



Naked lives: women with HIV/AIDS in the situation of gender violence

Vidas nuas: mulheres com HIV/aids em situação de violência de gênero


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Abstract

In patriarchal societies of peripheral countries, women suffer the effects of social and gender exclusion, which exposes them to the acquisition of HIV, and which remain after becoming ill. The aim of this paper is to explore the experiences of gender violence in the trajectory of women living with HIV. We conducted a qualitative study in which 61 women victims of gender violence registered in a Specialized Care Service for HIV/AIDS in a municipality in the interior of Rio Grande do Sul were interviewed, through a critical analysis of the discourse of the narratives produced by these women. All interviewees reported having suffered violations of rights throughout their lives, due to historical processes of exclusion, limitations in access to school, work, health services, and security. In health services, the care provided is based on a biopolitical medical model capable of postponing death, but not care for them fully. We denominate these women's trajectories as "naked lives," a concept of the philosopher Giorgio Agamben, considering that they are considered devalued and superfluous in society, marked by violence and HIV. **Keywords:** Women; HIV; Aids; Violence; Gender.

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Resumo

Em sociedades patriarcais de países periféricos, as mulheres sofrem os efeitos da exclusão social e de gênero, que as expõe à aquisição do HIV e que permanecem após o adoecimento. O objetivo deste estudo foi explorar as experiências de violência de gênero na trajetória de mulheres que vivem com HIV. É um estudo qualitativo em que foram entrevistadas 61 mulheres vítimas de violência de gênero cadastradas em um Serviço Especializado em HIV/aids de um município do interior do Rio Grande do Sul. Foi realizada análise crítica do discurso das narrativas produzidas por essas mulheres. Todas as entrevistadas relataram ter sofrido violações de direitos ao longo da vida, devido a processos históricos de exclusão, limitações no acesso à escola, ao trabalho, a serviços de saúde e à segurança. Nos serviços de saúde, o cuidado prestado pauta-se no modelo médico biopolítico capaz de postergar a morte, mas não de atendê-las com integralidade. Denominamos as trajetórias dessas mulheres de vidas nuas, conceito do filósofo Giorgio Agamben, tendo em vista que são consideradas desvalorizadas e supérfluas na sociedade, marcadas pelas violências e pelo HIV. **Palavras-chave:** Mulheres; HIV; Aids; Violência; Gênero.

Introduction

This study, based on narratives produced by women with HIV/AIDS, seeks to understand how *social and gender inequalities* and *health practices* can be central to the production of marginalized lives, devoid of rights and possibilities. Thus, we refer to women who are on the other side of the line, a situation of current capitalism that Boaventura de Souza Santos delimits as radical limits that divide the population into two groups: one *on this side* of the line and another *on the other side*, in which whoever belongs there disappears as a reality, becoming non-existent, irrelevant, and excluded (Santos, 2002, 2006, 2007).

For the female group, this exclusion was aggravated with the advent of contemporary neoliberal globalization, which seeks the “non-State” or the “State of non-law,” in which governors comply with international economic orders, to increase profit. In this model, the female domination and exploitation process is accentuated (Saffioti, 2001). Women continue to be the object of economic and sexual exploitation in the domestic and public markets (Pateman, 1993). The State is an agent of exclusion, representing the interests of those who hold economic power, and the inclusion of all as having rights does not matter to capital, because it is not a source of profits (Rocha, 1999).

The lives of women are neglected in favor of their preservation, since abyssal lines delimit borders and spaces of death, resulting from care only for the rights of the “universals.” This occurs when the State withdraws from social regulation and public services are privatized or cease to exist, increasing inequalities and violence (Atkinson; Blandy, 2008; Glon, 2005; Santos, 2002, 2006, 2007).

Violence is one of the means of control and subjection used by patriarchy and is triggered when there are failures in the imposition of power hierarchies in the female domination and exploitation system (Okareh et al., 2015; Schraiber; Barros; Castilho, 2010). The multiple forms of violence, including physical or sexual abuse, coercion, threats, and non-guarantee of rights, accentuate women’s vulnerability to HIV/AIDS, as many have been infected through sexual

violence (Jewkes et al., 2010). On the other hand, the acquisition of HIV increases the possibility of violence, both in conjugal relationships, when they reveal the diagnosis to the partner and are blamed for the acquisition of the disease, and in societal relationships, when they suffer prejudices, discrimination, and social rejection (Carvalhaes; Teixeira Filho, 2012; Santos et al., 2009; Villela; Barbosa, 2017). Violence, therefore, coexists with the HIV/AIDS condition, although it is not possible to establish a cause and effect relationship, even though one in seven infections could be prevented if women were not subjected to violence or were not in power inequality in relationships (Jewkes et al., 2010). Besides, individual, programmatic, and social conditions contribute to increasing the vulnerability of women (Ayres, 2008).

