

HIV/AIDS Policies, Activism, and Anthropology: A talk with Richard Parker

Políticas de HIV/Aids, ativismo e antropologia: conversando com Richard Parker

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RICHARD GUY PARKER IS A NORTH-AMERICAN ANTHROPOLOGIST, researcher and professor. Always sensitive to the social and political implications of AIDS in the social body, was one of the central actors for the implementation of what became known as the Brazilian response to the HIV/AIDS. Graduate and Doctor in Anthropology by the California University, author and organizer of a number of books, articles, anthologies, conferences, bulletins, among other publications, is one of the indispensable authors for a critical and engaged analysis of the paths leading to the conceiving of public policies, since the process of planning them to their execution. We seized the opportunity of his presence in the VIII Brazilian Congress in Social and Human Sciences in Health, of the Brazilian Association of Collective Health (ABRASCO), between the 26th and the 30th of September 2019, in João Pessoa/PB, to talk about his path in the field, and to discuss his perceptions on the political and epidemiologic scene of AIDS nowadays. The interview took place on September 28th 2019, in the Federal University of Paraíba, by researchers of the Group of Research in Health, Society and Culture (GRUPESSC). It was a part of the activities of the research project 'Fases e Faces do HIV/AIDS na Paraíba', developed by GRUPESSC between 2018 and 2020, aiming to investigate the incorporation of the pharmacological technologies of HIV prevention in the State of Paraíba.

Parker was a teacher of the Institute of Social Medicine of the University of the State of Rio de Janeiro (UERJ) for almost 20 years, and is Full Emeritus professor of Columbia University. Currently, acts as a visiting professor in the Institute of Studies of Collective Health of the Federal University of Rio de Janeiro (IESC/UFRJ) and since 1998 presides the Brazilian Interdisciplinary Association of AIDS, ABIA in this institution, was besides important political actors, that contributed to the fight for the rights of people who live and coexist with HIV/AIDS. ABIA is one of the main NGO/AIDS of Brazil that act in the monitoring of public health policies on HIV/AIDS. Besides contributing to the enhancement of the governmental efforts and to the debate on the epidemic, has been a potent instrument for the democratization of information on combat, control, prevention and treatment strategies¹.

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Defender of solidarity as an ethical and political project, critical of the ‘rebiomedicalization’ of the response to AIDS, Richard Parker discusses, in this conversation, ways of comprehending the epidemic and its impacts on life. In the interview, we had the participation of Vagner de Almeida, Parker’s partner and, also an activist, advisor of projects in ABIA and coordinator of the Project Sexual Diversity, Health and Rights among Youths. Vagner contributed significantly for the deepening of the debate. We may highlight that we lived in a context in which the challenges before the COVID-19 pandemic were not yet in the horizon of the debate, and we were facing the first year of the government of the then President Jair Bolsonaro, which helps us to dimension the analysis here present and courses of the conversation.

Mónica – Good morning. Before starting our interview, I would like to thank your availability for being here with us today. Our first question is related to your path in the field of AIDS and in Anthropology. How did you, an Anthropologist, get to the theme of the HIV/AIDS?

Richard – I started the doctorate in Anthropology in the University of California, in Berkeley, in 1980. I already had a degree in Anthropology before. At that time, in spite of the existing researches on sexuality and gender, this was not an area of specialization in the career, you could not even imagine there would be an opened post to hire a professor working with these subjects. Besides that, it was a time of crisis, the work for anthropologists was scarce, and the best chances to become a professor were linked to the exotic fields. I was interested in coming to Brazil and had a quite vague idea of doing research with the indigenous people in Amazonia. Then, in 1982, I came to spend three months here in some sort of pre-field, to see if I was going to adapt to the country. Promptly, I realized that leaving the big cities was not my path and decided to work in the ‘urban jungle’ instead of the Amazon

