated treatment adherence as well.

"Did you ever see an AIDS patient in here hoping for the Other's good?" Evangivaldo asked me as he was being quarantined because of his scabies. Residents constantly denounced each other's faults and demanded the rigorous application of the law: "Is there a law? Where is it? Why is it not being applied?" The Other's misbehavior was also a measure of their own progress, a measure of their own change and self-control. "I am not like him." "He did it to himself, and now wants another chance." Money was also at stake. The administration was mediating the extremely bureaucratized application for AIDS disability pensions, and priority was given to those residents who showed change. Well-behaved and compliant patients were also allowed to help in the storage room, where they then had priority in choosing clothing for themselves and for family members living outside.

I have been chronicling life in and out of Caasah for more than ten years, and at the end of the article I will take the reader back there to see what has happened to this "house" and its residents over time. Antiretroviral drugs are now embedded in hundreds of similar medico-pastoral sites operating all over the country. Novel ideas of citizenship and modes of subjectivity travel and gain currency among poor AIDS patients who use or who refuse to use ARVs. Medicines have indeed become key elements in state-civil society relations. But this is not a top-down form of control—one could call it a market-based biopolitics. In what follows, I show that pharmaceutical companies are themselves engaging in biopolitics, gaining legitimacy and presence in both state institutions and individual lives through drugs. The government is not using AIDS therapies and houses of support as "techniques…to govern populations and manage individual bodies."[17] Poor AIDS populations acquire temporary form through particular and highly contested engagements with what is made pharmaceutically available. The political game here is one of self-identification, and it involves a new economics of survival. Desires are fundamental to life chances, unfolding in tandem with a state that is pharmaceutically present (via markets) but by and large institutionally absent.

A Political Economy of Pharmaceuticals

Although a compacted and all-encompassing sovereignty is hard to locate in today's geopolitical order, states do not necessarily weaken amid economic globalization.[18] But they do reform and reconfigure themselves, developing new strengths and novel articulations with populations. Brazil's response to AIDS "is a microcosm of a new state-society partnership," Fernando Henrique Cardoso, Brazil's former president (1995–2002) and the country's most prominent sociologist, stated in an interview with me in May 2003: "I always said that we needed to have a porous state so that society could have room for action in it, and that's what happened with AIDS."

I met with Cardoso in Princeton, at the Institute for Advanced Study, where he was participating in a meeting of the board of trustees. After leaving the presidency, Cardoso had been traveling the international lecture circuit and had taken a professorship at Brown University. He had no qualms about extrapolating, using the AIDS treatment policy as evidence of the "success" of his state reform agenda—a state open to civil society, decentralized, fostering partnerships for the delivery of services, efficient, ethical, and, if activated, having a universal reach. "Government and social movement practically fused. Brazilian society now organizes itself and acts on its own behalf."[19] From this perspective, the state appears through its model policies.

This new state-society synergy reflected in the country's AIDS Program has developed in the wake of Brazil's democratization and the state's attempt to position itself strategically in the context of globalization, Cardoso argued: "We cannot do politics as if globalization did not exist. One must see and decide in practice what is good and what is bad about it. This new phase of capitalism limits all states, of course, including the United States, but it also opens up new perspectives for states. The old producing state had no ways to capitalize or compete. You must have competition in a market that is global and not local. The producer complains because he will have to invest more, but the consumer wins with that."

Brazil had registered one of the highest rates of gross domestic product (GDP) growth in the world from the beginning of the century until 1980, but from then on the economy had practically stood at a standstill, with hyperinflation and a stream of exchange devaluations that finally declined under the Cardoso administration. In the previous fifty years, the Brazilian state had increasingly intervened in the production of goods and services, but this was no longer resulting in growth. By 1990, Brazil had the largest foreign debt in world: $112.5 billion. The country's transition from a twenty-year military dictatorship to a democratic regime occurred under the weak, still centralized, and clientelistic government of José

Sarney (1985–89), and later the neoliberalizing administration of Fernando Collor de Mello, who was impeached in 1992 under allegations of corruption and abuse of power. Itamar Franco became interim president, followed by Cardoso. In 2003, Luis Inácio Lula da Silva from the Workers' Party (Partido dos Trabalhadores, PT) became Brazil's new president (he has been reelected for a second term).

Cardoso said that both he and the new president "in the end say the same thing." That is, "that globalization is asymmetric and that it does not eliminate the differences imposed on the nations. So we have to take concrete steps toward decreasing this asymmetry, mainly at the trade level so that we can have access to markets, and also to control financing mechanisms." He made the case that Lula's government was basically following the same "ultra-orthodox" economic line of his administration—but that, "surprisingly," the new government lagged in social program innovation: "The proposals they have are centralized, very vague, mismanaged, and don't match with what Brazil already is." Cardoso was proud of the ways the AIDS Program—with its multisectoral partnerships and high-tech delivery capacity—had pushed the envelope of what was governmentally possible.

"The idea that nothing can be done because rich countries are stronger is generally true, but not always," stated Cardoso. "You can fight and, in the process, gain some advantages. You must penetrate all international spheres, try to influence and branch out. The question of solidarity must be continuously addressed." Brazil's struggle for drug price reduction, he says, "shows that under certain conditions you can gain international support to change things. All the nongovernmental work, global public opinion, change in legislation, and struggle over patents are evidence of new forms of governmentality in action…thereby engineering something else, producing a new world."

The rhetoric of state agency and the abstractions that Cardoso articulated—mobilized civil society and activism within the state—are part of a new political discourse. This performative language belongs to a public sphere strongly influenced by social scientists, as well as by politicians who do not want to take responsibility for their decisions to conform to the norms of globalization.[20] For example, Cardoso makes no specific reference to the measures his administration took to open the economy such as changes in intellectual property legislation and the privatization of state industries. This political discourse does not acknowledge the economic factors and value systems that are built into policy making today.

As with all things political and economic, the reality underlying the AIDS policy is convoluted, dynamic, and filled with gaps. The politicians involved in the making of the AIDS policy were consciously engaged in projects to reform the relationship between the state and society, as well as the scope of governance, as Brazil molded itself to a global market economy. And one of this article's central arguments is that on the other side of the signifier *model policy* stands a new political economy of pharmaceuticals, with international and national particularities. Just a few months before approving the AIDS treatment law in November 1996, the Brazilian government had given in to industry pressures to enshrine strong patent protections in law. Brazil was at the forefront of developing countries that supported the creation of the WTO, and it had signed the Trade-Related Aspects of Intellectual Property Rights treaty (TRIPS) in December 1994.[21] Parallel to the new patent legislation, pharmaceutical imports to Brazil have increased substantially. Between 1995 and 1997, the trade deficit in pharmaceutical products jumped from 410 million to approximately 1.3 billion dollars.[22]

Moreover, in his "pragmatic" approach to globalization, Cardoso articulates a market concept of society. Citizens are consumers and have "interests" rather than "needs." Neoliberal governmentality has taken a new shape: as AIDS activism converged with state policy making, and as the public health paradigm shifted from prevention to treatment access, political rights have moved towards biologically-based rights. Rather than actively seeking areas of need to address, the new market-oriented state selectively recognizes the claims of organized interests groups (particularly around treatment access) that "represent" civil society, leaving out broader public needs for life-sustaining assistance in the domains of housing, economic security, and so forth. According to Cardoso, "There has never before been so much NGO action within the government as has occurred in the past ten years. In all our social programs there was some kind of social movement involved." The work of NGOs and their international counterparts gives voice to specific mobilized communities and helps to consolidate public actions that are "wider and more efficacious than state action," he argues.

In these conditions, lawmaking is the main arena of state action—and putting new laws into practice is an activist matter. Cardoso lauds the signing of the AIDS treatment law and "even the agrarian reform law. They said nothing would pass." In mobilizing for a law and approving it, the state realizes its social contract. In Cardoso's vision, specific policies and legislation replace a wider social contract.[23] In practice, people have to engage with lawmaking and jurisprudence to be seen by the state; as a result, the implementation of the law becomes subject to a whole range of exclusionary dynamics related to economic considerations and specific social pressures. The AIDS treatment policy, one can ague, illuminates what was at sake in past political decisions and economic maneuvers. It also gives evidence of how these "origins" can be somewhat remediated through novel state-medical-market initiatives.

Drug Markets and the Pharmaceuticalization of Public Health

In 2005, global pharmaceutical sales reached $602 billion—a growth of 7 percent from the previous year. According to Murray Aitken, a senior vice president at IMS Health, the market intelligence company that produced this sales report, "As growth in mature markets moderates, industry attention is shifting to smaller, developing markets that are performing exceptionally well."[24] The Brazilian market is of key importance for pharmaceutical companies operating in Latin America. Sales in Latin America grew "an exceptional" 18.5 percent to $24 billion in 2005. Febrafarma (Federação Brasileira da Indústria Farmacêutica), the Brazilian pharmaceutical umbrella organization, estimated the annual cumulative pharmaceutical market at $8 billion as of July 2005. However, according to Espicom, another business intelligence company, the market reached $10 billion in 2005, equal to $54 per capita. Currently, Brazil is the eleventh largest pharmaceutical market in the world.