The use of the *gender* category, within a perspective of the theory of patriarchy (Pateman, 1993; Saffioti, 2001) to investigate the lives of women with HIV/AIDS who suffer violence, implies recognizing them as subordinate, dominated, and exploited subjects since the social guarantee of its integrity is conditioned to male tutelage. The patriarchy playbook imposes on women passivity, formalism, and silence as a “screen in front of the public,” cemented by the myth of romantic love. Women are socialized to seek a partner, to yield to male sexual desire, regardless of what they want. However, those who acquire HIV/AIDS are seen as promiscuous and sexually reckless. Thus, in sexist and conservative contexts, there is an exacerbation of prejudice, stigma, and social rejection of women who do not behave according to the canons of patriarchy. Besides, health services, in most cases, focus their practices only on the biological aspects of AIDS and clinical care, with no concern with the integrality of care and with psychosocial problems that affect women (Gottert et al., 2016; Marcondes Filho, 2001).

The aim of this study was to explore the experiences of gender violence in the trajectory of women living with HIV.

Methodological strategies

This is a qualitative study in which narratives of women with HIV/AIDS who were victims of gender violence were heard. The narrative made

it possible to broaden the understanding of the women’s life context and to highlight elements that are invisible in the daily life of services and health care directed at them. Furthermore, it recognizes the importance of listening and narratives as a rescue of the narrator’s memory and voice (Marre, 1991).

The research participants were heard in 2013 at the Specialized Care Service for STD/HIV/AIDS (SAE) in a medium-sized city in the interior of Rio Grande do Sul, which, at the time of the survey, ranked 5th in Brazil in cases of HIV/AIDS. The choice for the location considered the high incidence of the disease (Brasil, 2014).

The study is part of a larger study in which, in the quantitative stage, 160 women who lived with HIV/AIDS participated (Cecon; Meneghel; Hirakata, 2014). When evidencing the high prevalence of violence (75%), women who reported having suffered gender violence were asked to freely narrate their life stories. Thus, 61 women over the age of 18, who lived with HIV/AIDS and were registered with the SAE, were heard. They spoke spontaneously about their life trajectories, reporting feelings related to living with HIV/AIDS and violence, based on the triggering question: “*Tell me your life and talk about HIV and the violence you have suffered.*”

The narratives allow us to understand how people construct explanations for their own experiences and the contexts in which they are inserted (Mishler, 1986, 1999, 2002; Ochs; Lisa, 2001; Riessman, 2008). The material obtained in the interviews was transcribed and organized according to two thematic categories: *gender*, defined *a priori*, and *naked life*, which emerged from the analysis of the material, being a concept developed by Giorgio Agamben (2004) to describe the process of necropolitics undertaken by governments in the current stage of capitalism, by leaving certain population groups absolutely excluded and unprotected.

The understanding of the narratives was based on the *critical discourse analysis*, aiming to show how the discursive practices are related to the socio-political structures of power and domination in society. The narrative discourse was understood as a social

practice that constitutes reality and how social actors are built for performance and resistance (Mishler, 1986, 1999, 2002; Ochs; Lisa, 2001; Riessman, 2008).

The research respected the recommendations of the Declaration of Helsinki (AMM, 1964) and was conducted according to Resolution No. 196/1996 of the National Health Council (Brasil, 1996). The study is part of a doctoral thesis presented to the Postgraduate Program in Nursing at the Federal University of Rio Grande do Sul, and the project was approved by the Research Committee and by the Research Ethics Committee under number 22209.

Results and discussion

Gender and violence: the lives of women with HIV/AIDS

The narratives produced by women showed female itineraries marked by unequal power relations that occur in a class-based society, which is racist and patriarchal. Violence was understood as any act that results or is likely to lead to physical, sexual, psychological, or suffering for women, including the threat of such acts, coercion, or arbitrary deprivation of liberty in a public or private environment (WHO; UNODC; Unids, 2012).

