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HIV and AIDS in Brazil: neoliberalism and neoconservatism

Abstract

In Brazil, a country of great inequalities, people with HIV and AIDS commonly need health services and care freely provided by the State. This study was carried out based on historical-dialectical materialism, finding out the social determinations, mediations and contradictions of Brazilian health policy. The research corpus was made up of from the following data sources: legislation that deals with fiscal austerity and restricts the public budget; official reports from the Ministry of Health on HIV and AIDS cases, and gray literature published by the non-official media. In order to go deep into the subject, a narrative review of papers and books was also carried. The results pointed out that in the last six years, under neoliberal deepening, the downsizing and budget cuts for social policies which were underpinned by a blend of neoconservative and neoliberal ideologies. It also found out that during the neoliberal and neoconservative governments, there was an increase in HIV cases among young gay men and impoverished black people. Women in the Northeast, the poorest region in the country, continue to be infected with HIV at a higher rate than in regions with better income and education indicators. Due to resource cuts, HIV comprehensive prevention work tailored in Brazil, which was mainly implemented by progressive non-governmental organizations, has been significantly reduced and, its coverage was also limited because of conservative approaches, restricting information addressed to key populations, such as homosexuals and sex workers.

Keywords: HIV and AIDS, health policy, neoliberalism, neoconservatism

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Introduction

Brazil is among the countries with the greatest inequalities in the world. The Gini index, calculated by the United Nations Development Programme (UNDP),[1] provides not only the Human Development Index but also the Gini Coefficient, which demonstrates and evaluates income inequalities within and between countries. Brazil, which ranks 89th in human development (a score of 0.760), is among high human development countries. It places 6th among the most unequal countries in the world, with 193 countries evaluated. Its Gini Coefficient is 52.9, according to UNDP (2024)[1]. Only the champion of inequality for many years, South Africa (63.0), Namibia (59.1), Zambia (55.9), Eswatini (54.6), and Botswana (53. 3), African countries that have been exploited by developed countries for long, are more unequal than Brazil.

What does this ranking represent? That one of the countries that has a high gross domestic product (GDP) cannot carry out the distribution of wealth to its entire population. Redistributive comprehensive social policies would be a way to tackle this inequality. They would deliver part of the wealth produced to the vast majority of poor people living in the country. Health is certainly one of these key policies.

Sistema Único de Saúde (SUS) [the Brazilian Unified Health System], was approved in 1988, while the country was re-democratized after a dictatorship that began in 1964, leaving behind access to public health services limited to formally employed workers who were mandatory contributors for social security system. SUS provided universal access to health services and comprehensive care for the entire population, with integrality (both basic and medium complexity care and high-complexity procedures), with no payment required. Its proposed funding stems from the State, which would have to ensure the necessary funds. A guideline of the new health system is decentralization: it is controlled by the Federal Government and implemented by states and cities. Community participation and health conferences were also established through deliberative councils at the three levels of government.

The proposal for SUS in the 1988 Federal Constitution was the result of a long engagement by Movimento de Reforma Sanitária Brasileiro [Brazilian Health Reform Movement], which aimed to democratize the right to health, ensuring universal access to health services at all levels of care. The healthcare model changed with SUS: from a medical-curative, hospital-centric system, with a biomedical character, to a recognition of the social determination of health and a comprehensive conception of health. The 1988 National Constitution recognizes that the right to health comes from social and economic policies that seek to reduce the risk of disease and other health problems, delivering universal and equal access to healthcare services.

Despite its approval and the promulgation of Law 8,080/1990 and Law 8,142/1990, which set the State's responsibilities and means of funding, in the 1990s neoliberal guidelines began to influence the logic of democratically elected governments, which began running the country. Since then, the universal right to health has been ensured contradictorily, not being fully put in place or denied. Health as a right for all, as a duty of the State, has been limited by fiscal austerity policies carried out by succeeding governments, with different political orientations. However, is possible to state that some governments have deepened neoliberal measures, hindering the consolidation of SUS.

Materials and methods

Supported by historical-dialectical materialism, we carried out a bibliographical research, based on critical authors who sought to understand Brazilian governments after 2016, their main trends and hallmarks, thinking about their impacts on Brazilian health policy. We analyzed legal, governmental, and media documents about these governments and health policies during the period. The reflections arising from the discussion of social determinations, contradictions,

and links among economy, politics, and social reality came up with ways to think about these impacts, towards a totality approach.

Results and discussion

Fiscal austerity and consequences for the right to health

Due the process of the health system decentralization, the State is tasked with distributing the resources collected through taxes among the segments of the federation – states, municipalities, and the Federal District. Shortly after SUS was settled, during Fernando Henrique Cardoso's government, the main foundations of fiscal austerity were laid. Nowadays, they undermine SUS, based on Plano Diretor da Reforma do Estado [Master Plan for State Reform], Lei das Organizações Sociais [Law on Social Organizations], and Lei de Responsabilidade Fiscal [Fiscal Responsibility Law]. The State Reform establishes that health and education sectors, as other social policies fields, are not exclusive to the State. They can be developed by non-public, non-state institutions, with public funding, following guidelines designed by governments.