Brazil began its pharmaceutical production in the 1930s, largely dependent on the import of chemical components. National production intensified during the Second World War, and by the late 1950s several foreign pharmaceutical companies began to invest in the country. About six hundred pharmaceutical companies operated in Brazil in the 1960s and 1970s. Due to the country's economic instability this number fell to four hundred in the 1980s.[25] The international pharmaceutical industry welcomed the country's recent economic reforms and friendly drug-pricing policy. Between 1996 and 1999, the pharmaceutical business environment became more regulated, with the approval of the intellectual property law, the creation of ANVISA (Agência Nacional de Vigilância Sanitária, the National Health

Surveillance Agency) and the regulation of generics. Currently, about 550 pharmaceutical companies (laboratories, importers, and distributors) operate in Brazil and compete for a slice of its lucrative market.

The Brazilian case is much in line with global trends. Consider this recent statement by another market research company: "Positive economic growth, stabilizing political structures, growing patient populations and increasing direct foreign investment in the emerging markets of Brazil, Russia, India and China (BRIC) are creating significant opportunities for pharmaceutical companies to expand into these markets and maximize future revenue potential. Pharmaceutical sales across the BRIC economies grew by 22.3 percent in 2005, compared to single digit growth in the major markets of the U.S., Europe and Japan."[26] By 2010, the developing world is expected to account for approximately 26 percent of the world pharmaceutical market in value, compared with 14.5 percent in 1999.

Dr. Radames, a Brazilian infectious disease specialist and adviser to the WHO explained to me: "Pharmaceutical companies had already recouped their research investment with the sell-off of AIDS drugs in the United States and Europe and now with Brazil, they had a new fixed market and even if they had to lower prices, they had some unforeseen return. If things worked out in Brazil, new AIDS markets could be opened in Asia and perhaps in Africa."[27]

Dr. Jones, an executive of a pharmaceutical multinational that sells ARVs to the Brazilian government does not put things so explicitly, but he asserts that "patents are not the problem. The problem is that there are no markets for these medications in most poor countries. Things worked out in Brazil because of *political will*" (emphasis added).[28] For him, "no markets" in Africa, for example, dovetails with local governments' lack of a holistic vision of public health, in which the public and private sectors work in tandem: "AIDS lays bare all the inadequacies of a country's approach to public health. Unless the government recognizes this and addresses the totality of public health, you don't deal with HIV/AIDS. We see an evolution in countries that have coordinated efforts, a strong national AIDS program, partnership with private sectors, and the country's leader supporting intervention."

Dr. Jones continued: "Health is not an area that the Brazilian government allowed to deteriorate anywhere near the degree of what we see in other developing countries. You had an existing structure of STD clinics and World Bank funding helped to strengthen the infrastructure."[29] In this rendering, Brazil's "massive political will" to treat AIDS coincides with the country's partnership with both international agencies and the pharmaceutical industry: "Different than in Africa, in Brazil we had a successful business with our first antiretroviral products. And we will continue to have tremendously successful businesses based on our partnership approach with the government. Brazil continues to be an example of how you can do the right thing in terms of public health, understanding the needs of both the private sector and the government and its population. The government was able to take advantage of existing realities. There was no intellectual property protection for our early products, and given Brazil's industrial capacity, they were able to produce the drugs."

I asked Dr. Jones how the pharmaceutical industry reacted to this strategy. "We were angry," he said. But rather than withdraw from Brazil, the company used the incident over pricing and generics to negotiate broader market access in Brazil. "The downside could have been 'why bother and continue to invest in Brazil?' But anti-HIV products are not the sole bread and butter of most companies. So from a portfolio perspective, any private company balances its specific activities vis-à-vis the entirety of what it is doing. This one sector was being affected but our company had been in Brazil for a long time and we continued to be ranked as a top company there. So we had to look at it in a much broader perspective than an action taken in one product category."

The pharmaceutical industry's capacity to neutralize and redirect any form of counter-reaction to its advantage is indeed remarkable. Just as big pharma has played a key role in setting global trade rules (through TRIPS, for example), it has also helped to shape the international health agenda. The advocates of the neoliberal reforms of the 1990s encouraged the participation of the private sector in resolving social problems. Nevertheless, this discourse of corporate social responsibility did not translate into large-scale partnerships to eradicate disease among the global poor.[30] But it definitively enabled the private sector to enter the decision-making process at institutions of global governance, and from there to defend its interests and vision.

By juxtaposing the arguments of both corporate actors and policy makers one can identify the logic of such a pharmaceutical form of governance. Here, political will means novel public-private cooperation over medical technologies. Once a government designates a disease like AIDS "the country's disease," a therapeutic market takes shape—a captive market. As this government addresses the needs of its population (now unequally refracted through the "country's disease"), the financial operations of pharmaceutical companies are taken in new directions and enlarged, particularly as older lines of treatment (generic ARVs) lose their efficacy, necessitating the introduction of newer and more expensive treatments (still under patent protection) that are demanded by mobilized patients. Patienthood and civic participation conflate in an emergent market. Development agencies (such as the World Health Organization, UNAIDS, and the World Bank) assist this process, which has crucial ramifications for the nature and scope of national and local public health interventions.

Magic-bullet approaches (that is, delivery of technology regardless of health care infrastructure) are increasingly the norm, and companies are themselves using the activist discourse that access to medicines is a matter of human rights. This pharmaceuticalization of public health has short and long-term goals, as Dr. Jones puts it: "At what point does it get to the government that today citizens put a huge premium on access to health? And it is not just a matter of guaranteeing access to the available medications but to the new ones being developed. If you don't have the capacity to produce this new medication, then you have to find a way to align yourself and trade with those who are doing it. With a global disease like AIDS, you must play together and not on your own."

I asked former Health Minister José Serra (now governor of the state of São Paulo), whether the state had the capacity to address other large-scale diseases pharmaceutically. "Without a doubt," the economist said. "But the problem does not lie in government. The government ends up responding to society's pressure, and with AIDS, the pressure was very well organized. See the case of tuberculosis. It is easier to treat than AIDS, and much cheaper. The major difficulty lies in treatment adherence. But you are unable to mobilize NGOs and society for this cause. If TB had a fifth of the kind of social mobilization AIDS has, the problem would be solved. *So it is a problem of society itself*" (emphasis added).[31]

For Cardoso, too, the management of AIDS is clear evidence that politics have moved beyond the control of parties and ideologies. "There is no superior intelligence imposing anything…a party, a president, an ideology. But there are assemblages, alliances, strategies," he stated in the interview in 2003. "Today Brazilian society is much more open than people imagine and very mobilized. In reality, people do not live in a state of illusion as intellectuals and journalists generally think of them; they have learned to mobilize and know how to make pressure and activate those in congress with whom they have affinities."

This is also true for the pharmaceutical industry and its powerful lobby, I added. Cardoso replied, "Indeed, they also mobilize because there is a struggle going on. A bet on democracy leads to this kind of diversity. The government has to navigate amid all these pressures. It must set some specific objectives and develop directives to that end amid this confusion. It cannot just be on this or that side, it must more or less pilot."

Brazil has indeed seen an incremental change in the concept of public health, from prevention and clinical care to community-based care and drugging—that is, public health is increasingly decentralized *and* pharmaceuticalized.[32] But as I discovered in my fieldwork in the southern and northeastern regions, the flow of this universal and pharmaceutically mediated health care delivery is discontinuous and highly unequal. The availability of essential medicines has, in fact, been subject to changing political winds; treatments are easily stopped, and people have to seek more specialized services in the private health sector or, as many put it, "die waiting" in overcrowded public services.[33] Even though the responsibility for distributing medicines has become increasingly decentralized, the lobbies of patient groups (modeled after AIDS treatment activism) and of the pharmaceutical industry has kept the federal government responsible for the purchase of drugs for diseases included in "special national programs." An increasing number of patients are filing legal suits, forcing regional governments to maintain the inflow of high cost medicines that are entering the market.[34] According to public health expert Jorge A. Z. Bermudez "an individualized rather than collective pharmaceutical care" is being consolidated in the country."[35] A critical understanding of the AIDS policy's success must keep in sight this mobilization over inclusion and exclusion as global drug markets and certain forms of "good government" are being realized.