It became evident that the women interviewed are on the other side of the line (Santos, 2006), included in the modern sub-humanity in which the excluded live, those who are not even considered candidates for social inclusion since the current stage of capitalism separates groups by apartheid. Thus, these poor, black, uneducated, prostitutes and women with HIV/AIDS are inserted in the sub-humanity destined to sacrifice (Santos, 2006), with another humanity composed of included individuals considered *universal*, represented by white and rich heterosexual men. It is not a matter of deviations from alleged normality, but of being placed in a marginalized place, due to poverty, skin color, low education, less valued jobs, and the disease that causes abjection (Veiga-Neto, 2011), as shown below:

I've suffered my whole life. I've lived on the street, never went to school, I don't even have anything to eat. My ex-husband raped me my whole life. In the

city where I live, no one wants to know about me, not my family, not a health clinic or the police. Then came HIV. When I thought there could be no more suffering, I got AIDS. It's a joke, right? I didn't even know what that was. I found out in pregnancy and I despaired, I thought I was going to die. My life is over. It was supposed to be a good time, my daughter coming into the world, but it was awful. He already had AIDS before I met him, and he never told me. My life was over. (female, 26 years old, poor, black)

The women interviewed reported having suffered rights violations throughout their lives, mainly limitations on access to school, work, health services, and security. They live in a city where poverty and social exclusion have intensified in recent years, in a context of growth and wealth of agribusiness, undertaken by regional elites. Financial and social power is perpetuated for generations among a few families, aggravating social inequalities (Campos, 2011).

The fact that the women interviewed reported restricted or non-existent access to housing, education, food, income, and protection throughout their lives shows the situation of political, legal, and social unprotection determined by the absenteeism of the State and the predatory performance of non-state agents (Santos, 2006). State absenteeism can be considered in situations where the services are only symbolic, not guaranteeing the implementation of protective measures, or exist with such scarcity that they fail to achieve minimum coverage, such as temporary shelters for women in situations of violence or the insufficient number of professionals in the SAEs.

The AIDS epidemic in Brazil affects a large number of women and poor, dispossessed, voiceless, and powerless people who are *on the other end of the line*. In addition, institutions broadcast increasingly authoritarian and conservative speeches, which include mandatory heterosexuality and threats to women's sexual and reproductive rights, such as non-access to HIV prophylaxis after sexual violence, increasing female vulnerability (Carvalho; Piccinini, 2008). The social determination of health/disease is replaced by the attribution of individual

responsibility, and sexually transmitted diseases are seen as the result of morally objectionable behaviors. Thus, women with HIV/AIDS are considered transgressive and promiscuous, with no empathy for them and no social commotion with their deaths (Sontag, 1989).

The patriarchal, capitalist and racist ideology in force in society divides and separates, excludes, and limits access to rights, focusing mainly on the most vulnerable in terms of economic condition, gender, and race. It is empowered in politically democratic societies in its formal, yet authoritarian, conservative, violent, and exclusionary mechanisms in practice (Ceccon, 2016). This ideology is also configured as a state of exception that operates using violence as a mechanism of control, discipline, and submission, and the naturalization and trivialization of violence, in addition to blaming the victims themselves, a fact that hinders their confrontation (Santos, 2002; Segato, 2007). This mechanism maintains the abyssal line between women who will be protected and cared for and those whose lives are eliminable, invisible, and disposable. They constitute precarious lives, such as the interviewed black and poor women who acquired HIV/AIDS and whose only certainty, after diagnosis, is that “life is over.”

The subordination/exploitation of women through violence is part of the current phase of capitalism, denominated as “apocalyptic,” whose lives are tied to a “politics of violence” (Segato, 2003). This situation, observed in the study, was considered a marker of gender inequality, in which women with HIV/AIDS reported having suffered, throughout their lives, assaults of various types, perpetrated by people who fulfilled the function of care, such as family members, parents, brothers, husbands, companions, boyfriends, and even bosses and strangers. The trajectories are constituted by violations of rights that resulted in violence and acquisition of HIV:

Since I was a child, I was sacrificed by my family and had to work early. I was adopted by many people and always returned. It was a house with 10 brothers, and I, the eldest, had to clean, please,

wash, cook, mop, and take care of them. [...] I couldn't study. I can barely read. I was beaten like an animal by my father and my brothers. With canes, splinters of wood, and whatever they found around. My mother was also beaten. Nobody ever took care of me. My uncle had been abusing me since I was six years old. He ran his finger and tongue over my vagina and my anus. He took my hand and put it on his cock. But he never penetrated. When I cried, he told me to shut up and not tell anyone, otherwise, he would kill me. This went on for five years, and I still suffer from it today. (woman, 50 years old, white, poor)

Women reported that physical and sexual aggressions were frequent in childhood, a situation that forced them to secrecy, constituting family practices, a place where violence is used to correct, discipline, and submit (Garbin; Queiroz; Rovida, 2012; Santos, 2002). Furthermore, in the family, the hierarchy and obedience of the family group are directed to the male figure, characteristics naturalized and legitimized by the patriarchal system (Narvaz; Koller, 2004).