The Law on Social Organizations – Law 9,637 of May 15, 1998[2] – establishes the conditions for private institutions to manage public healthcare facilities and services, with the assignment of workers and control over state owned facilities and equipment.

It states that social organizations cannot undertake profitable activities; must have a philanthropic nature and participate in public notices for the management of public services, which define goals to be met and financial amounts. Therefore, private institutions may possibly have access to public funds, resources collected by the State to perform activities that were not State exclusive after the State Reform. While the 1988 Federal Constitution states that the actions of private institutions can be complementary to those State owned, the law approved during Cardoso's mandate allows them to unrestrictedly provide services, that should be carried out by the State.

In search of fiscal balance, the Fiscal Responsibility Law, Law 101 of May 4, 2000,[3] sets limits for personnel spending in the three spheres of government: the Federal Government can only spend up to 50% and states and cities can use up to 60% of Current Net Revenue on personnel. If government officials exceed this percentage, without taking measures to comply with the limit, they may face penalties. The idea is important, yet it interferes with the hiring of personnel in labor-intensive areas, such as health sector, leading governments to outsource the hiring of workers, which may induce greater expenses, favoring private companies, besides reducing the number of public servants, selected through public competitions. Hiring workers formally or hiring workers registered as companies makes services more susceptible to employee turnover, with poorer quality of activities. From the perspective of privatization of public services, there is also a widespread idea that anything that is state owned has lower quality than what is done by the private sector organizations, introducing private standards into public services.

The Fiscal Responsibility Law complements the Law on Social Organizations by indicating that the executive branch may classify non-profit legal entities governed by private law, whose activities are aimed at teaching, scientific research, technological development, environmental protection and preservation, culture and health, as social organizations (SOs). The SO can receive resources from public funds to undertake core and secondary activities, subcontract other private institutions, pay its managers, hire workers, and define the wages value and payments to be made. It can also invest the resources on the finance stock market (which is forbidden for public institutions). Its objectives and goals must be established in agreements made with public bodies. They are not subject to the social control put in place by social policy councils nor do they need to follow public sector purchasing and bidding rules. In the health sector, SOs became widespread, so they manage healthcare facilities and services with a plenty of sizes.

The neoliberal policies and practices, initially adopted during Cardoso's government remained, affecting social policies, including health. From the mid-2010s onwards, other measures were approved, amid political changes in the country, which deepened the undercut of SUS.

In 2016, in her second term, President Dilma Rousseff, of Partido dos Trabalhadores (PT) [Brazilian Workers' Party], was impeached. Her first mandate lasted from January 1, 2011 to January 1, 2014, when her second term began, after winning the presidential election with 51.64% of the votes. The country was facing urban clashes and riots leaded by different social forces that criticized the government. PT had been the target of protests, and its main leaders had been involved in several operations in an anti-corruption lawsuit, with the aim of removing prominent political figures from power. In the 2020s, Brazilian Justice recognized that some of these lawsuits were conducted in a manner contrary to justice, mainly those leaded by then-judge Sérgio Moro. On April 17º, the Brazilian Chamber of Deputies[2] set up the impeachment process in motion and the President was suspended from office. Vice-president Michel Temer, from Partido do Movimento Democrático Brasileiro (PMDB) [Brazilian Democratic Movement Party], took over the presidency provisionally. On August 31, 2016, Rousseff was impeached.

Temer became president of the country, with support from industry and commerce entrepreneurs and right-wing parties, responsible for large popular demonstrations and riots on the streets. Conselho Nacional de Igrejas Cristãs [National Council of Christian Churches], Conferência Nacional dos Bispos do Brasil [National Conference of Bishops in Brazil], deans of 41 federal universities and technical institutes, Central Única dos Trabalhadores [Unified Workers' Central], Movimento dos Trabalhadores Rurais Sem Terra [Landless Workers' Movement], União Nacional dos Estudantes [National Union of Students], Confederação Nacional dos Trabalhadores na Agricultura [National Confederation of Agricultural Workers], the World March of Women, governors of 16 states and mayors of 16 capitals were against the impeachment.

According to Braz,[4]

Despite having created a government (as PT had done since 2003) predominantly focused on the big capital agenda and its Brazilian partners and, as of 2015, having adopted a government program very similar to the one presented (and defeated) by the PSDB [Brazilian Social Democracy Party] candidate in 2014, Dilma was removed from the Presidency of the Republic because she was deemed incapable of sustaining the capitalist interests she so served. They now needed a genuinely bourgeois government, capable of not giving way to the workers, of taking away what little they had achieved, and of completely serving big capital, without concessions. The class pact was no longer useful (pp. 87–88).