jungle. I liked Rio a lot and decided to stay there. In 1983, when I returned to Berkeley, I designed a doctorate project on Carnival, specifically on the political manipulation of Carnival. I was interested in how different political forces since the thirties had invested in Carnival aiming to guarantee their political interests. With this project, I got a scholarship from Fulbright Foundation, and that’s how I started the research. Meanwhile, the AIDS epidemic was in the beginning, the first cases had been reported in 1981, in California, where I studied, and in 1982, exactly when I stepped in Brazil for the first time. Although I did not yet imagine that I was going to do research on this theme, as a young gay man, I was quite worried about the epidemic. I opened a folder and started saving newspaper clippings, to gather documents about the theme, without imagining that one day that could become a research field. My doctorate thesis² was, in fact, on Carnival. However, the strong presence of the symbology of sexuality and gender in Carnival drawn my attention and I started writing about it. In parallel, Vagner and I met in 1983 and, in the following year, he went back with me to Berkeley, where we spent about four years. We had to find a way of living between two cultures, between two countries, in a moment when there was not the slightest chance of getting a visa due to a homosexual relationship. In 1985, I was in the middle of the writing of the thesis, and we came to spend a few months in Brazil to organize some things. At that time, AIDS was no longer a newspaper headline, it had become a much more present reality. And it was during this return to Brazil that we met Herbert Daniel and his partner, Claudio Mesquita. I remember quite well the four of us going up to the neighborhood of Santa Teresa to stay in the apartment where they lived and starting to talk about policies on AIDS. In 1985, the first NGO/AIDS had been created in Brazil, the GAPA/São Paulo. There was no organization in Rio – it was only in 1986 that Betinho and Daniel started talking about creating ABIA –, but in 1985, the

political issue was already outstanding. Daniel was already thinking a lot about these issues and it was him that stimulated me to make AIDS a research theme. Between 1985 and 1986, when I finished the doctorate thesis, I decided to get on with this suggestion. Initially, I started from the research on sexuality and gender in Carnival and wrote an article on AIDS in Brazil, that was published in 1987, in the second number of the journal 'Medical Anthropology Quarterly'. Following, from 1987 to 1988, Vagner and I decided to return to Brazil, because Vagner had exhausted all the possibilities to renew the student visa in the United States. I wrote a research project on AIDS' policies and got a small funding, of five to ten thousand dollars, from the Wenner-Gren foundation, which is the only foundation in the world that only funds Anthropological research, and a research scholarship from the Social Science Research Council, one of the main supports for Social science research in the United States. And that was the way that in 1988 we returned to Brazil. I had a one year cultural visa for research, but, in fact, we came to stay, sold everything in the United States, and our dog went to live with my sister.

That was a quite intense moment of the response to the epidemic in Brazil. ABIA had been created in 1986 and had formalized its statute in 1987. Peter Fry, who was also an Anthropologist and gay, therefore, had great interest in the pandemic, was acting as a representative of the Ford Foundation in Brazil, had started to be concerned about the theme. Peter had got funding from Ford to ABIA and was interested in designing a program on AIDS, not a formal program, because it was not possible, but a line that allowed to fund the first activities of the NGOs/AIDS from the other existing programs, such as education and race. Peter hired me as a consultant to help to organize those fundings, and I spent a few years gathering resources for the GAPA in different places, in Ceará, in Rio Grande do Sul, we funded Grupo pela Vida that existed in Rio and in São Paulo, we were in Curitiba, however I cannot

remember if we funded any organization there. We had very little money, some years we got around 50 thousand Dollars, in others, a little bit more, this value was the minimum to cause some impact. Besides the fundings for the NGOs, Peter also wanted to stimulate research on AIDS in Social Sciences. He had contact with a group in the Social Medicine Institute [IMS] in UERJ: Sérgio Carrara, that had been in the master with him, and Andrea Loyola, whom he had contact with at the time Peter worked in UNICAMP. He asked me to facilitate this project, many connections were activated and they got a scholarship of newly-doctor for me, that allowed to stay three years as a visiting professor in IMS. We expected UERJ to open a tender and I would possibly be hired, and that was what happened. This first project of IMS was basically composed by anthropologists and Jurandir Freire Costa, psychoanalyst, and there was also a project that funded a demographic study, made by Elza Berquó and by her group in UNICAMP. This was my first nucleus of social studies on the AIDS issue.