In adulthood, they continued to suffer psychological, physical, sexual, and patrimonial abuse by men who were parents, brothers, boyfriends, husbands, partners, bosses, or pimps. Violence, as a fundamental part of the patriarchal social mandate, is a condition for the reproduction of unequal relations, with positions marked by hierarchical distancing. This means that violence plays a necessary role in the reproduction of the symbolic economy of power and gender inequality (Segato, 2003). The reports of violence, present in all life stories, indicate how much this fact is part of the process of subordination of women with HIV/AIDS:

He threatened me with death, called me a bitch, said I fucked anyone. He was rude and stupid. [...] I've never been beaten so much in my life. Every day, I was beaten. After we got married, he became a demon: he used to hurl me against the wall, hit me on the head, knock me down. I had a black eye and a sore head. When I managed to get rid of him, I became a hooker. It was the way

I found to survive because I had never studied or worked in my life. I was dependent on him for everything. I ended up suffering more. (woman, 30 years old, black, poor)

Violence works as a punishment against women who have left their place, from subordinate and tutored positions in a status system. This place shows the signs of female sociability and sexuality, governed by the needs and interests of men, and the simple movement of women in a position that is not intended for them in the hierarchy puts into question the male position in this structure, based on status as a value in the system of relationships. Violence is used to discipline and control, and the act of punishing and depriving women of vitality is also a moralizing gesture. This social mandate is not aimed at a specific woman, but at a generic woman, since her subjection is necessary for the rapist's symbolic economy and for the balance of the gender order to remain intact. Generic women are those who are subject to the feminine role, whose fixed itinerary in the structure reinforces the need for violence marked by gender inequality (Segato, 2003).

A group of women interviewed only found the possibility of survival in prostitution. This activity, which, in past times, was managed by women themselves, has now been appropriated by the Mafia patriarchy, making them need to pay for the "protection" of pimps and hustlers, which means an increase in exploitation. Currently, the sex market and the sexual exploitation of women is one of the most profitable sectors worldwide. In this market, prostitutes are given the status of sexual objects, which can be easily discarded when they become ill, rebel, or grow old, and it is maintained continuously by the entry of poor young people, minority ethnicities, migrants, and those from countries at war or war conflicts, where they are the target of human trafficking, drugs and commercial sexual exploitation (Carcedo, 2010). Among the factors that lead young women to prostitution are poverty, family abuse, pregnancies without resources in traditional societies, and the lack of social and financial support networks (Ribeiro; Oliveira, 2011).

The practice of prostitution is, most of the time, carried out in territories where the law of the strongest and violence prevails, where gangs, dealers, pimps, male escorts, and hustlers prevail, which subject women to violence, abuse, and exploitation. As users pay for sex, they feel entitled to use the paid body according to their wishes, making them objects of violence and even death, in addition to causing a high risk of contracting HIV/AIDS, since many men reject condom use or withdraw it during sexual practice (Lipszyc, 2003). At the same time, prostitution operates in places of production of affections and cultural, academic, and political products. It is carried over and built by people with subjectivities that do not fit into cohesive constructions of "groups," let alone "risk groups" (Guimarães; Merchán-Hamann, 2005).

The rights of women, often nonexistent or confiscated as a result of patriarchy, make them, instead of being citizens, subservient to men in all areas of life, in the form of submission or because they have a body capable of being sanctioned with violence whenever it breaks the rules. They are subjected to the patriarchal and capitalist system, excluded, victims of violence as a corrective practice, deprived of rights, citizenship, and reduced to precarious and unprotected lives. Furthermore, compared to other job options, prostitution can be understood as an effective way to guarantee these women a sufficient amount of money not only to survive but to rehearse a socioeconomic rise (Blanchette; Silva, 2009).