Global Health Politics

The AIDS crisis in the developing world is finally on the radar of transnational organizations, governments, and citizens alike. Many public- and private-sector treatment initiatives are being launched, and the international debate has now shifted to how this can be most effectively done in contexts of limited resources. According to activist groups, the Global

Fund to Fight AIDS, TB, and Malaria "represents the globalization of Brazil's model of harnessing the forces of government and civil society to confront the AIDS challenge."[36] More than one hundred countries have together committed a total of $3 billion to the Global Fund—an international health financing institution—with the United States pledging to donate the most, $2 billion. Here, governments and civic organizations focus on funding rather than implementation. The development of aid projects (mostly aimed at helping women and vulnerable children) is left to local groups. When the United Nations' AIDS Program was founded in 1996 it had $300 million available for loans to middle- and low-income countries. This budget increased to $4.7 billion by 2003. The World Bank, which has supported the development of the Brazilian AIDS program, has played the largest role in financing UNAIDS.

This increase in AIDS funding in recent years "is largely a fruit of the well-coordinated activism of the international community," stated Dr. Paulo Teixeira, Brazil's former AIDS coordinator, in a Global Health Governance Workshop in São Paulo in June 2005.[37] "We have changed the discourse and paradigm of intervention," he told me. "It has become politically costly for development agencies and governments not to engage AIDS." Yet, the operations of global AIDS programs and their interface with governments and civic organizations "reflect and extend existing power relations, and this synergy can be quite negative," Dr. Teixeira added. "The negotiating power of developing countries is simply too low, be it at the United Nations or at the World Trade Organization. AIDS gave poorer countries a small window of opportunity to intervene in global governance and to try to recast the uneven correlation of forces." Brazil has done so by challenging the patents and pricing structures of global pharmaceutical companies at the WTO, and by spearheading alternative south-south cooperation programs.

Dr. Paulo Teixeira is an insider to these emergent forms of transnational (pharmaceutical) governance. Alongside Dr. Jim Yong Kim, he helped coordinate the joint WHO and UNAIDS "3 by 5" campaign, aimed at providing antiretroviral drugs to 3 million people by 2005.[38] In June 2005, the WHO reported that approximately 1 million people were on ARVs in low- and middle-income countries, in contrast to 400,000 in December 2003. Dr. Kim reflected on falling short of the desired target: "We didn't do enough, and we began to deal with the problem too late." Yet, "before '3 by 5' there was no emphasis in saving lives," he said. "Many world leaders thought that we had to forget this generation of HIV infected people and to think only of the next generation. We did something to change this."[39] Indeed, increased availability of ARVs averted an estimated 250,000 to 350,000 premature deaths in the developing world in 2005 alone.[40] Yet, funding bottlenecks, personnel shortages, and continuing debates on drug pricing and patents have limited this and many other AIDS initiatives. As Dr. Teixeira put it, "In the name of their own interests, private foundations, rich governments, and pharmaceutical companies keep putting all kinds of obstacles to a more rapid scale-up of AIDS treatments. Interventions of the pharmaceutical companies are paralyzing the WHO."

In early October 2005, I talked to Dr. Jane Walker, the executive vice president of a U.S.-based pharmaceutical company. For her, the Brazilian AIDS treatment program worked "not so much because of politics, but because of a good allocation of resources." As for treating AIDS in poorer regions, Dr. Walker insisted that "drug price is not the problem; the problem is infrastructure." Dr. Walker was now leading her company's efforts to "not just" bring antiretroviral drugs to women and children in hard-hit places in southern and West Africa, "but to build up local treatment capacity."

This medical care and research endeavor was carried out in partnership with global AIDS initiatives, local health care groups, and NGOs. For this executive, it seemed matter-of-fact that public-private partnerships did better infrastructural work than state institutions alone. This discourse of state replacement, I thought, added an activist and morally urgent spin to a central tenet of neoclassical economics: the idea of a self-regulating market. The challenge, Dr. Walker told me, "is to find treatment models that can be inexpensively scaled up. Every one of the estimated 40 million people living with HIV is a person. We must do something as a world. We must save every one of these lives. The solution is not medicine as we practice and as we know it. We must save every one of these lives."

Here, one saves lives by finding new technical tools and cost-effective means to deliver care: that is, medicines and testing kits. The civil and political violations that precede disease are apparently lost of sight in this pharmaceutical humanitarianism, and the economic injustices reflected in barely functioning health-care systems are depoliticized.[41] In the end, governments function on the business side, merely purchasing and distributing medicines, while nurturing—now a technological endeavor—is left to communities and patients.

The U.S. president's $15 billion Emergency Plan for AIDS Relief (PEPFAR) reflects this global pharmaceutical frame of assistance. Announced in early

2003, PEPFAR aims to bring therapy to 2 million people and to prevent 7 million new infections by 2008 in fifteen of the neediest countries in Africa and the Caribbean. However, there is a catch: rather than subscribing to the WHO's drug-approval process, PEPFAR requires separate approval from the Food and Drugs Administration (FDA). Officials claim that this is to protect the safety and quality of drugs. But critics have accused the Bush administration of delays and of actually reserving money for expensive brand-name drugs, thus reducing the number of potential recipients.[42] Defying these and other criticisms, in May 2004 PEPFAR began buying generics, and in July 2006 the FDA approved a generic 3-in-1 combination antiretrovival drug made by the Indian manufacturer Aurobindo Pharma.[43] According to Dr. Mark R. Dybul, acting U.S. global AIDS coordinator, it is unclear if the generic drug will significantly cut costs, but by requiring patients to only take one pill two times a day the combination drug "should facilitate better therapies and better adherence."[44]

Global ARV rollouts rightly open the door to drug access, but they also exemplify the inadequacies of a magic bullet approach to health care. The methodological designs of AIDS treatment programs (pilot and otherwise), as well as the models they employ, have to be scrutinized and politicized. PEPFAR, for example, has an expeditionary quality, implemented from without, and is designed to save lives. It favors large-scale drug distribution but does not adequately address the issue of public health care infrastructure improvements, or, for that matter, prophylaxis and treatment of opportunistic diseases. Critics have rightly pointed out that, generally speaking, the strategies underlying new global health interventions are noncomprehensive and ultimately of poor quality.[45] Many question their sustainability in the absence of more serious involvement of national governments and greater authority for international institutions to hold donors and partners accountable in the long term.

Drugs are ancillary to the full treatment of the disease. Alone, neither money nor drugs nor even a sophisticated pilot model guarantee success. Healing, after all, is a multifaceted concept, and "healing" is no more synonymous with "treatment" than "treatment" is with "drugs." Statistical strategies and corporate profit motives hover above, by and large missing cultural systems and the interpersonal networks that link patients, doctors, and governments, which are especially important in resource-poor settings, where clinical infrastructures are not improving. This displacement of the local from the planning framework leaves unaddressed the clinical continuity necessary for successful AIDS treatment. As a result, extremely well-endowed efforts—facing the humanitarian paradox of "life-saving drugs versus caregiving infrastructure"—are by and large falling short of the mark, without effecting the changes hoped for.

As Susan Reynolds Whyte and colleagues note in the context of ARV access in Uganda, "in principle, affordable treatment will change the meaning of AIDS (and of life!). But the process is a rough and inequitable one. As drugs for AIDS become more common, they expose the nature of healthcare—its dynamism, its unevenness, and the order in its disorder."[46] With drugs available and structural violence ongoing, politically motivated and deceiving discourses have surfaced to rationalize in a perverse fashion the survival dilemmas the most vulnerable now face in the absence of improved living conditions—poor HIV-positive mothers in sub-Saharan Africa, for example, who used medicines to prevent vertical transmission are now left "to choose" to breastfeed their newborns (as the least lethal option) because lack of clean water makes formula feeding a riskier practice. Pre-modern and modern ways to access resources and convert risk into life possibilities routinely overlap to redistribute technology and care unequally.

The work of anthropologist-physician Paul Farmer and Partners In Health provides an opposing community-based model for AIDS treatment. The HIV Equity Initiative in Haiti does not operate like a traditional non-governmental organization, that is, removed from people. A pragmatic solidarity with the ill and destitute is its starting point. It uses the local clinic as the nexus of care within integrated prevention activities and ARV administration. "Improving clinical services can improve the quality of prevention efforts, boost staff morale, and reduce AIDS-related stigma," writes Farmer.[47] In this holistic approach, accounting for individual trajectories and staying with patients through the progression of the disease (the work of *accompagneteurs*) is considered as important as tackling the social factors that impact patients' families and mitigating the decays of clinical infrastructures.

While Partners In Health's treatment initiative is by no means accepted as a gold standard, its presence has created dents in the prevailing rationalities that guide the treatment of AIDS in resource-poor settings. In challenging the view that comprehensive care of this sort is unsustainable, the project has gained a kind of iconic role/value, expressing unforeseen possibilities and articulating a new human rights imperative.