At that time, as AIDS was exploding and there were not many organized responses, I ended up being involved in many projects. During two years, I was coming and going from Rio to Geneva, because the World Health Organization [WHO] had created the Global AIDS Program in Geneva. I worked in the unit on social and behavioral research, fomenting projects and activities of qualitative research, because they had many quantitative researches on sexual behavior, but wanted to know the cultural dimensions of the epidemic. Thus, besides my work in UERJ, I traveled regularly to Geneva, where I did some longer practices, during a few months. It was a very interesting time, however quite incipient, because there was no research center specialized in AIDS. In the absence of an institutionalized initiative, was created a transnational network of researchers on AIDS. As always happens, it was harder to mobilize researchers in countries of the south, the industrialized

countries had more resources and, therefore, had a faster response. Brazil, however, was pioneer in this mobilization. The work that Peter Fry implemented in Ford Foundation, where I worked, was the first funding for the NGOs/AIDS that Ford had anywhere, only after that they formalized similar initiatives in New York and in other countries. And in the beginning of the 1990s, the field exploded in a way that it is even difficult to describe, we could stay hours here only talking about this. It was a quite intense time.

Marcos – Just a question, this time question, you start to get into WHO in which year?

Richard – In 1987 I start to publish on AIDS, 1988 I return to Brazil, and in 1988, I start this work, with Ford in Rio and with WHO in Geneva. I only stayed in Geneva until 1990, when there was a very strong political fight between the first director of the program, Jonathan Mann, and the director of WHO. Jonathan Mann was an epidemiologist, but had a quite progressive point of view, believed that the idea of the Human Rights could revolutionize the work with AIDS. Because of his ideas, he ended up fighting the WHO direction and was forced to request resignation. At the time Jonathan was leading the Program, he invited many people that belonged to the communities most affected by the epidemic to work with him, activists of sexual workers, gay men, ex-drug users. All those people were banned when Jonathan left. It took quite a while until WHO reopened the doors for the not so desired people that had worked in that first period.

Then, in the beginning of the 1990s, things really exploded in a quite intense manner in Brazil. The NGOs started to get intensely mobilized and critical because the response of the Brazilian Government to AIDS was very poor, especially in Collor's Government, although in Sarney's Government it had been also quite complicated. Collor's Health Minister, Alcenir Guerra, gave an extremely prejudiced response

to the epidemic, stigmatizing, with campaigns that we called terrorists, such as 'If you don't take care, AIDS is going to catch you'. And in the mobilization of the civil society for Collor's exit, pushed by the Movement for Ethics in Politics, one of the most important articulators was Betinho. It was him that got up the ramp of the Congress with the civil society letter in his hands asking for Collor's impeachment. It was a quite thrilling moment because Betinho was physically very fragile and his figure walking up the ramp, making the long march in the Esplanade of the Ministries, in his fragility, was moving. Returning to the AIDS issue, thanks to the articulation of the movement, Alcenir Guerra was fired, and Adib Jatene took over the Ministry of Health, he was with the conservative party, then PFL, but he was a little bit more enlightened. He remained in the Ministry after Collor left, already with Itamar Franco as president. Jatene reestablished the AIDS Program, called back the first director, Lair Guerra, invited many people with national significance at that time. Paulo Teixeira, that had directed the program in São Paulo, was invited to lead the civil society, Celso Ramos from Rio de Janeiro was also invited, and I was invited to lead the prevention unit. This was an important moment because it really restructured the AIDS Program, started to transform a stigmatizing program in a program based on the perspective of the human rights, a conceptual picture that would be deepened later to renew the policies. This period marks the beginning of what would be the most positive response that Brazil could develop during the 1990s and the 2000s. In the current decade, these advancements are being undermined, but during some 20 years, the Brazilian National Program of AIDS was a quite successful program.

I soon realized that I had no talent to act in the State and left the Ministry of Health in 1992, in the same year that Herbert Daniel died. At that time, I had already done a work ABIA's backstages, and when Daniel died, Betinho invited me to take over a part of ABIA's