Also in 2016, Temer implemented actions to deepen neoliberalism. His main measure was sending a Constitutional Amendment Draft to Congress. It became Constitutional Amendment Number 95 of

December 15th, 2016, that created a New Fiscal Regime, which decreased resources for social policies, such as health and education. It sets a threshold for primary expenses, which is to be updated yearly, only according to inflation rate at least for the next 20 years, and approves the decoupling of the minimum budget for health and education expenses, dismantling the SUS.

A study carried out by Vieira and Benevides[5] found out that the estimated loss of federal resources adressed to SUS is R$ 654 billion over 20 years, in a conservative scenario (2% GDP growth per year). With an estimated higher growth (3% per year), the figure reaches R$ 1 trillion. It means that, the more the Brazilian economy grows, the greater the loss of monetary resources for health. A 2016 document written by PMDB provides precise guidelines about health policy, highlighting the adoption of managerialism as a need, considering poor public management as the main cause of challenges for SUS. It proposes state funding services focused on the poorest people (those who cannot afford private health insurance) and recommends encouraging increased coverage of private plans.[6]

The Minister of Health appointed by Temer, the engineer Ricardo Barros, standed for the need to reduce SUS because, in his opinion, the country was unable to uphold the rights provided for in the 1988 Federal Constitution, for instance, the universal access to comprehensive healthcare. Thus, he suggested low cost or affordable health insurances as the pillars of his mandate, coming up with a project that included health insurances that only covered primary care and auxiliary diagnostic services and low-and medium-complexity therapies, without hospitalization. The government intended for all Brazilians to get in health insurance and for SUS to be used only by very low-income populations, which would free up resources for the capital accumulation, as to pay interest on the public debt. Following Collor and Cardoso, Temer aimed to remove the universal, free right to health from the constitution.

Many of the proposals issued by Temer's government stems from private hegemonic think tanks, such as the World Bank, which stand for the interests of the private healthcare sector, bringing together health entrepreneurs, academics, and both private and public care providers. The Federal Government even negotiated agreements with private institutions, creating SOs to carry out training processes for public managers, wide spreading the concepts of private management to public healthcare facilities and teams throughout the country.[7]

One of the organizations that worked closely with the Temer government was the Instituto Coalização Brasil, which stands for the argument that the public and private sectors need to build up an integrated network of continuous care, with greater participation of the private sector in managing services.[7] This idea follows the logic of the management of public healthcare units by the private sector, through SOs for health, regulated by Cardoso's government. It does not intend to get rid of SUS. However, according to these private hegemonic organizations, the new healthcare system must to create more spaces for the private sector, ensuring greater access to the public fund for private capital in health.

Due to Brazil population – the projection for 2024 is 217,684,462 (IBGE, 2024)[8] – there has been great potential for the growth of private health insurance in the country. Changes in Política Nacional de Atenção Básica [National Primary Healthcare Policy] were implemented, discussed with no participation of Conselho Nacional de Saúde (CNS) [National Health Council].[9] Despite setting family medicine as the priority strategy for the expansion and consolidation of primary healthcare in Brazil, the text contradictorily breaks with its centrality and establishes forms of funding for care arrangements that do not include multidisciplinary teams with community health agents, based on principles that oppose those guiding primary healthcare. The new healthcare policy, published by Temer's government in 2017, represents a setback in relation to the existing model, as Vieira, Soares and Melo indicate.[10] Physician-centered, individualized actions return, devaluing activities conducted by community health agents and collective actions in communities.

The Temer government also promoted changes to Política de Saúde Mental [Mental Health Policy], aiming to strengthen admissions to psychiatric hospitals and establishing beds in general hospitals, through increased resources for such purposes. These changes express interests that are against SUS, to the Psychiatric Reform, and to the preventive paradigm, which defend health beyond clinical interventions, attacking the holistic idea of health.

These counter-reform health measures affect the care provided to people with HIV and AIDS (along with all SUS users). Their needs are not limited to the use of antiretrovirals. They rely on SUS for their healthcare, which goes beyond the HIV. They need not only health policy but also other social protection policies that, since 2016, under the Temer government, have been devalued and defunded.[7]

During this mandate, the structure of the program Farmácia Popular [Popular Pharmacy] changed. The program was created in 2004. There were around 400 public units distributing 112 subsidized medications to all Brazilians. All public units were closed, and the program began to distribute only 32 medications, including those for asthma, hypertension, and diabetes, through 34 thousand private pharmacies, under the modality "There is a Popular Pharmacy Here". The population was penalized with the end of public units distributing free medicine.