However, its expansion also begets an array of questions concerning the ethical grounds for prioritizing AIDS over other diseases of poverty (malaria, diarrhea, for example), as well as political questions regarding its operationalization and sustainability over time.[48] The WHO's difficulties in pushing forward with the "3 by 5" campaign leave no doubt that even the noblest of efforts must be politicized and understood in relation to the strategies of both national governments and global initiatives. Nonetheless, Partners in Health has opened up new spaces and redefined the perceived boundaries of feasibility.

Drug Resistance and the Future of ARV Rollouts

In our conversation in June 2005, Dr. Teixeira expressed concern about the sustainability of Brazil's AIDS treatment policy. "I always voted for the Workers' Party, and I had high hopes in this government. But for reasons that have not been made public, the government has been reluctant to make bold moves as far as generics, patents, and international relations are concerned." By early 2004, for example, the national AIDS program had taken the technical and juridical measures that were needed for the government to issue compulsory licenses for the production of two patented drugs that took up almost 60 percent of the country's AIDS treatment budget. "We had preliminary agreements with Indian companies to provide us the necessary chemical materials, and I was at the WHO to provide international support," Dr. Teixeira stated. "It was just a matter of the health minister appearing on national television and announcing it, but he did not."

Other public health scholars at the Global Health Governance Workshop told me that the AIDS policy had actually lost some of its political currency, as it was taken as a "success story of the previous administration." The current administration wants to construct "its own success stories." As is always the case in Brazil's political culture, electoral motives take priority over policy continuity. Besides political factors, "there is also confusion and administrative incompetence," pointed out Michel Lotrowska, an economist working for Doctors Without Borders' research program on neglected diseases in Rio de Janeiro. Given new budgets and bureaucracies, for the first time in 2005 there were shortages of ARVs in the health care system, Lotrowska stated.[49]

"The preparedness that was in place is being compromised," Dr. Teixeira added. "We are lagging in technology."[50] The ARV reverse engineering program at Farmanguinhos (the state's main laboratory) has been partially dismantled and generic drug development is not keeping pace with the market. Lotrowska gave the example of Tenefovir, an important rescue drug: "Brazil is one of the few emerging markets in which companies make money with ARVs. So they isolated Brazil in terms of pricing. It is a very expensive drug, it takes a lot of the AIDS budget, and there is nothing to replace it. India never got interested in producing it, and Brazil did not think prospectively. The government cannot issue a compulsory license for it. Things are disorganized, and people at various levels of government are fighting each other. The country's machinery of AIDS drug development is stalled. Of course, all this is good for big pharma."

Brazil is now experiencing what other countries treating AIDS will soon face. It has very inexpensive first line ARVs, but a growing number of people are going into new drug regimens (either because earlier combinations did not work or because patients and doctors are demanding access to more sophisticated drugs, with fewer side effects) that are entering the market. With patients taking advantage of new treatments Brazil's ARV budget has increased to nearly $500 million in 2005. In spite of the country's generic production, about 80 percent of the medication in the budget is patented. "We are moving toward absolute drug monopoly," concluded Lotrowska: "In a few years, the price of AIDS treatment will increase significantly. Given patent restrictions and all the bilateral agreements that are in place, we have less and less generic competition. We have to find a mechanism that can lead to price reduction without this competition. Without such a mechanism, medics will soon have to tell patients 'I can only give you first-line treatment, and if you become drug resistant then you will die.'"

In the meantime, as I have been arguing throughout this article, a pharmaceutically centered model of public health is being consolidated worldwide, and medicines have become increasingly equated with health care for afflicted populations. As with other disease entities, pharmaceutical companies have operated astutely within legal and regulatory windows of opportunity in the case of AIDS, redirecting activist and political gains to their own advantage—be it as public relations gains through corporate philanthropy, as financial profits from global treatment projects, or as market expansion via developing states that have made AIDS "the country's disease" (as it is with Brazil, now a captive purchaser of ARVs).

Consider Roche's recently introduced drug, T-20 (Fuzeon). This drug is the first of a new class of drugs—called fusion inhibitors, which keep HIV particles from fusing with lymphocytes—that will undoubtedly have great impact in preventing or coping with drug resistance. In Brazil, some 1,200 patients were prescribed T-20 immediately after the drug's debut, with a yearly cost of $20,000 per patient. "When the starting price of a drug is as T-20's, it is evident that after some time you will get a 30 to 50 percent price reduction," Lotrowska told me. "But even with this reduction, what will happen to the country's AIDS budget when thousands more will need it or want it?"

While back in Salvador in June 2005, I learned that Roche was training local infectious disease experts to make T-20 a first-line treatment rather than simply a rescue drug. This is a common practice, according to Bart Kroger, a Dutch medical researcher now living and working in Salvador. "These opinion-makers are extremely well paid, and they present the drug and treatment options in local congresses," he said, astounded by the trans-local state of medical science and ethics. "The specialists take on a 'neutral' position, generally presenting positive aspects of the drug in question but also criticizing less important aspects of the drug. They don't want to sound as if they had been bought by the company. This is important for them not to lose credibility among peers and also to keep open the possibility of working for other companies in the future."

I also heard of cases where doctors began prescribing the rescue drug Kaletra at the time of its 2002 launch in the United States, before its registration in Brazil. These doctors referred patients to a local AIDS NGO and to public-interest lawyers, forcing the government to provide medication not yet approved by the country's National Health Surveillance Agency. For better or worse, such developments compromise the sovereignty of the state in the fields of biological and pharmaceutical governance. In the face of pervasive pharmaceutical marketing enmeshed with patient mobilization, regulatory incoherence thrives. And these local "medical sovereigns" are now also market operators. They mediate the introduction of new drugs in the public health care system and, in the name of adherence and concern over drug resistance, triage away patients who could benefit from the system's caregiving capacity, dismal as it is.

Meanwhile, policy makers have to ceaselessly invent new political strategies to keep the country's pharmaceutical policy in place. Brazil crossed a new threshold when for the first time it issued a compulsory license for an AIDS drug in May 2007. The government stopped price negotiations with Merck over Efavirenz which is used by 75,000 Brazilians, and decided to import a generic version from India. Officials claim that this will save the country some $236.8 million by 2012. Activists praise this move as an important advance in the widening of access to the newest and most expensive therapies.

How Has AIDS Activism Changed?

During my fieldtrip to Brazil in June 2005, I talked to several AIDS activists who were frustrated not with the national AIDS program—which bravely continues to work towards sustainable ARV rollout—but with the "industrialization of nongovernmental work," as Gerson Winkler (former director of GAPA, an AIDS NGO, and of the AIDS Program of the southern city of Porto Alegre), put it: "The social movement has been swallowed by the government. Street and juridical militancy is now replaced by computer-based chats and petition signing—it is truly virtual. Moreover, the control of AIDS became a big market. Thousands of people are employed by AIDS NGOs and work as consultants for the government. How many AIDS NGOs have closed in the last decade? Very few. Something feeds them, and don't tell me that it is solidarity."[51] Conflicts of interest abound, says Winkler, whose critique has been discredited by other activists as anti-governmental and retrograde: "There is a true promiscuity in this relation movement-state. You don't know who is who and what is what. You have a researcher paid by the AIDS program working in an NGO studying the efficacy of a harm reduction program…for whom are the results written?"

Michel Lotrowska agrees that AIDS NGOs have become increasingly run by professional advocates: "You see fewer and fewer HIV-positive poor people in these spaces. There is now a huge gap between the kind of mobilization taking place and the AIDS the poor experience." There is little doubt that social mobilization facilitated a change in the treatment of AIDS and the discourse surrounding it. But social mobilization around AIDS is not as coherent and steady as policy makers and official reports portray it—it cuts across class lines. The AIDS NGOs that were supposed to have taken over assistance, "have long lost idealism and passion," argues Winkler. "They keep selecting their clientele and find all kind of ways to pretend that they do the work of their projects."

Both Winkler and Lotrowska are well aware of the real difficulties that AIDS activism faces in retaining its connection to problem-solving in a world filled with poverty, inequality, and violence, a world in which institutions of care are few and under-funded. Emergent realities that accompany the ARV rollout, particularly those that affect the poor, remain unaddressed, says Lotrowska: "Why, for example, has there never been a mobilization in Brazil for a 3 in 1 pill [to combine the first line drugs AZT, 3TC, and Nevirapine in one pill and thus to facilitate adherence]? I have a simple answer: the well-educated urbanites, [they] still mobilize, but for the fifth line of treatment…who cares about better medication that would benefit the rural poor who are now getting infected?" For Winkler too, AIDS mobilization has now become a kind of "parallel polity" that is largely concerned with financial flows and the sustainability of the technological gains in place, as well as the new ones on the horizon. Meanwhile, the everyday battlefields over survival remain unconsidered: "It is indeed very difficult for the poorest with AIDS to enter the hermetically closed world of AIDS NGOs," states Winkler. "The activism of poor AIDS patients has been reduced to begging."[52]

Yes, people's real needs have to be addressed, but it is also a matter of being willing to incorporate the practical and difficult knowledge of disenfranchised AIDS subjects into policy and politics at large. Winkler continues: "All these prevention materials that have been produced…look at their content and format, from 1988 to 2005. It all looks pretty much the same. The discourse of solidarity is the same, the norm is the same: use condoms, don't share needles—the imperative tone is the same. There is such a vast and tense history of all people who had some form of engagement with these institutions, goods and services, people who lived and died trying to access them…The principles guiding NGO action remained the same. But where is the plurality of local perspectives and experiences?"