The production of naked lives

Social inequalities and gender-based violence can be considered one of the *modus operandi* to maintain patriarchal capitalism, exclude and reduce women to "naked life," a concept proposed by Agamben (2004) to refer to unprotected subjects, whose lives are expendable. Poor, black, and HIV-infected women become deprived of possibilities since the protection mechanisms used by the dominant groups in society are not available to them. However, these lives are not eliminated in clearly observable acts, but their survival is

rendered unsustainable, and the State, in its governance mechanisms, is the entity that lets them die (Agamben, 2004; Reihling, 2010).

Although letting women with HIV/AIDS die is not a deliberate act of power, biopolitical actions operate through mechanisms of coercion and control related to subtle practices that require the participation of women themselves (Reihling, 2010). Even if their lives are reduced to “naked lives,” forms of intervention need not necessarily occur through direct interventions. They can take place through the lack of efficient forms of protection, and, in the case of the disease, the non-availability of prevention, care, and health care mechanisms that consider women in full and have a significant expression in the population, through public policies, not being reduced to specific actions (Douglas, 1976).

The instances capable of determining the limit between protected life and “naked life,” politicizing the phenomenon of life by including it or excluding it from the legal sphere, are part of the biopolitical regime, which has the power to protect or discard the lives of these women. In this way, the state of exception, in which “naked life” is simultaneously excluded from the legal order and imprisoned in it, constitutes the contemporary rule and the hidden foundation of the sovereign organization of political bodies in the West (Foucault, 1976).

The narratives produced by women show that the State also does not guarantee sexual and reproductive rights, including access to contraceptive practices and HIV prevention drugs in the face of rape or guaranteed abortion provided for by law, according to the excerpt:

I went to live with an aunt because I didn't have a job. It was also there that I suffered my first rape. I was at home and I was abused by my cousin, who was 10 years older and much stronger. I cried, tried to kick, struggled. He took off my shorts and panties. After a while, he released me. He came on me. I was hurt, black and blue, with sore arms. I didn't look for a hospital or a police station. I never had a partner who wanted to use a condom. (female, black, 41 years old)

Most of the time, women are infected for not having adequate protection, for male refusal to use condoms, for suffering sexual abuse, rape, commercial sexual exploitation, or even in the course of dating and conjugal relations (Ceccon; Meneghel; Hirakata, 2014). The sexual morality of society reinforces “the myth of romantic love,” in which women must satisfy men at the expense of their sexual and reproductive autonomy (Santos et al., 2014).

The large number of women still infected by HIV in Brazil is an indication that there is a female contingent without autonomy to protect themselves, to use condoms and to refuse unwanted sex, acquiring HIV/AIDS early, although currently, the epidemic has increased again among men, especially homosexuals and in urban centers. However, in relation to women, it is still men who decide when, and how sex will be done. Therefore, gender inequalities maintained by patriarchy are conditions that, by subjecting and making women vulnerable, contribute to the production of leftover, superfluous, and expendable lives (Saffioti, 2001).

The trivialization of life also occurs when health services focus only on the clinical care of AIDS, ignoring the inequalities, violence, and suffering that affect them, thus breaking with the principle of integral care. Thus, the health sector provides, as a State, fragmented and partial care, which fails to meet the needs of users in its entirety:

Here at SAE, when I found out, they supported me. But they just wanted to know about medicines, consultations, and tests. The other misfortunes of life I had to deal with alone. I was beaten by my husband, I had no money to live, my son was in prison. I didn't even have the money to take a bus. I was unemployed. Those who work here do not have time to know if you are beaten, if you are hungry, if you suffer. (woman, 36, black, poor)

The care practices offered to women who have the virus are centered on biomedical interventions through early diagnosis, clinical consultations, periodic exams to monitor CD4 and viral load levels, and supply of medication. There is not always

non-judgmental and qualified listening, with the necessary time and the proper ambiance. These actions, by not including biopsychosocial aspects, constitute a fragmented biomedical practice restricted to the medicalization of life. Even so, these actions, which do not respect the principle of integrality, are not carried out in the same way for all women, with others that, due to difficulties in access or adherence, or even due to obstacles encountered due to race, ethnicity, class, sexual orientation or job insertion will receive unfair treatment, with discrimination and impairment in treatment adherence, many of them needing to live with disabling opportunistic diseases, and others dying precociously (Cecon; Meneghel; Hirakata, 2014).

Getting someone to live just with the supply of medication, treatment, and tests are not enough considering the precariousness of women's lives. The care of life goes beyond what is prescribed in the offerings of the health sector and definitely enters the field of politics. And AIDS remains one of the diseases that most have a political interface. Medicalization is unable to solve a series of questions derived from it, having to exercise other ways of responding to the disease, understood in its necessarily social face, although without giving up pharmaceutical advances (Paiva et al., 2015), although, at the present historical moment, even that is at risk.