direction. From 1992 to 1995, I worked as general coordinator of ABIA, acting effectively as executive director. In 1995, I entered ABIA's Council, as secretary general. In 1997, Betinho died, and in the following internal election, 1998, I became ABIA's president, and continue to be till this day. At that time, from 1991 to 1992, I acted simultaneously in two fronts: at one side, I build my academic career as a researcher on sexuality, gender and AIDS, on the other side, I worked in the direct activism in ABIA. I even think this was a way of maintaining my mental sanity; there were bleak times before the existence of any medicines, people died quickly and in quite violent ways, with a lot of suffering. Then I continued doing some researches on sexuality that had nothing to do with AIDS as a way of escaping the toughest feature of the epidemic. I also got involved in projects related to the AIDS' policies, in which we could unite activism and research in a way that did not work very well. ABIA and IMS had great partnerships that resulted in books, such as 'A AIDS no Brasil'³ and 'Quebrando o silêncio'⁴, both published by the extinct Relume-Dumará, an editor from Rio that was quite opened to the progressive thought. I believe that the partnership academia/NGO, as we made, was a very positive enterprise that characterizes what I would name golden time of the response of the epidemic in Brazil.

Another aspect that I have been writing about, and that it is worth retaking here, is that the creation of ABIA happened in Brazil in a unique historic moment, in full democratic opening after 20 years of dictatorship. The people that had been important in mobilizing the civil society in the resistance to the dictatorship were the firsts to become organized in the field of AIDS, in civil society and in the State. There was the cream of the sanitary movement, that was resistant during the dictatorship, people like Paulo Teixeira, that took over the state program of AIDS in São Paulo in the government of Montoro Franco, when there were direct state elections, but not

yet national elections. People involved in the response to the epidemic lived intensely the redemocratization movement. That's why I usually say that it was a historic accident that worked out, in the sense that there was in Brazil a political basis to think a progressive response to the epidemic. It took yet some time until that movement could get to the Federal Government, because Sarney was still there, indirect elections for President, the 'Diretas Já' movement failed, but in the states there was a lot of positive things happening. After the failure of the Collor's government and of the Itamar period, finally the change got to the federal government, with Fernando Henrique Cardoso's election, a direct election of someone who, although we may criticize for his alignment to the neoliberal policy, had a deep compromise with democracy. PSDB brought a lot of people, such as José Serra in the Ministry of Health, that had important trajectories. It was a quite interesting period, when were stimulated partnerships between NGOs, civil society and academia, one of historical characteristics of the Brazilian response to AIDS. A lot of what we got at that time had to do with this intersectoral dialog. I believe ABIA did this very well, convening academics, civil society leaderships, managers, people in the health care services, different sectors to sit at the same table, to dialog and to debate. This helped us out to make advancements through the years.

Luziana - After more than 30 years of epidemic, what AIDS has been teaching anthropology?

Richard - Excellent question! More than 30 years and soon getting to 40. The anthropology's response in the first two decades was quite positive and intense. In the United States, before existing formal research institutions on AIDS, it was created the 'AIDS and Anthropology Research Group', that was very important to connect people who worked on the theme and felt isolated and, also, to stimulate new researches on AIDS. Besides

that, in the 1980s and in the first half of the 1990s, was AIDS that opened space for the researches on sexuality. This situation changes a bit after the second half of the 1990s, the movement generated by AIDS loses strength, and are the LGBT and feminist movements that start influencing more in the opening of academic spaces. During the initial period, the anthropological researches did two things: In the first place, created many work opportunities for people who would research HIV and AIDS, specifically in the United States, that is the biggest world market for Anthropology. In the second place, the anthropological researches, and, also, the researches carried out by sociologists, were social alternatives for biomedical researches that were being produced in public health, in medicine schools. The Psychologists, in the United States, at least, adopted a behavioral perspective and got closer to the biomedical researches; this is no Brazil's case, where social psychology was always more sensitive to the social matters. Anthropologists and Sociologists made a counterpoint to this tendency, highlighting the importance of social and cultural matters. In Brazil, social scientists also had a fundamental role in the 1990s, bringing up concepts such as structural violence, vulnerability, concepts that emphasized the social health determinants and brought a social perspective for the field of AIDS. In this sense, Brazil was lucky to have a long tradition of sanitary reform and the collective health field, that placed the social, political and economic matters as fundamental to think health care matters. The behaviorism that was dominant in the United States was not prominent in Brazil. Here the field of research on AIDS, that was established and built in the 1990s and during the 2000s, is richer than in the United States, and that was quite positive to launch important matters for the academia and, also, for the practices.