Another significant change in SUS under the Temer government was straight fund-to-fund intergovernmental transfers. A program called SUS Legal was created, which redefines the form of transfers. Resources are now transferred in two stages, one for funding resources and the other for capital, which may reduce resources in areas such as basic healthcare and health surveillance to mainly favor medium- and high-complexity procedures, which have always been wanted by the private health sector. SUS financing is processed in accordance with Laws 8080/1990, 8142/1990, and Complementary Law 141 of January 13, 2012. They define the minimum amounts to be spent on public healthcare actions and services annually by the Federal Government, states, the Federal District, and cities, taking into account criteria for resource apportioning for health transfers.

The Federal Government must spend at least 15% of its Current Net Revenue of the financial year. The states account for 12% of the sum of directly collected taxes and constitutional and legal transfers received from the Federal Government, linked to health. Cities must disburse at least 15% of the sum of directly collected taxes and constitutional and legal transfers received from the Federal Government and states. The social security budget, which includes health, was never able to establish itself, ensuring the necessary actions to implement SUS. The fiscal adjustment that has been affecting social policies in the country applies some mechanisms to remove resources from the social security budget and allocate them elsewhere. These mechanisms include the decoupling of government revenues and tax waivers, as was stated by Salvador.[11]

In September 2016, the aforementioned decoupling was extended until 2023. Its percentage increased from 20% to 30%, removing even

more resources from the social security budget. Furthermore, the decoupling of revenues was extended to states and cities, reducing resources for social security and enabling these sectors to use them discretionarily, allocating resources where they deem necessary.

The tax waiver reduces funding for social security by affecting the sources of revenues, consisting of the abdication of collection for the Federal Government, with a direct impact on the financing of health policy and the delivery of services. Resources are no longer collected to support companies, considering the capital crisis, and health, social assistance, and social security thus lack capacity for action. In practice, the State stops collecting revenue to favor some economic segments.

Salvador 2017,[11] observes that

The (de) financing of the Social Security Budget with the removal of resources through the decoupling of government revenues and tax waivers reached the amount of R$ 269.50 billion in 2016, i.e., 37.60% above resources that were allocated in the same year to health and social assistance policies in the State budget, which totaled R$ 195.86 billion (p. 434).

Tax spending increased significantly between 2010 and 2016, 46.93% above inflation. The exemption of economic sectors represents a form of aid to capital at a time when the capital crisis is deepening and these sectors pressure on governments to make concessions in their favor. However, this only occurs to the detriment of other segments, in this case, SUS users, who see lines growing, delays in service, lack of basic inputs, and the difficulty of guaranteeing universality and integrality of care with quality.

Soares (2018) thinks that Temer's government renders SUS inoperative in three aspects

I. Universality – budget restrictions lead to the defunding of health policies and the proposed affordable health insurance encourages everyone to pay for healthcare, relieving SUS of healthcare for the majority of the population

II. Promotion of the notion that SUS is unfeasible, generating user disengagement

III. Social participation – overvaluation of spaces and groups formed by representatives and consultants of private health capital (so-called think tanks) and overvaluation of the Tripartite Commission to the detriment of health councils and conferences.

At the end of Temer's mandate, elections brought Jair Bolsonaro into power, representing Partido Social Liberal [Social Liberal Party], which obtained 55% of the votes. What are the hallmarks of this government? Continued deepening of neoliberal path, established as ultra-neoliberalism. Continued restriction of workers' rights and favoring of the interests of capital.

Borges & Matos, 2020[12] in an accurate reflection, believe that Bolsonaro's ultra-neoliberalism and ultra-neoconservatism are two sides of the same coin:

What happens, in Brazil, but not just here, is that the economic-financial agenda has been aligned with a deeper rise of neoconservatism. The government has demonstrated its cult of police violence and repressive ideology (lowering the criminal age, bearing of arms, extension of penalties) and also of intolerance towards sexual "minorities", with a strong religious appeal (against legalizations: abortion, drugs/psychoactive products, same-sex marriage) (pp. 74-75).

They state that there are fascist elements in Bolsonaro's positions, acknowledging that, under the "pretext of combating the left and in defense of an ultra-right-wing project, they express hatred of human diversity, emphasize misogyny, defend the use of fire weapons to confront expressions of social problems, among others" (Borges & Matos, 2020, p. 76).

Another hallmark, highlighted by Castilho & Lemos,[13]: "The Brazilian government consciously adopted a policy of death or, in Mbembe's terms (2016), necropolitics, as the official State policy" (p. 271).

The defense of the traditional family values conceals/invisibilizes some population groups while favoring capitalist interests and sectors that support the government:

His choice of necropolitics imposes extermination on all those who threaten big capital, as is the case of actions orchestrated against indigenous, riverside, and quilombola peoples; against the Amazon and its criminal deforestation; the release of hundreds of pesticides; the anti-crime package; the counter-reform of social security; guaranteed weapons to large landowners; budget cuts for social policies; successive cuts for universities and culture, therefore, discrediting towards science and culture, as fields for raising consciousness.[13]

Besides ultra-neoliberalism and necropolitics, conservatism was consolidated during Bolsonaro's mandate. He managed to bring together right-wing groups that had been silenced in previous governments, with advances related to gender, race, and sexual orientation. To implement neoliberal values, the power of the Minister of Economy, Paulo Guedes, was broad. He worked with Constitutional Amendment 95/2016, approved during Temer's mandate.