In the poverty-stricken settings where I worked, I saw AIDS sufferers engaging in a range of social and medical exchanges to be seen by AIDS NGOs and public institutions and to guarantee their own existence. For many, the AIDS policy was becoming the state, so to speak, with people participating in all kinds of administrative and medical exchanges in order to be linked to the national and local branches of the AIDS policy. The processes at work here are not easily reduced to mere access to AIDS disability benefits, condoms, therapies, or food baskets. They also involve personal transformations and new relations. A multitude of interpersonal networks and variations in AIDS care have emerged, creating different levels of quality of life for the patient—the underside of the pharmaceuticalization of public health. Only a few manage to constitute themselves as patient citizens-citizen scavengers.

By approaching the circuitous paths through which these socially abandoned AIDS patients negotiate their condition and invent a domesticity and health to live in and by, one begins to illuminate the immanent fields in which life chances are forged—the crucial economic and moral significance of care. "Nature is not a form, but rather the process of establishing relations."[53] Furthermore, by following this analytic route, one raises an array of micropolitical questions concerning the implementation and redirection of Brazil's AIDS policy. The alternative approach—a strict institutional analysis of the policy—would leave invisible these important elements and life pathways.

Local Economies of Salvation

What most interests me as an anthropologist is this process of returning to the field. Repeatedly returning, one begins to grasp what happens in the meantime—(I like to think of this work as *an anthropology of the meantime*)—the events and practices that enable wider social and political change, alongside those that debilitate societies and individuals, dooming them to stasis and intractability. In such returns, entanglements and intricacies are revealed. We witness the very temporality of politics, technology, money, and survival. We get an empirical sense of how people make the transition from patienthood back to personhood.

When I returned to Caasah in December 2001, things had changed dramatically. Caasah had been relocated to a new, state-funded building. Located in a residential area near the famous Igreja do Bonfim (the church of the good end), the new facility was gated all around. With treatment regimens available, functional residents had been asked to move out, and Caasah had been redesigned as a short-term care facility (a "house of passage," *casa de passagem*) for ill patients and a shelter for HIV-positive orphans. The triage room had been closed, and a team of social workers and nurses now worked directly with local hospitals and admitted the patients that "fit into the institution and its norms," in the words of Celeste Gomes, still presiding over Caasah. Disturbingly, there was no systematic effort to actively track these patients and their treatment once they left.

"This is a beautiful building, but that's all the state gave us," stated Celeste. Institutional maintenance was a daily struggle. "We owe more than $1,000 to local pharmacies. Our patients come from the hospital with their antiretroviral drugs but nothing else. No vitamins, no pain-killers, no bactrim to treat opportunistic diseases." As AIDS became more chronic than fatal, local programs were not necessarily readjusting themselves to meet the new needs of patients. The national ARV rollout was supposed to be matched by regional government's provision of treatments for opportunistic infections. But it was clearly up to proxy-health services such as Caasah or to the patients themselves to regiment treatment beyond ARVs.

At the state hospital I learned of the existence of a triage system which Caasah is part of. "Homeless AIDS patients remain outside the system," one of the hospital's social worker told me. "Doctors say that they do not put these patients on ARVs for there is no guarantee that they will continue the treatment. They are concerned about the creation of viral resistance to medication." The hospital's leading immunologist confirmed that "if a patient is a drug user we tell him that he has to come back. If he demonstrates a strong will then we put him on treatment. But they never, or rarely, come back." Against an expanding discourse of human rights and technical possibilism, we are here confronted with the limits of the on-the-ground infrastructures whereby accountability and the right to envision a future are realized, but only on a partial basis.

I looked for my former collaborators and tracked down those who had left Caasah. Of the twenty-two residents we had gotten to know in 1997, ten were alive. Only Tiquinho, the hemophiliac child who had been raised there, was allowed to stay. All of the adult survivors created new family units. They lived with other AIDS patients, reunited with estranged relatives, married, and some even had children. All of them had disability pensions and were entitled to a monthly food basket at Caasah. By charting the trajectories of these AIDS survivors—those who lived pre- and post-ARV rollout—we can identity some of the everyday mechanisms that, alongside medical technology, make AIDS a chronic disease.

"Today is another world," Luis Cardoso told me. "One Luis has died and another has emerged. One has to think differently, forget the past." First diagnosed with AIDS in 1993, Luis lived in Caasah from 1995 to 1999. When the time of treatment came, a different subjectivity had to be produced: "I have nothing to say against the antiretroviral drugs. I am under Dr. Nanci's care, a very well-known doctor. Celeste and the psychologists motivated me a lot. But I don't live here anymore, and I must take care of myself. I got used to the medication. Medication is me. I must have this conscience: to take food and medication and to sleep at the right time, to schedule my medical appointments. I am the effect of this responsibility."

For Celeste, "Luis is like a son." He represents Caasah and the state of Bahia in national meetings of people living with AIDS, and he runs HIV/AIDS prevention workshops in the interior. Even his doctor calls Luis "my teacher." As Dr. Nanci told me: "I find this fantastic. The patient had a history of self-abuse, remains poor, but rescues himself and teaches others to do the same." Besides his AIDS disability pension, Luis also earned a salary as Caasah's office assistant. This allowed him to rent a shack with a friend, to eat well, and to save a little, because, as he put it, "I want to have my own corner." Open about his homosexuality, Luis insinuated he was dating. He also proudly told us that he had adopted an AIDS orphan in Caasah and was paying for the boy's grandmother to take care of him. "The world is a school in getting lost. But it is up to me to take life forward."

I asked Luis whether religion had helped him adhere to the ARV regimen. "I think religion is within us," he said. "I always believed in God, and now more than ever before. But religious talk does not help if you don't have the will to live inside you." For Luis, organized religion is actually a fraudulent practice of medicine when it comes to AIDS: "How many times I saw people having religious conversions in Caasah. Priests coming and asking patients to surrender to God, saying that their crises were henceforth over, that they would be cured. But cure never came. It is when you go to the doctor, do the tests, that you see whether your CD4 count increased or not."

Luis is an amazing person, hard-working, witty, *and* a master of moral discourse. He speaks of a new economy of life instincts organized around AIDS therapies. And he himself is the dominant human form that emerges from this economy: "I face my problem. I take advantage of the help I get. I struggle to live." He is indeed the representative of a new medical collective, and his discourse conveys present-day forms and limits of society and state: "I have nothing to do with society," he says. "From my perspective, society is a set of masters deciding what risk is, and what is bad for them. I have never participated in that. As for the government, I must say that I am thankful for the medication. This is the good aspect of the state. The rest is for me to do."

Luis made treatment adherence seem too easy. As much as I admired his resilience, I also found his righteousness quite disturbing. For him, individual conscience was the a priori of a healthy existence, and mourning a loss, any kind of loss, was a defect to be overcome. Moreover, the overemphasis on individual responsibility was self-serving. It clearly reflected Caasah's house of passage modus operandi and, more broadly, the hegemonic discourse that one has to be ever more self-conscious, lord of oneself, upbeat and upwards. The institutional and interpersonal forces that have thrown Luis into action in the first place were absent from his life-extending account, particularly as he spoke of noncompliant *marginais*. It was evident from his recent past recollection that without belonging to Caasah, ARVs wouldn't have had the same kind of efficacy they had for him, and that he kept harnessing strength from being the object of regular public attention.

In Luis's technocratic moral discourse, social abandonment exists in a vicious circle with self-destruction and self-created risks. His pharmaceutical subjectification has indeed led to salutary effects, yet it remains built on the exclusion of those who can't conform: "It is not a matter of getting them [homeless AIDS patients] help. For they already have it [in the form of medication]. They use their social condition as an excuse to keep their habits…It is a question of self-destruction. As I see it, these people are more for death than for life. But I also know many people who struggle to live and to earn their money honestly and don't surrender…See Rose and Evangivaldo…It is your mind that makes the difference."