What we need to discuss now is that if this situation still remains, because things have changed a lot in the last decade. There was a watershed in the middle of the 2000s, and all

we built in the 1990s and in the beginning of the 2000s started to be thrown away. What we experience now is the return of the biomedicalization of the epidemic. The perspective that considered vulnerability, structural violence and other processes that sought for demedicalizing the response to the epidemic starts to change in an accelerated manner since 2005. At this medicalization moment of the epidemic, we have the challenge to think issues such as the one you are researching (PEP, PrEP, Treatment as Prevention) in its social dimensions. This approach is more difficult now because the emphasis in such technologies emerges from the biomedical field. Many doctors and biomedical scientists believe that the social responses to the epidemic cannot work, and that's why they have to find a 'magical bullet' that will solve the health problem without changing society. This is an opposing view to the one we have been working on, because the idea of vulnerability implies that it is necessary to change the social structures, it is necessary to face inequalities for, in fact, facing the epidemic. The doctors were never convinced of that need, and the biomedical power reacted towards the seek for simple solutions, that could be 'sold', almost as advertising slogans: Test and Treat, Treatment as Prevention... Such technologies are presented to society as sayings that could be used to sell detergent! In a certain way, many actors of the biomedical field were convinced that people would not change their behavior and that only superheroes in white lab coats would be able to solve things. And the history of AIDS shows that is not with superheroes and magic bullets that we face an epidemic.

Marcos - Very nice what you brought up, of the counterpoint of the social sciences to an exclusively biomedical point of view; but, in your speech, you point out that also existed, at that time a cooperation at that moment among epidemiologists, other professionals and anthropologists, in the field of collective health, including social, human and health sciences. You

see that changing? Because the epidemiological view is not an exclusively biologic view, it considers social determinants.

Richard – Of course! The epidemiology in Brazil and in Latin America has this perspective in a stronger way than in other places. In fact, different countries, different cultures, have different traditions, even inside public health. In South Africa, for example, epidemiology is seen as an ally in the fight against apartheid, almost all epidemiologists were linked to the communist party, that was aligned against apartheid. In Brazil, there is a social epidemiology tradition, that is also very strong. In the United States and in most of the countries in Europe, this tradition is a lot weaker, the influence of biomedicine is higher, yet is still possible to find people that support a social vision of the epidemic. Then, the knowledge fields do not map the world in a totally equal manner, however, there are political globalized processes that push in certain directions. For example, after 2005, it got much harder to gather international resources for researches on social matters. All the resources are turned to new prevention technologies, that are biomedical. Resources to do the type of research that I historically did, on response policies to the epidemic, almost completely vanish. We still got fundings for a great research, from 2005 to 2010, on religious responses to AIDS, approaching the different religious traditions: Catholicism, evangelical churches, African-Brazilian religions. It was a multi-centric research in collaboration with a number of researchers: Fernando Seffner in Porto Alegre, Vera Paiva in São Paulo, Felipe Rios in Recife, Veriano Terto ABIA's people in Rio de Janeiro. This type of research that we managed to fund between 2005 to 2010, with resources of the NICHD – National Institute of Child Health and Human Development, is not the type of research that today would be seen as interesting for the funders. Then the movement was in this direction of the biomedical technologies that eventually can be used to try

to respond to the epidemic as if the problem was simply the pharmaceutical matter. In this topic, the word really changed, and we, of the social sciences, are against actual tendency.

Mónica – Still thinking about this actual tendency that you mention, I wanted to bring up a little bit of our experience and ask a question to continue the conversation. The first funding in GRUPESSC was in 2007, for a research on serodiscordant couples, in which we approached conjugality, sexuality, vulnerability, risk, stigma, finally, a range of social matters on living and living together with HIV. Almost a decade later, in 2015, we had the opportunity to accompany the X National Congress of HIV/AIDS, that took place here, in João Pessoa. In the occasion, I remember that it surprised us a lot the jingoism climate around the 90/90/90 strategy and the emphasis on the discourse on the 'end of AIDS'. It seemed to exist an enormous trust in the potential of the technological advancements to overcome any barrier. And then I ask you, why do you think that the social sciences suspect this discourse? What places us, as you pointed out, against this tendency?