The government managed to approve a pension reform, reducing rights and guarantees achieved by workers throughout the 1900s and 2000s, freeing their employers from contributions to finance pensions.

Health policies in the Bolsonaro government were faced with an unexpected situation: the Covid-19 pandemic, starting in 2020. However, it faced it from a science-denying approach, also applied to the guarantee of the universal right to health.

The Minister of Health, Henrique Mandetta (January 1, 2019 to April 20, 2020) was fired at the beginning of the pandemic for stand against the denialist orientation of the president. The former minister claimed to defend SUS; yet, contradictorily, he defended a strong private sector and did not acknowledge that SUS was being defunded. Regarding mental health, the Bolsonaro government retreated the Psychiatric Reform even further, reducing the importance of Centros de Atenção Psicossocial [Psychosocial Care Centers] and strengthening therapeutic communities, nursing homes for the treatment of alcohol and other drugs, most of which are run by Evangelical and Catholic right-wing groups.

In order to make AIDS invisible, Departamento de IST (Infecções Sexualmente Transmissíveis), Aids e Hepatites Virais [Department of STIs (Sexually Transmitted Infections), AIDS and Viral Hepatitis] was renamed, becoming Departamento de Doenças de Condições Crônicas e Infecções Sexualmente Transmissíveis [Department of Chronic Diseases and Sexually Transmitted Infections], along with malaria, tuberculosis, AIDS, and viral hepatitis. The director of the old department, internationally renowned in the field, was fired. One of her assistants took her place, later assessing that the fight against HIV and AIDS remained unchanged, which was not agreed upon by the academics and social movements that work in the field of HIV and AIDS.

Even before being elected, the president already said that he opposed access to free treatment for people with HIV and AIDS through SUS since they are infected due to put in place behaviors that are considered sexually inappropriate and unnatural, demonstrating a lack of knowledge regarding HIV and AIDS.

Consistent with his opposition to social participation in social policies, right at the beginning of the mandate, on April 11th, 2019, Decree 9,759/2019 has closed the councils and collegiate bodies of the federal public administration that were established by decrees and not by laws. Savings, bureaucracy reduction, and reduction of the power of politically equipped apparatuses justified the attitude. It was not able to eliminate Conselho Nacional de Saúde nor state or city councils, these are mandatory and created through laws. However, it devalued the former, strengthening expert councils, such as COSEMS [State Councils of City Health Departments] and CONASEMS [National Council of City Health Departments]. Within the scope of the Ministry of Health, it eliminated the Secretariat for Strategic and Participatory Management, responsible for promoting social control.

Regarding Covid-19 pandemic, due to pressure from civil society, health institutions, and the international community, the Federal Government under Bolsonaro was pushed to purchase and provide vaccines to the population. However, due to the delay in taking the necessary actions to combat Covid-19, there were more than 700,000 deaths in the country. It is necessary to highlight that as a characteristic of Bolsonaro's mandate, the conservative mindset made the country go backward in guaranteeing human and social rights to several minority groups. In the 2018 government plan and in the 2023-2026 plan proposal, there is no reference to the LGBTQIA+ population nor to the black population. During his government, we heard hate speeches rise against university quotas for black and poor people from public schools.

As for women, conservatism looks at motherhood, at the reproductive role of women, essential for the reproduction of capitalism. Women are seen as the natural caregivers for their husbands, children, and family. The topic of abortion was marginalized, even in cases secured by law–victims of rape, when the woman's life is at risk, and when the fetuses are anencephalic.

The persecution of progressive movements took place throughout the mandate, with government support. The LGBTQIA+ movement, women, quilombola and indigenous people, and environmental protection were targets of criticism. The so-called gender ideology, combining agendas regarding sexual and reproductive rights, against misogyny, among other agendas, was rejected and became an enemy to be phased out.

These conservative proposals, however, express the positions of part of the population and remain alive and active despite the end of the government in January 2023.