"Welcome to the end of the world," Rose said jokingly as we entered her brick shack, located at the lower end of a muddy hill in the outskirts of Salvador. "I am sold on the antiretrovirals," she told us. "I am part of this multitude that will do whatever is necessary to guarantee our right to these drugs. I am proud of Brazil." Caasah helped Rose to get the shack from the government, and she was living there with her one-year-old daughter. She had also taken in her now teenage son who had been under the custody of Professor Carlos, Caasah's chief nurse. "I am always struggling to pay the bills and raise my children, for I am mother and father."

Tearful, she recollected the death of her partner Jorge from AIDS-related diseases, a few months before the girl was born. She had done all that was medically possible. "Jessica got AZT, but the last exam showed that she is still seropositive." Rose knew that the child's HIV status could change until she reached the age of two: "She has never been ill and we hope for the best." Rose was proud to be "a good patient, but not a fanatic one," she added. "I drink a beer and have some fun on the weekends, but I know my limits, what my body can take. I don't live better for I lack material conditions. I tell you, I want to be alive to see a cure. In the name of Jesus, I want to be a guinea pig when they test the vaccine." Yes, "people are still dying with AIDS in the streets," Rose stated, "but I am no longer there."

The political economy of AIDS, spanning both national and international institutions, creates an environment within which individual and local AIDS organizations are codependent and simultaneously recraft positions and possibilities with every exchange. Their transactions are legitimated by a humanitarian and pharmaceutical discourse of life-saving and civic empowerment. In adhering to drug regimens and making new and productive lives for themselves, patients are—in this discourse—saved. However, merely guaranteeing existence in such dire contexts, amid the dismantling of institutions of care, involves a constant calculus that goes well beyond numbers of pills and the timing of their intake.

The political grounds of existence have been increasingly individualized and atomized, and poor AIDS patients rarely become activists. Even as they search for employment, AIDS survivors work hard to remain eligible for whatever the state's paternalistic politics and remedial programs have made available—renewal of disability benefits, free bus vouchers, and additional medication at local health posts, to name a few. Being adopted by a doctor and becoming a model patient greatly facilitates this. And this material calculus becomes all the more important as patients form new families and resume a life considered normal, which was previously impossible to them.

"What a joy you give me by coming back," beamed 38-year-old Evangivaldo. His face was barely recognizable. But the aesthetic side effects of antiretrovirals were the least of his concerns. We met him by chance, as he came by Caasah, looking for help: "Today I woke up anguished. We had no gas to cook. I hope you can help me." Evangivaldo and his partner Fatima left Caasah in 1999 and they had a two year-old daughter Juliana. "A child is what I wanted most in life. Juliana fulfilled my desire, a dream I had. I thought I would die without being a father." He said he was on antipsychotic medication and then added: "It is the financial part of life that tortures me."

Evangivaldo showed me a piece of paper in which he had listed how his income was allocated and the debts he had to pay. "When Fatima cannot do the work, I am the man and woman of the house. Sometimes I wake up at 4 a.m., leave everything ready, and ride my bike for two hours, to get downtown. I go door to door, asking for a job. There are days when I cannot get the money we need and I panic. My head spins, and I fall down. I hide in a corner and cry. Then I don't know where I am. But I tell myself, 'Focus Evangivaldo, you will find your bike and your way home.'"

"And do you know why I manage to do this?" Evangivaldo asked me.

"It is because my daughter is waiting for me."

Indeed, to have someone to live for and to be desired by seemed to be a core element in the account of the AIDS survivors with whom I worked.

Will to Live

"If you look carefully, nothing has changed. Things are the same as you saw last time," a tired Celeste told me in June 2005 during my last trip to Salvador. Caasah was still the only place in Salvador that provided systematic care to poor AIDS patients who have been discharged from public hospitals. "They recover here, but medication for opportunistic diseases is difficult for us to get. Some patients return to their families. Others go back to the streets. I would say that half of people living in the streets are HIV infected. The situation remains the same: disease keeps spreading, and the government pretends not to know of it, so that it does not have to intervene." At the state's main AIDS Unit, Dr. Nanci also told me that "things here have not changed." As she put it: "The reality of our Unit is the same as it was in beginning of the epidemic: full of miserable and wasted patients. The difference is that they now come from the interior, where no new services have been created. Access to therapies has been democratized, but health has not."

I asked Celeste for news about the patients I had followed over the years. Out of the initial group of twenty-two patients with whom I had worked in 1997, seven were still alive in 2005—among them, Luis, Rose, and Evangivaldo. This life extension is obviously a result of technological advancements, argued Celeste, "but it would not have happened if they had not learned to care for themselves." In the end, treatment adherence "is relative to each person. It requires a lot of will." Subjectivity—a person's manufactured will to live—had become a fundamental cog in the ARV adherence machine. Yet, as I would soon learn, all of the former residents who were still alive also possessed a place they called home, a steady if meager income, and a social network. And, in case of an emergency, they could still resort to Caasah. This tie to Caasah, as momentary and uncertain as it now was, remained vital to them.

Luis was still working at Caasah. He was in charge of the institution's fundraising activities. "I am not concerned with HIV. What I want is to live. If there is medication, let's take life forward. Life is to fight for." In the previous year, Luis had experienced kidney failure and had been hospitalized for two weeks. "Work keeps my mind occupied and one needs to have projects and objectives to meet—if not life has no meaning." Becoming a father, he said, "is the best thing that ever happened to me." Davi, his adopted son, was now a healthy seven year old—"He is a prankster. He is my passion. He makes it all worthwhile."

"I don't have the aid of a father and a mother, and I can only count on the tenderness of Fatima and Juliana," Evangivaldo told me as we met again. "When I see them with no food, it makes me ill… But when I find a job or get a donation, and there is nothing lacking at home, and all is normal, then for me it is another life, and it is all good." I asked Evangivaldo whether he had told his doctor all he has to go through in life. "Yes," he had once mentioned to his doctor that he routinely rode his bike for two hours "with only coffee and medication in the body" to get to downtown Salvador in search of a job. "Dr. Jackson said that he did not believe it, that my HIV was almost undetectable and that I acted as if I did not have AIDS. I told him that my bike was parked outside the hospital, that I would show it to him. He was amazed. He then called his superior and some residents and asked me to tell them my story."

After the spectacle Evangivaldo had become, "The doctors said that they were proud of me, and that if all HIV-positive people had the same will to live that I have then no one would have to be hospitalized. They said that I was an example for other patients." Evangivaldo took the opportunity to ask the doctors for advice on where to go to actually find a job. To which Dr. Jackson replied: "I feel bad for not being able to help, but I am sure that God will show a path for you to get where you want to." Meanwhile, Evangivaldo had to take 12 pills a day, and his doctor never considered putting him on a newer medication already made available by the government (fewer pills and fewer side effects).

Poor AIDS patients like Evangivaldo continuously interact and trade with AIDS NGOs and civic groups that channel assistance, albeit minimal, from regional and national programs. The NGOs, which depend on their clientele to back up reports and authorize new projects (now mostly related to treatment adherence and income generation), become venues for some patients to access food, rent aid, and specialized medical consultations, among other things. Overwhelmed with assistance demands and concern for their own institutional survival, NGOs rarely succeed in placing the person in the market, but they do successfully differentiate politicized patients who defend their rights from those who passively circulate in the medical service system.

Only a few, like thirty-years-old Sonara, manage to become “AIDS workers.” She was Caasah’s new poster-person. A nurse introduced me to Sonara—“She was a drug user, but she now takes the medication, eats well, and takes care of her daughter, who is also HIV positive”—as she was running a candle-making workshop for a group of twelve patients. Sonara was the only white person there. Her style of dress, manners and speech were characteristic of the Brazilian middle-class. As much as I admired Sonara’s transformation, I could not have been more disturbed by her moral reasoning: “Today, people only die of AIDS if they want to.”

The AIDS survivors I interviewed acted coldly towards fellow patients. For many, I thought, health corresponded to a measure of moral uprightness. Mutual empathy was rare. I will never understand why, for example, Luis did not let us take Rose’s food basket to her as we were heading back to her shack in the Cajazeiras district in early June 2005. The previous day, over the phone, Rose had asked me to do just that. She would save a long trip and transportation expenses, I told Luis. But my request met a series of obstacles, both external and internal: “The baskets are not ready. Professor Carlos is not here to release them. I don’t have much time. I must be back no later than 11 a.m. We have to go.”

Rose was euphoric to see us. She was doing great. I was particularly happy to learn that her daughter had turned HIV-negative. Ricardo, her 15 years-old-son, was helping two workers to finish the house’s second floor: “It is my skycraper. Water was infiltrating, and in the long run I plan to rent it out.” She was disappointed that we had not brought her basket. I offered Rose a ride back to Caasah, but she said that she couldn’t leave the construction unattended: “That’s life. Each one is on her own.”