Richard – Basically, this discourse is constituted as if the social, economic, political differences did not exist. The 90/90/90 strategy, the care cascade, those biomedical constructs that are almost always made rooted in the United States experience and then applied as a finished recipe for the other countries. They are descriptions of what occurs in rich and developed places, where many barriers and socioeconomic impediments do not exist or exist in a different way from what occurs in other contexts, and later are transformed in models, going from empiric descriptions of reality to public policies that should be implemented in other countries, even when the conditions are extremely different. Then, when we transport the care cascade to a country like Brazil, with a health care system that works in a precarious manner, with the services much less structured to welcome people, the model does not work.

And how does biomedicine understand this situation? As a ‘treatment failure’, in other words, people are treated as fails because they cannot develop their treatment in a way that fits the model elaborated in the United States and transported to Brazil, or to South Africa, or to other countries that have conditions and health care systems deeply different from that model. It is a way of individualizing social situations, as if that particular individual did not do things right, as if being adherent depended only on his willingness, it was not his doctor who failed, it was not the health care system that failed. This type of reasoning comes from a neoliberal perspective, that throws responsibility and guilt on individuals, as if was not a wider social process.

Recently, we had been talking a lot about it in ABIA, especially considering the experiences brought from people of the team more directly involved with the services, as Juan Carlos Raxach, a Cuban doctor that came to Brazil in the 1990s. As a doctor, he works closely with the people that are in treatment, and he does the following analysis: in Brazil, we have universal access to medicines, what is super positive; and thanks to that access, we have less AIDS cases, but we are having more HIV infections and, also, we have more people that cannot follow the cascade, that cannot fit in the 90/90/90 and, therefore, are dying. This death is treated as lack of adherence of the individual, not as a lack of support of this individual by the system. And when I say system, I refer to prejudice, to the stigma that yet exists in the health care systems; it is the lack of care about the HIV, the judgment of the people in the health care system that should support, but that are stigmatizing, discriminatory. In the case of PEP, in Rio, it is quite difficult to get information, people do not know what is PEP, do not know how to refer you, and when the person finally can find a service that offers PEP, after many barriers, is treated as being someone that did something wrong. After having to face

this stigmatizing treatment once, twice, thrice, people decide not to seek for the service anymore.

Vagner – Bringing this reflexion to my work, I would like to give a contribution to our discussion. I work directly with youths in an extremely vulnerable situation, especially structural. What happens is, although there are those new technologies available and free of charge – PrEP, PEP, antiretroviral –, the youths I work with do not care about them because they need to face other vulnerabilities, such as structural violence, unemployment, the difficulty to go to a University, or even to a secondary or primary school, family problems... If you talk to them about PrEP, they are going to ask: ‘What is PrEP? I have to think about food, about the risk of being shot because I am black, in how many times police stops me on the street’. Besides those problems, that we many times do not listen to, there are also the difficulties they bring on the attendance: CD4 exams that take six months to be available, the lack of infectologists and how people end up self-medicating because they have no one to orient them when they have a herpes crisis, for an example. Then, we many times see those processes from top to bottom, but in our project, we work in a horizontal manner, learn from the people what they really need. I have already heard a mother say to me: “*Before thinking about this AIDS thing, I need to find out where I am going to leave my son to go to work, because there is no nursery*”. This vulnerability precedes the HIV infection, and we need to be quite attentive to it.

Richard – Vagner’s intervention is quite important because it brings up that, besides criticizing, we need to propose alternatives. In other words, we need to continue criticizing the rebiomedicalization of the epidemic, but it is important to remember that the biomedical prevention is socially constructed, and all that is constructed can be deconstructed and reconstructed. In ABIA, we have been doing that rooted in the idea of ‘pedagogy prevention’, that is

