

Comparing the US and Brazilian Policy Responses to the HIV/AIDS Epidemic

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Re: "[What the United States can learn from Brazil in response to HIV/AIDS: international reputation and strategic centralization in a context of health policy devolution](#)" Gómez, 25(6): 529-541 doi:10.1093/heapol/czq047

We read Eduardo Gomez' paper comparing the American and Brazilian responses to the AIDS epidemic with great interest. We, too, laud the Brazilian response to HIV/AIDS and note Brazil's progressive policies and their impacts on health costs, health outcomes and global public policy (Nunn et al. 2009a; Nunn et al. 2009b; Nunn et al. 2007; Marins et al. 2003; Greco and Simao 2007; Galvao 2005; Nunn 2009; Malta et al. 2010). However, Gomez largely misses the mark in his article, both in his comparative analysis, his highly critical tone of the United States (US) response to the AIDS epidemic, and in his historical analysis regarding the reasons Brazil's program has been so successful. We examine each in turn.

First, Gomez argues that Brazil "did a better job than the USA when it came to responding to HIV/AIDS". We note the United States has also had a robust and laudable response to the AIDS epidemic as well as remarkable improvements in health outcomes. As in Brazil, social mobilization of gay men and other affected groups had sweeping and lasting changes on national AIDS policy. The US has implemented a comprehensive national program and response to the HIV/AIDS epidemic. In 1990, the US Congress passed the Ryan White Comprehensive AIDS Resources Emergency Act, which has been reauthorized four times: in 1996, 2000, 2006 and 2009. The Ryan White Program is a federally funded, decentralized program that provides over \$2.2 billion to cities, states and municipalities for technical assistance, comprehensive treatment and care services to people living with HIV/AIDS in the US, and special programs for minority populations disproportionately infected and affected by HIV/AIDS (HRSA 2010).

Additionally, the CDC funds robust HIV/AIDS prevention programs nationwide and has done so for over 20 years. CDC directly finances hundreds of AIDS Service Organizations nationwide and many CDC funds allocated to states, cities and other municipalities are ultimately distributed to AIDS Service Organizations and other non-government organizations. Moreover, while Gomez claims there is little or no collaboration between civil society and governments in the US, it is noteworthy that the CDC and Ryan White programs require every municipality receiving AIDS-related funds to develop a Community Planning Group that provides counsel and input on local policy development and expenditure outlays. We also note that CDC and Ryan White programs have expanded in scope over the last two decades, and that the public policy response to HIV/AIDS in the US continues to improve and evolve: President Obama also recently launched a national AIDS strategy that includes a focus on reducing racial disparities in HIV infection with an appropriation in the Health Reform Act of 2010, and the US Congress recently lifted the ban for using federal funds to finance needle exchange programs in the US. All of these important facts about historical development of HIV/AIDS prevention and care services in the US are glossed over in Gomez' article.

It is worth noting that overall rates of new HIV infections plateaued in the US in recent years (Hall et al. 2008). It is simplistic to assume that simply because CDC budgets expand, that HIV/AIDS budgets should expand in tandem, particularly at a time when the epidemic has plateaued and there have been dramatic increases in life expectancy and AIDS-related mortality. Moreover, HIV incidence among injecting drug users has decreased 80% in the last decade; this public health

triumph is attributed to needle exchange programs and more widespread use of sterile syringes (Hall et al. 2008). Although incidence continues to rise among African Americans and men who have sex with men, there has indeed been a robust expansion of Ryan White and CDC funds to target minorities and special populations most affected and infected with HIV/AIDS in recent years. All of these issues warrant more nuanced discussion than they receive in Gomez' article.

We furthermore note that Gomez has misrepresented some of our own scholarly contributions (Nunn 2009) throughout his article. He cites our work when claiming that Brazilian "AIDS officials benefited by receiving World Bank support for technical training to diagnose, deliver and treat AIDS patients" and "activists hired through World Bank financed consulting contracts, were able to obtain high-paying salaries and experience, while at times facilitating promotion". These claims have misconstrued the intent and findings of our own research, and overlook our primary and most important research findings: namely, that the primary reasons for Brazil's success in combating the AIDS epidemic are its social movement related to HIV/AIDS, steadily rising costs associated with AIDS treatment that prompted innovative political strategies to address the epidemic, and Brazil's extraordinary political leadership during the country's transition to democracy.

While the US and Brazilian responses have differed in some ways, there are many important parallels, particularly related to the federal nature of the response to the AIDS epidemic in both countries; this includes historical and ongoing partnerships between federal, state and local governments. Additionally, in both countries, social movements have played a critical role in propelling HIV/AIDS policy forward. These factors have been carefully documented in peer-reviewed literature about the AIDS epidemic in both countries and best explain each country's response to the HIV/AIDS epidemic. Gomez' article would benefit from more careful and nuanced empirical and historical analyses of both countries policy responses to the HIV/AIDS epidemic.

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Conflict of Interest:

Amy Nunn receives consulting fees from Mylan Inc.