Rose intelligently navigated the local circuits of AIDS care. She had garnered the support of other NGOs and opened up a little business she called “Rose tem de tudo” (*Rose has it all*), and had also devised a construction fundraising campaign among religious philanthropists. She was proud of having been able to enroll her son in project Teenage Citizen (*Adolescente Cidadão*), which Dona Conceição was running with World Bank funds.

Later that week, I met with Dona Conceição. She had accomplished much and now headed the IBCM (the Conceição Macedo Assistential Institute). With the help of a local sociologist, she had designed a project to employ 120 children of AIDS patients in local industries. She kept working with homeless and poor AIDS patients. “In the morning I am at IBCM, and in the afternoon I am in the streets.” Dona Conceição aided a total of two hundred families, she said: “Once a month, I also hold a general meeting for these AIDS patients to share experiences. I offer breakfast and they get their food baskets.” Dona Conceição regretted that she remained the only institution to address AIDS in the streets; her funds from the World Bank would only last a year: “We cannot meet all the demand for help. It’s a disgrace.”

Pauper patients are not the problem in themselves. With no political voice, they have been both disregarded and made invisible. This is not due to governmental inability or ignorance. Where there has been active HIV search, testing, and care—in maternity wards, for example—infection has been curtailed. If this is ethically acceptable and technologically possible, why not tinker with the HIV testing apparatus and organize alternative forms of on site testing, side-by-side with medical care? To ensure quality care, policy makers would need to discuss interventions with particular vulnerable groups and make adequate medical information and technology available to them, along with sustained assistance. A deliberate engagement by AIDS NGOs in local politics might break open some new ground on this front.

The Unexpected and the Possible

In this article, I have examined the political economy of pharmaceuticals that lies behind global and national treatment programs, illuminating the institutional and medical changes that have occurred in Brazil and in the field of AIDS. There are times when political and market institutions cannot so easily resist demands for change. Social mobilization and novel rational-technical interventions have universalized AIDS treatment in Brazil. As a byproduct of AIDS treatment scale-up, a pharmaceutically-centered model of public health has emerged. Amid the dismantling of public health care services, grassroots initiatives triage quality treatment. AIDS mortality has declined, but the pharmaceuticalization of public health also promotes models that exclude some segments of the population.

In charting the unfolding of this policy of biotechnology for the people, I also located specific points of entry for re-envisioning care as far as the urban poor are concerned. One of the positive and perhaps unintended effects of therapy access has been to denaturalize unequal laws of reality and reveal them as amenable to human action. Therapy access reveals the urgency of improving people's basic living conditions. Moreover, damaging side effects should not be diverted to the afflicted themselves, but should be guarded against by more and not less preventive policy making.

Local politics matter and public institutions are indeed co-functions of successful AIDS treatment. This calls for ongoing self-examination by those who implement policies of their own effects on events. It also involves a rethinking of how to reach the afflicted in their own terms, acknowledging self-destructiveness and human struggles for recognition in a largely hostile world. Likewise, at issue is a reconsideration of the systemic relation of pharmaceutical research, commerce, and public health care and a search for ways to break open the widespread societal deafness to those most vulnerable, people who remain unheard despite all they have to say.

Caasah's former residents are the new people of AIDS. After experiencing social abandonment, they have come into contact with the foundational experiences of care and biotechnology. Refusing to be overpowered, they plunged into new environments and became agents in other people's routes. They have by all standards exceeded their destinies. Yet, this is not an inclusive form of care or citizenship. Many are left out, saddled with other kinds of categorizations such as drug addict, prostitute, beggar, and thief. Burdened by these labels, it is difficult for individuals to self-identify or to be identified as AIDS victims deserving of treatment and capable of adherence—they largely remain part of the underground economy and a hidden AIDS epidemic.

Now receiving treatment, Rose, Luis, Evangivaldo and many others refuse the condition of leftovers, humanize technology, and redo themselves in familiar terms. And they face the daily challenge of translating medical investments into social capital and wage-earning power. They live between-moments, between-spaces, scavenging for resources. At every turn, they must consider the next step to be taken to guarantee survival. And throughout these medical, economic, and affective trajectories—a second nature of sorts—they actualize the dignity and the desires that had hitherto been virtual to them. Theirs is a force of immanence—call it a language of hope.

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ENDNOTES

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[2] Hirschman Albert O. *A Bias for Hope: Essays on Development and Latin America*. New Haven: Yale University, 1971, p. 37.

[3] See Biehl, João. *Will to Live: AIDS Therapies and the Politics of Survival*. Princeton: Princeton University Press, forthcoming 2007.

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[6] See Castilho E, Cherquer P. 1997. "A Epidemia da AIDS no Brasil." *Epidemia da AIDS no Brasil: Situação e Tendências*. Brasília: Ministério da Saúde, pp.9–12.

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[7] See Okie S. 2006. "Fighting HIV—Lessons from Brazil." *New England Journal of Medicine* 354(19):1977–1981.

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[9] See Cassier, M, Correa, M. 2003. "Patents Innovation and Public Health: Brazilian Public-Sector Laboratories' Experience in Copying AIDS Drugs." *Economics of AIDS and Access to HIV/AIDS Care in Developing Countries: Issues and Challenges*. Paris: ANRS, pp.89–107.

[10] See Galvão, J. 2002. "A política brasileira de distribuição e produção de medicamentos anti-retrovirais: Privilégio ou um direito?" *Cadernos de Saúde Pública* 18(1):213–219.

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[11] Ministério da Saúde. 2002. *A Experiência do Programa Brasileiro de Aids*. Brasília: Ministério da Saúde.

[12] See Biehl, João. 2005. "Technologies of Invisibility: The Politics of Life and Social Inequality." *Anthropologies of Modernity: Foucault, Governmentality, and Life Politics*, edited by Jonathan Xavier Inda. London: Blackwell, pp. 248–271.

[13] See Collins, John F. *The Revolt of the Saints: Popular Memory, urban Renewal and National Heritage in the Twilight of Brazilian 'Racial Democracy.'* Ph.D. Dissertation, University of Michigan.

[14] See Biehl, João (with Torben Eskerod). 2006. "Will To Live: AIDS Drugs and Local Economies of Salvation." *Public Culture* 18(3):457–472.

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[16] See Abadia-Barrero CE, Castro A. 2006. "Experiences of Stigma and Access to HAART in Children and Adolescents Living with HIV/AIDS in Brazil." *Social Science and Medicine* 62(5): 1219–1228.

[17] Nguyen,Vinh-kim. 2005. "Antiretroviral Globalism, Biopolitics, and Therapeutic Citizenship." *Global Assemblages: Technology, Politics, and Ethics as Anthropological Problems* edited by Aihwa Ong and Stephen J. Collier. Malden, MA: Blackwell Publishing, p.126.

For a discussion of AIDS treatment activism and citizenship in South Africa see Robins, Steven. 2006. "From Rights to 'Ritual': AIDS Activism and Treatment Testimonies in South Africa." *American Anthropologist* 108(2):312–323.

[18] For an anthropological discussion of contemporary statecraft and sovereignty see:

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[19] See Cardoso, Fernando Henrique. 1998. "Notas sobre a Reforma do Estado." *Novos Estudos do CEBRAP* 50:1–12.

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[20] As I interviewed Cardoso and other policy makers, I was struck by the ethos of power and innovation they conveyed and by their extensive use of social scientific idioms to describe their work and vision. While speaking of political alternatives under the constraints of global trade rules, they frequently mentioned terms such as networks, assemblages, governmentality, contingency, and flexibility—terms by now familiar to many social scientists studying contemporary politics.

See Riles, Annelise. 2004. *The Network Inside Out*. Ann Harbor: Michigan University Press.

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[21] See Sell S. 2003. *Private Power, Public Law: The Globalization of Intellectual Property Rights*. Cambridge: Cambridge University Press.

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[23] See Comaroff, John L., and Jean Comaroff. 2006. "Law and Disorder in the Postcolony: An Introduction." *Law and Disorder in the Postcolony* (edited by Jean Comaroff and John L. Comaroff). Chicago: Chicago University Press, pp.1–56.

The Comaroffs elaborate on the contemporary "judicialization of politics." Class struggles, they argue, "seem to have metamorphosed into class actions. Citizens, subjects, governments, and corporations litigate against one another, often at the intersections of tort law, human rights law, and the criminal law, in an ever mutating kaleidoscope of coalitions and cleavage" (p. 26).

[24] See the press release by IMS Health (March 21, 2006): "IMS Health Reports Global Pharmaceutical Market Grew 7 Percent in 2005, to $602 Billion" http://www.imshealth.com/ims/portal/front/articleC/0,2777,6599_3665_77491316,00.html

[25] See Bermudez, Jorge. 1992. *Remédios: Saúde ou Indústria*. Rio de Janeiro: Relume Dumará.