a way of reconstructing the way we think the biomedical prevention including the communities affected, as the epidemic history shows. In this sense, the arriving of new biomedical prevention technologies creates a situation very similar to the first movement of treatment access. In that context, the activists, the groups, the NGOs that worked with AIDS created the idea, in English, of treatment literacy, that we translated as *'pedagogia do tratamento'*. When the first treatments arrived, there was a range of extremely complicated procedures, with treatment regimens of complex administration. In Brazil and in other countries with generalized epidemic, as in South Africa, were created communitarian programs for popular education to teach people how to use the medication. Today, we are in a very similar situation to the biomedical prevention, that is also complex to understand: PEP, PrEP, the Treatment as Prevention are complex ideas for the health care professionals, what to say for the users. Then, when it was imported for Brazil the idea of combined prevention, what lacked was a pedagogy that could support it. In practice, we left the 'condom mantra' for the 'mandala of combined prevention' without these technologies getting to people. A combined prevention pedagogy would have to be thought in a simple manner, using popular education techniques, that are very well developed in this country. Unfortunately, in a time when Paulo Freire and popular education are so criticized, the public power did not invest in this. Simply started to recite a new mantra, that is the mandala, without placing this change inside the pedagogical methodologies that really talked about people's reality in a way that allowed them to incorporate such resources. A prevention pedagogy should work for empowerment of people, allowing them to have more control of their decisions, because if these technologies remain restricted to an expectancy that people follow medical orders, nor the

prevention nor the treatment will work. It did not even work with the condom, the continues to be one of the more effective methodologies for prevention.

If we look at the past, what occurs now with the combined prevention is quite different from how the two more effective prevention methodologies have emerged in the epidemic history. The idea of a safer sex and the idea of damage reduction. Both emerged in the beginning of the 1980s, the HIV virus had not yet been isolated and they emerged in the affected communities. Those methodologies were efficient, especially because they made sense for such communities. Things changed when public health specialists, the AIDS experts, hijacked those methodologies and transformed them in technocratic interventions, torn apart from the communities. In this sense, I argue that we need a great return to the affected communities, to work with them, to define a prevention pedagogy that makes sense in those people's lives. However, it would be dangerous to treat those technologies as a cake recipe that an expert prescribes and it is only necessary to follow all the steps until it works. That is what is happening to PrEP, that it is being positive for a very specific and small range of the population: people reasonably educated, with reasonable resources, that can minimally dominate the system, access and use the PrEP. For the gays and men who have sex with men who are poor, more marginalized and affected by oppressions, for the women, for the transvestites, for the trans, for all that group that is not a small population reasonably empowered, the PrEP is not working, is not being accessed, is not being followed. There are adhering problems that are absolutely predictable if the pedagogical option is for a bank pedagogy, in Paulo Freire's expression, that treats people as having information deficit.

Vagner - Besides all this, the technicians in the services do not know how to work with PrEP. What we have been observing in our practice is that the doctors have a very plain knowledge

of those technologies and establish a moral judgment about people who seek for PrEP. They perceive those people as being promiscuous and believe that the government is paying for a promiscuity that they morally condemn. They do not discuss the HIV with the users do not discuss other STI [Sexually Transmitted Infections], do not inform that PrEP blocks the infection by HIV, but not syphilis, that is increasing significantly. We have been listening to many statements of doctors in the services that do not know how to discuss PrEP, and do not wish to know.

Richard – And in today’s situation, are the doctors that do the screening to decide who deserves, who needs PrEP. It is not possible for people to be subjects of rights in a system organized like that. People are treated as mere objects of the medical power, they cannot choose. I understand that this limitation is given because the resources are not sufficient to offer the necessary quantity, but when a system is structured like that, the problem is the system, not the people. And then, we return to the matter of the contribution of anthropologic research in the field of AIDS. I believe that anthropology’s role in translating cultural systems and knowledges is crucial at that moment. Clifford Geertz, a very well-known anthropologist, that never worked on medicine, even less on HIV and AIDS, defended that the exercise of anthropology consists in the translation of concepts close to people’s experience to the concepts and the language more distant from the social sciences, using this path as a way of offering a better comprehension of people’s experience in their life context. In this sense, anthropology can contribute for the actual moment taking seriously the experience in the most vulnerable communities, understanding their world, to help developing pedagogical works that may talk more adequately to them. This is a role that anthropology has taken over since the beginning of the epidemic, but that, at this moment, few people continue taking

forward. AIDS, definitely, left the priorities’ scene. There are important being made on gender and sexuality, that could be broadened for sexual health and that, certainly, would give excellent practical results.