Borges & Matos, (2020)[12] emphasize

These ideas, however, were not born with Bolsonaro. They were already germinating in society. He and his allies knew how to capitalize on them and transform them into power, joining the reactionary forces, with a fundamentalist matrix. They were reached in the depths of society, with its slave-owning, racist, elitist roots. And here we call on Gramsci (2016, p. 83) when he states: "ideas and opinions are not 'born' spontaneously in the brain of each individual: they had a center of formation, irradiation, diffusion, and persuasion [...]" (p. 72)

It is impossible to talk about Bolsonaro's mandate without talking about fake news. The dissemination of lies and false truths using new informational communication technologies was one of the hallmarks of this government. A statement by CNS confronts fake news related to AIDS:

Last Friday (Nov. 12), National Health Council posted on 11/12/2021 published a motion to repudiate the statements made by the President of the Republic, Jair Messias Bolsonaro, delivered during a live broadcast on October 21, 2021. On that occasion, the head of State expressed, through his social networks, the untruth that those vaccinated against COVID-19 would develop Acquired Immunodeficiency Syndrome, a disease popularly known as HIV/AIDS, "faster than expected" (Brasil, CNS, 2021)".[9]

Health policies for people with HIV and AIDS

Over the years, Brazilian health policies for people with HIV and AIDS have become an international benchmark for HIV prevention, due to cooperation with organized civil society in the work carried out with key populations. Non-governmental organizations (NGOs) fight for the rights of people with HIV and AIDS and develop preventive and educational actions with transvestites, homosexuals, and sex workers, among other groups, who are more prone to HIV infection. Social struggles in the 1980s and 1990s led to the enactment of Law 9,313, of November 13, 1996, which guarantees the distribution of antiretrovirals by SUS, in cases defined by international protocols.[14]

There was a greater reduction in resources for social policies, with an emphasis on health, since SUS was approved, with Constitutional Amendment 95/2016. It affected the entire health field, with cuts that influenced basic care, medium- and high-complexity procedures, hiring, and medicine supply. Our perspective indicates that:

The AIDS epidemic exposes the exploitation and social inequalities in health, inherent to capitalist sociability, which is intersectionally classist, patriarchal, and racist (ROCHA *et al.*, 2019). After all, HIV prevention and the quality of life of HIV-positive people depend on access to health, social security, and social assistance services, antiretrovirals, and the deconstruction of sexist, homophobic, and transphobic cultural values. Therefore, it is linked to social processes that antagonize the ultraconservative, neoliberal project currently defended by certain groups and parties, mostly of the far right.[15]

Antiretrovirals were still distributed, even with these cuts, since their distribution is guaranteed legally. At times, there are temporary shortages, as explained by local governments or the Federal Government, due to delays in the purchasing process. However, cuts in the program Farmácia Popular restricted the distribution of free or subsidized medicines, affecting people with HIV and AIDS – if they do not take antiretrovirals regularly, they become more vulnerable to opportunistic diseases and need other medications, not always available on these services, even for domestic use. They include dermatological medications, antibiotics, and antivirals, for diseases that affect people with HIV, whose profile, currently, differs from that of the 1980s, when the disease began to be known.

Initially, in Brazil, AIDS was a disease that affected mainly middle- and upper-class homosexuals and white people. "In Brazil, from 1980 until June 2023 [...] 1,124,063 cases of AIDS were detected [...]. In 2022, 36,753 cases of AIDS were recorded" (Brasil, MS, 2023, p. 9). AIDS has been notifiable since the 1980s, but HIV has only been notifiable since 2014.

In 2022, 43,403 HIV cases were detected in the country – 15,064 in the Southeast (1st place in total cases) and 11,414 in the Northeast (ranking 2nd). The sex ratio indicates that for every 2.8 men one woman is infected with HIV, almost 30% of cases. The highest incidence of

HIV is in the age group of 25 to 29 years, both for men and women (21.8 and 13% of cases, respectively). In the age group of 60 and over, there has been an increase in HIV cases. In 2012, 2.1% of cases among men were in this range, in 2022, 3.7% occurred; among women, it was 3.0% in 2012 and 6.6% in 2022, more than double.

Regarding AIDS, 36,753 cases were detected in the country in 2022 – 13,527 in the Southeast and 8,812 in the Northeast. Considering the detection rate (per 100,000 inhabitants) of reported AIDS cases, according to state and region of residence, the highest value is in the Northern region: 25.7. Since 2012, the Southeast has seen a decrease in this rate. It went from 21.6 to 15.0 in 2022, probably the result of consistent actions to combat HIV and AIDS. The Southern region went from 33.1 in 2012 to 21.1 in 2022. The rate in the Northeast was 15.9 in 2012 and increased to 15.2 in 2022, showing a certain stagnation of actions in relation to AIDS. In this region, the highest rates, in 2022, are in Maranhão (18.5) and Alagoas (18.3), while Paraíba has the lowest rate (12.5).

Considering race/color, among men, in 2012, there were 49% of HIV cases among white people, 8.7% among black people, and 32.9% among brown people (41.6% of black people). In turn, the percentage of black women has been higher than that of white women since 2012: the rate was 39.8% for white women and 51.2% for black women.