[26] See "Pharmaceutical Growth Opportunities in Brazil, Russia, India and China: Healthcare Reform, Market Dynamics and Key Players." Business Insights, Aug 1, 2006.

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Note that Mexico has recently displaced Brazil, becoming the largest pharmaceutical market in Latin America. Argentine and Venezuela rank third and fourth respectively.

[27] Personal communication, August 2000.

[28] Personal communication, May 2003.

[29] For a discussion of how pharmaceutical companies inform public health practices see Applbaum, Kalman. 2006. "American Pharmaceutical Companies and the Adoption of SSRI's in Japan." *Global Pharmaceuticals: Markets, Practices, Ethics*, edited by Adriana Petryna, Andrew Lakoff, and Arthur Kleinman. Durham, NC: Duke University Press.

[30] See Farmer Farmer, Paul. 2003. *Pathologies of Power: Health, Human Rights, and the New War on the Poor*. Berkeley: University of California Press.

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Sterckx, Sigrid. 2004. "Patents and Access to Drugs in Developing Countries: An Ethical Analysis." *Developing World Bioethics* 4(1):58–75.

[31] Personal communication, June 2003.

[32] As part of a policy of rationalization and decentralization of assistance, in the mid-1990s the Brazilian government began to recast the costly and inefficient basic pharmacy program whereby municipalities distributed state-funded medicines to the general population (this program preexisted the ARV rollout). Provinces and municipalities were urged to develop their own epidemiologically specific treatment strategies and to administer federal and regional funds in the acquisition and dispensation of medicines.

Brazil's trajectory towards specifically targeted medical interventions, especially those comprised of a particular biological technology or drug, mirrors the development of international health care methods throughout the late twentieth and into the twenty first century.

See Yunes J. 1999. "Promoting Essential Drugs, Rational Drug Use and Generics: Brazil's National Drug Policy Leads the Way." *Essential Drugs Monitor* 27: 22,23.

[33] See Cosendey, Marly Aparecida, Bermudez JAZ, Reis ALA, Silva HF, Oliveira MA, Luiza VL. 2000. "Assistência Farmacêutica na Atenção Básica de Saúde: A Experiência de Três Estados Brasileiros." *Cadernos de Saúde Pública* 16(1): 171–182.

[34] See Petryna, Adriana. 2007. "Clinical Trials Offshored: On Private Sector Science and Public Health." *BioSocieties* 2:21–40

[35] Bermudez, J.A.Z, R. Epsztein, M.A. Oliveira, and L. Hasenclever. 2000. "O Acordo TRIPS da OMC e a Proteção Patentária no Brasil: Mudanças Recentes e Implicações para

a Produção Local e o Acesso da População aos Medicamentos." Escola Nacional de Saúde Pública, FIOCRUZ/OMS.

[36] See Langevin, South Asian Research Institute for Policy and Development at http://www.sarid.net/health/healthdocs/050701-hiv.htm).

The Global Fund is meant to be an "innovative approach to international health financing" between governments, civil societies, afflicted populations, and the private sector (see http://www.theglobalfund.org/en/).

[37] See Wogart J.P. and G. Calcagnotto. 2006. "Brazil's Fight Against AIDS and Its Implications for Global Health Governance." *World Health & Population* January, pp.1–16.

[38] Announced in December 2003, this initiative began with a good deal of momentum, and the Indian generic triple fixed dose capsule (FDC) provided its pharmaceutical backbone. Supporters of the initiative hailed "3 by 5" as opening up "a new era in international public health," while critics claimed that it was irresponsibly unrealistic, with "little vision, no credible framework, and insufficient technical assistance."

See http://www.healthgap.org/press_releases/03/051903_HGAP_BP_WHO_TA_TX.html

[39] Jim Kim cited in Madeleine Morris's report "OMS admite fracasso em meta de combate ao HIV," *Folha Online*, 11/28/2005 (my translation).

[40] World Health Organization. 2006. "Progress Towards Universal Access: 3 by 5 and beyond." Geneva: WHO.

By February 2006, more than 30 countries had convened national consultations on universal ARV access, and nearly 100 other countries had initiated the planning process. Over the past year, the number of people receiving treatment increased by about 300,000 every six months. Scale-up in sub-Saharan Africa has been particularly dramatic, from 100,000 at the end of 2003 to 310,000 at the end of 2004 and 810,000 at the end of 2005.

[41] See Farmer, Paul. 2003. *Pathologies of Power: Health, Human Rights, and the New War on the Poor*. Berkeley: University of California Press.

Fassin, Didier. 2007. *When Bodies Remember: Experiences and Politics of AIDS in South Africa*. Berkeley: University of California Press.

[42] See http://www.avert.org/pepfar.htm

By May 2003, this declaration had been approved into law as the United States Leadership Against HIV/AIDS, TB, and Malaria Act of 2003 (PL108–25). Initially, the commitment was set at $15 Billion over 5 years in addition to $17 Billion for domestic HIV/AIDS for 2005. Like the Global Fund, women and children are also the target of PEPFAR. Forty-one percent of the funds committed for 2006–2008 will be used to purchase and distribute ARVs with 1/3 of prevention funds spent on promoting abstinence and 2/3 spent on other methods of prevention, such as condom dissemination. Though proposed, the $15 Billion is not guaranteed since Congress must annually appropriate the amount each fiscal year.

[43] Activists say that by using generics, PEPFAR's policies can finally be brought closer to those of other organizations, such as the Global Fund, helping reverse the confusion that marks drug procurement and supply in many places.

[44] *The New York Times* July 6, 2006.

See also http://www.un.org/ecosocdev/geninfo/afrec/vol19no1/191aids.htm

[45] See Epstein, Helen. 2007. *The Invisible Cure: Africa, the West, and the Fight Against AIDS*. New York: Farrar, Strauss, and Giroux.

Ramiah, Ilavenil and Michael R. Reich. 2006. "Building effective public–private partnerships: Experiences and lessons from the African Comprehensive HIV/AIDS Partnerships (ACHAP)." *Social Science & Medicine* 63(2):397–408.

[46] Whyte, Susan Reynolds, M. A. Whyte, L. Meinert, B. Kyaddondo. 2006. "Treating AIDS: Dilemmas of Unequal Access in Uganda." *Global Pharmaceuticals: Markets, Practices, Ethics* edited by Adriana Petryna, Andrew Lakoff, and Arthur Kleinman. Durham, NC: Duke University Press, pp. 241.

[47] Farmer, Paul. "Introducing ARVs in Resource-Poor Settings: Expected and Unexpected Challenges and Consequences," available online: http://www.pih.org/inforesources/Articles/intro-ARV-plenarytalk.pdf

See also Walton, David A., Paul E. Farmer, Wesler Lambert, F. Léandre, Serena P. Koenig, and Joia S. Mukherjee. 2004. "Integrated HIV Prevention and Care Strengthens Primary Health Care: Lessons from Rural Haiti." *Journal of Public Health Policy* 25(2):137–58.

[48] See Das, Veena. 2006. "Power, Marginality, and Illness." *American Ethnologist* 33(1):27–32.

[49] See Leite F. Laboratórios apontam atraso de repasses. *Folha Online*, February 24, 2005 http://www1.folha.uol.com.br/folha/cotidiano/ult95u106036.shtml

[50] See Prada P. "Brazil Again Seeks to Cut Cost of AIDS Drug." *The New York Times* August 19, 2005, (http://www.nytimes.com/2005/08/19/business/19abbott.html).

See the report "ONGs querem quebra de patente de medicamento contra a Aids." *Folha Online* December 1, 2005 (http://www1.folha.uol.com.br/folha/cotidiano/ult95u115814.shtml).

See also the report "Programa do Brasil para Aids 'é insustentável.'" *Folha Online* May 31, 2006, (http://www1.folha.uol.com.br/folha/bbc/ult272u53675.shtml).

[51] Personal communication, June 2005.

[52] See Abeles, Marc. 2006. "Globalization, Power, and Survival: An Anthropological Perspective." *Anthropological Quarterly* 79(2):483–508. Abeles has been studying the dual displacement in governmentality and resistance that accompanies the work of nongovernmental organizations as "life and survival" are put "at the heart of political action." As he argues: "A sense of powerlessness has become the backdrop for political action. It is as though the citizen's capacity for initiative were going through a more or less explicit reassertion of this admission of powerlessness, tied to the awareness of a radical reappraisal of our terms of belonging. The other side of this position is a projection towards a vaguer collective interest relating more to survival (*survivance*) than to the art of harmonious living together (*convivance*) (pp.493–494).

[53] Deleuze, Gilles. 1997. *Essays: Critical and Clinical.* Minneapolis: University of Minneapolis Press, p.59.