Geissy – We have been doing research in a specialized care service here in João Pessoa, and I, specifically, discuss the issue of the TASP, of the Treatment as Prevention. What we have been noticing is that, at the service, the TASP does not exist, the workers do not refer to this form of prevention. The TASP is at the Ministry of Health protocol, the workers know the information that the person with the undetectable viral load does not transmit (although they have reservations regarding the matter), but they do not share this information with the users. We do understand that democratizing this information is totally necessary for the person to access his/her non-transmissible identity, to re-signify his/her condition of person living with HIV, best deal with the stigma and, in the end, to have a better life. What do you think of that?

Richard – I believe you are completely right about the lack of knowledge on TASP in the service. It is one of the least researched areas at this moment. During the last year, me and four more colleagues of different countries made a survey on biomedical prevention for a book that we are organizing on the theme. We wanted to include PrEP, TASP, I=I (undetectable=non-transmissible), and sought for people throughout the world to contribute. We found many interesting researches on PrEP, but we could not find almost anything on TASP, on how the TASP is being lived by people in the service. We also could not find many researches on I=I. It is important to know better those dynamics and to show how and why this communication, dialogue failure occurs, those mismatches between the patients and the professionals, not only the doctors, but all the health care team. To document what is happening is fundamental to think better how to work with TASP.

Vagner – I belong to many youth groups, and every day this question comes up: “*my partner is undetectable, can I have sex without a condom?*”. Much as you explain this technically, that you forward written material, people still have an immense suspicion. If even in their own group they are suspicious, even more among the teams in the services, that are not inserted in networks that deal with that issue. The decision of not using a condom goes through other places, through love, through passion, through the moment. At the time of having sex, you may even know the risks, but you take the risk. The reflexion comes later, and at that time, where is the information to seek for a PEP, for example?

Richard – In Rio and in other places, what we are seeing is that the system that was created to deal with HIV is being dismantled in a tragic way in all levels: municipal, state and federal. Sometimes, in that place where there was a service, now there is none. This is another reality of our time: we have more tools nowadays that in any other moment of the epidemic that could be used to face HIV efficiently, but, at the same time, there is a terrible conservatism, many times linked to religious values that lead us back to the 1980s, and a disassemble of the policies in the services turned to HIV and to AIDS. The successful National Program of AIDS is now part of a chronicle disease department. This is a quite serious situation that shows how the sexuality, gender, AIDS, sexual health issues are being affected by macro politics conjunctures, that we need to face to preserve what was built over 30 years. The most terrible of all is that we need a lot of time to build, but it is quite easy and fast to dismount what was built. I am talking about a dismount that started in the beginning of Dilma’s government, was deepened in Temer’s government and today, in Bolsonaro government, is progressing rapidly and intensely. And what to do about all this? This is a dilemma for which none of us has the solution. We understand that the actual situation is quite bad, we know that we have

in front of us a long fight of resistance and that we need to elect new governments that try to reconstruct what was destroyed.

Marcos – You talk about resistance, and that reminded me that, in the 1980s, a very important motto for the social mobilization around AIDS was the appeal to solidarity. I was thinking: what is the role of solidarity today?

Richard – I think solidarity today has a fundamental role. The starting point to solidarity is our capacity to comprehend the pain and the suffering of other people. In this sense, our moral progress depends on our capacity to extend this comprehension for the others and for the violences that affect them. Solidarity implies in committing ourselves to the obligation of fighting against those violences, even if they do not affect us directly. In the history of AIDS, the solidarity emerged in a moment when there were no technical resources to offer, no medicines, nothing that medicine could give. In this situation, solidarity emerged in a very strong way in the thinking of people like Herbert Daniel and Betinho. Moreover, Betinho talked about solidarity as the only vaccination available for the HIV, and I think that this analogy is still worthy nowadays. At present, we have more technical resources than we had, but the oppression has no technical medicine, has ethical-political medicine. If we understand the political, social, economic and cultural determinants of the oppression, we also understand that the ethical-politics principles that allow to move forward. In this sense, solidarity was the starting point to face the epidemic since the beginning, and I think it continues to be. Without solidarity, we go nowhere; and I believe that our dilemma at the moment is just that our political leaderships, not only in Brazil, but also in the United States and in other countries, have the lower level of solidarity in the history of the epidemic. This is tragic. The lack of solidarity is our worst enemy. It is much more dangerous than the epidemic.

Collaborators

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