The majority of people infected with HIV in 2022 are therefore brown and black, totaling 19.931 black men, representing 62.4% of males at birth. Among women with HIV, in 2022, 64.1% were black (black and brown), totaling 7,322 women. The social determination of health leads us to understand that, in Brazil, black people have less education, lower income, live in homes that do not always have running water or sewage, and have less access to health information and services, making them more vulnerable to HIV.

Among 13,076 men with AIDS detected in 2022, 59.8% are black (black and brown). Among the 4,634 women, 61.1% are black. In percentage terms, there is a greater difference for women, both in cases of HIV and AIDS. How is this explained? Perhaps women believe they are less susceptible to HIV, take less preventive care, and have greater difficulty, even today, in negotiating the use of condoms with their partners. They may only discover their positive serology when they already show signs of disease. They can also delay going to the doctor due to activity overload, as mothers, workers, and caregivers for family and neighbors. The fact is that it is necessary to review care for HIV and AIDS, making women aware of the importance of knowing the forms of HIV infection and preventing it. Data from the HIV/AIDS 2023 Epidemiological Bulletin also show that HIV is mainly spreading among people with up to 9 years of schooling. The Bulletin does not include data on income, but education can be understood as a proxy in relation to income, i.e., an indicator – with lower education, people's income is presumably lower.

Deaths due to the basic cause of AIDS, presented in the Bulletin, establish many points for reflection. Between 2012 and 2022, there was a reduction – there were 12,019 deaths in 2012 and 10,994 in 2022 (a reduction of 8.52%). This decrease is below those of other countries after the international protocol indicated that antiretrovirals should be distributed immediately after detection of the HIV virus, without immune defenses being compromised by HIV. In Brazil, since 2013, antiretrovirals have been distributed to people with HIV, regardless of viral load, changing the protocol in force since 1996. Globally, in 2015, the World Health Organization removed all limitations on eligibility for antiretroviral therapy among people living with HIV. This means that they must use these medications immediately after the virus is detected.

However, the reduction in HIV deaths does not occur in all regions of Brazil. In the North, there was an increase in AIDS deaths, from 903 to 1,328, during the period (an increase of 47.06%). In the Northeast, deaths rose from 2,132 in 2012 to 2,519 in 2022 (an increase of 18.15%). In the Central-West, there was a small increase, from 771 deaths to 777. Only in the Southeastern and Southern regions was there a reduction in AIDS deaths. In the Southeast, there were 5,524 deaths in 2012 and 4,147 in 2022 (a reduction of 24.92%), and in the South deaths increased from 2,519 to 2,302 (8.61%). The data allow us to think about the healthcare network in different regions, indicating that the population in the North and Northeast has a more unreliable SUS and greater difficulties of access, besides more precarious living conditions, with lower income and less structured social policies.

AIDS deaths also show that cases of black women with AIDS in 2022 are 12.5% of the total, but deaths of black women are 16.6% of cases – why is the percentage of black women with AIDS who die greater than those who suffer from AIDS? The same thing happens among black men in 2022 – 13.8% die, while the percentage of AIDS cases is 11.5%. Besides, why is the percentage of deaths among black women higher than that of black men? A racial issue is raised for discussion and for the design of public policies, which must take this into account.

With this new profile of people with HIV and AIDS, it is necessary to think about the actions to be developed, considering the region of residence, education, age group, living conditions, poverty, and misery among infected people. The Federal Government must have guidelines that contemplate the morbidity and mortality profile due to HIV and AIDS, and state and city governments, which implement healthcare actions, cannot ignore the profile of infected people in their territories, in order to develop more effective actions, not only in relation to the health/illness issue, but also considering the social determinations of health. A person with HIV, without a job and regular income, who relies on informal work, may not have money to travel to the nearest Serviço de Atenção Especializada em HIV e Aids (SAE) [Specialized HIV and AIDS Care Service] to have access to antiretrovirals and clinical monitoring. This can lead to treatment interruption and increased resistance to medications, which have side effects and require adequate nutrition. This situation makes it clear that it is necessary to go beyond medication to ensure that treatment is not interrupted, and that the person has an undetectable viral load and does not transmit HIV.

The Bolsonaro government suspended food security actions, abolished the specific council in this field, and reduced investments for social vulnerable populations. The huge number of people in poverty during the years of his government shows the increased risk of people unable to provide their livelihood.

From the Bolsonaro government onwards, neoconservatism was added to ultra-neoliberalism, leading to restrictions on HIV and AIDS policies. In one of the government's first actions, through Decree 9,795, of May 17, 2019, the structure of the Ministry of Health was modified – the Department of STIs, AIDS, and Viral Hepatitis became the Department of Chronic Diseases and Sexually Transmitted Infections.[16] Associação Brasileira Interdisciplinar de Aids [Brazilian Interdisciplinary AIDS Association] assessed that this act represented the extinction of the Brazilian AIDS program, reinforcing the disagreement in relation to a democratic experience of confronting the AIDS epidemic, as the actions of the former department were guided by processes with social participation. The existence of a department

with the name AIDS in the Ministry of Health gave visibility to the disease, and the new name makes AIDS invisible. It should be noted that not only the name changed, but also the social networks related to HIV and AIDS of the Ministry were all deleted and the communication team that developed preventive and informational campaigns about HIV and AIDS was also dismissed.[17]

People have access to testing and guidance if they test positive for HIV. They have access to antiretrovirals and monitoring at SAEs). In fact, services are concentrated in capitals and metropolitan areas, requiring people to travel to other cities to access services, which could also be provided in basic care, which cannot always cover all the expected actions. Even in SAEs, there is not always an infectious disease specialist, who are concentrated in large urban centers. Preventive work in relation to HIV, which was carried out mainly by NGOs in the 1990s and 2000s, suffered a significant reduction with the redirection towards medication actions and the reduction in government funding for information work.

The decrease in the number of health workers also affects the development of preventive actions and even the monitoring of health indicators and the administration of antiretroviral drugs. Furthermore, its reach was limited due to conservative constraints, which restricted information aimed at key populations, such as homosexuals and sex workers.

A study on health policies for people with HIV and AIDS, developed between 2018 and 2023, in Pernambuco, identified that several SAEs were unable to incorporate new users with HIV into outpatient care due to a lack of staff. This occurred in state owned services, such as Hospital Oswaldo Cruz, at the University of Pernambuco, and city services, such as the SAEs in Olinda and Jaboatão dos Guararapes, in the metropolitan region of Recife. The state and cities had no resources, due to financial austerity restrictions, to replace retired or dismissed employees for some time. Some services were only provided for new users because a U.S. NGO, the AIDS Healthcare Foundation, supplied doctors, nurses, social workers, and other professionals, allocating them to SAEs in exchange for access to data, obtained through patient records.

These professionals are hired through scholarships, which means they have no employment ties or rights and can be replaced at any time. Continuity of the service is fragile, with personnel without formal employment contracts, themselves affected by productive restructuring and processes to reduce public servants, with the limits imposed by the Fiscal Responsibility Law since 2000.[18]

Therefore, it is noteworthy that drug treatment predominates, with antiretrovirals, transformed into preventive action – PrEP (HIV Pre-Exposure Prophylaxis, taken by people who are more vulnerable to become infected, such as gay men, trans people, and sex workers, among others) and PeP (HIV post-exposure prophylaxis, for people who are injured with sharp objects and other possible forms of infection). These are ways to prevent HIV infection, just like the use of antiretrovirals immediately after detection of the virus, when testing, is implemented both to avoid recurrent opportunistic infections and to avoid the transmissibility of the virus since it is not transmitted if the viral load is undetectable. It is necessary mention that the existence of services such as SAEs or others that prescribe PrEP and PeP does not necessarily entirely meet demand. For some time, only one state service in Recife delivered these inputs, and not even those who worked in other sectors of this healthcare facility knew about it. Knowing demand and planning services accordingly is essential to guarantee access. Currently, PrEP is available in other regions of the state. The offer has been expanded to a greater number of people with HIV who meet the access criteria.

People with HIV and AIDS suffer discrimination and face difficulty finding formal jobs, especially if they are less educated – and we are dealing with a country of great inequalities, the 6th most unequal country in the world. The reduction in resources with Constitutional Amendment 95/2016 affected other social policies, such as social assistance, reducing guarantees for people without access to formal jobs or with insufficient wages to support their families. Without money to pay for mobility, people with HIV and AIDS, who need to travel to pick up medication every month, often miss appointments and interrupt treatment. Services do not always have staff to actively search for those who are absent, given the reduced workforce available.[19]

Conclusion

With the deepening of the ultra-neoliberal orientation and neoconservatism, healthcare actions, social assistance, and other social policies have been affecting people with HIV and AIDS – in this context in which black people, with less education and lower income, become infected at a higher rate than people with better income and higher education and white people. In an extremely unequal country, HIV and AIDS spread among poorer, less educated, black people, who have no access to formal jobs, live more precariously, and are more vulnerable to racism and sexism.

The reduction of HIV infections in the poorest regions of the country – North and Northeast – at lower levels than in the South and Southeast clearly demonstrates the greater risk which people in the most deprived areas are exposed to, simply because their life indicators are more fragile. Meanwhile, in the poorest regions, social policies are more incipient and more strongly influenced by the reduction of social policies, making people more exposed to unemployment, hunger, inadequate housing, including the stigma associated with a disease with clinical and moral dimensions, at a time when neoconservatism is expanding.

The goal proposed by the World Health Organization to end AIDS by 2030 is increasingly difficult to achieve, with budget cuts and measures that restrict preventive work in the name of neoconservative right-wing principles, which deny the sexual and reproductive rights of people living with HIV and AIDS.

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Conflicts of interest

The authors report there are no competing interests to declare.

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