Following the strategy of offering treatment and not facing the political side of AIDS establishes two action fronts that do not lead to the same objective. They represent counterpoints: one makes you live, another lets you die. One speech advocates for testing and treating, another denies equal rights. It is necessary to ensure the autonomy of subjects, regardless of race, gender, and social class to face the disease, and this implies designing possible futures for these lives because life's viability is also a project of happiness. It is necessary to talk about sex, rescue the erotic, promote access to human rights, and build a world of equal opportunities between people. AIDS indicates, above all, the precariousness of life - naked life - and is, therefore, a political problem that can be solved

with equitable and universal policies (Seffner; Parker, 2016).

This situation can be made invisible by the neutrality discourse of the clinical and biomedical model, which is not concerned with the desires and social, psychological, and affective needs of women (Reihling, 2010). On many occasions, due to the precariousness of their lives, they do not consider AIDS as a problem and do not realize the limitations of the care practices offered by the service.

Then AIDS came. But you know, I suffered so much in my life that this disease didn't seem like much to me. The SAE is for me to take my medication and do my exams. And this is fine with me. As for that, everything is fine. The problem is the other things in my life that no one even asks about. And this is my life: AIDS and beatings. So I already left SAE and then I had to go back dozens of times. (woman, 32 years old, black, poor)

The abandonment of care offered by the service was reported by several women and many others who were on the service register and have already abandoned it. In Brazil, there is a lot of evasion of users in SAEs, and the services do not carry out an active search, considering them as "archive," whose death is already contained in the metaphor. In turn, the services face difficulties, with incomplete teams of professionals, creating work overload and making it difficult to offer collective activities (Schraiber; D'Oliveira; Couto, 2009).

In relation to gender-based violence that affects women, the health sector is part of the coping network, but services are not yet concerned with identifying these situations, limiting themselves to treating injuries. Professionals, in most services, including SAEs, are limited to inquiring about the materiality of violence, doing little to change it, and women with HIV/AIDS are faced with the low resolution of the institutions that are part of the network to confront and prevent violence. The mechanisms used to curb aggression are also inefficient, as noted in this study, in which many of the interviewees had sought out the police to report the same aggressors who continued to victimize them (Meneghel; Hirakata 2011; Meneghel; Iñiguez, 2007).

To overcome situations of violence, society must deconstruct the ideological mechanisms that maintain hierarchies of power between the sexes (Meneghel et al., 2013), but the patriarchy continues to use these mechanisms to maintain the situation of submission/exploitation of these women, whose trajectories have been marked by so many inequities that they can only be considered as naked lives.

It is not possible to think of the State without relating it to the figure of the *homo sacer*, the one whose life is sacrificable - such as that of women with HIV/AIDS in this study - so that as long as there is a sovereign power, there will be naked life exposed to abandonment and death. The one who has power and who can sacrifice anyone without restrictions is sovereign is, while the *homo sacer* is the one who can have his life without possibilities and be eliminated without constituting a homicide. This is the treatment of the State for the poor and excluded classes, for those who live in the slums and apartheid regions of large cities. This is the treatment offered to those *on the other end of the line*. One of the ways to operationalize this regime is to limit the distribution of resources and social equipment, making universal access to rights guaranteed by the Constitution not for everyone, in such a way that a portion of the population is left to die (Agamben, 2004; Santos, 2002, 2007).

If the state of exception has become the norm in the contemporary world, there should be no surprise with the rise of totalitarianism, with the existence of extermination camps and refugees, with the increasing number of slums, with the ostensible presence in the territories of paramilitary groups, militias, and mafias, responsible for the summary elimination of the undesirable people. In today's society, the biopolitical regime becomes increasingly rigid, continually redefining and reducing the threshold between what is within the political order or the lives that will be protected and the lives that are on the other side, considered superfluous lives (Agamben, 2004).

Agamben's reflection helps to identify contemporary types of *homo sacer* as the legal status of modern biopolitics. Among these types, there are

the human guinea pig for medical experiments; the patient in a deep coma kept alive by technological means; survivors in refugee camps; suspects linked to terrorism or illegal immigration, detained and held incommunicado; the inhabitants of ghettos and slums on the outskirts of large cities, especially in cases where the confrontation between two sovereign forces, the police, and organized crime, generates a space of indistinction in which naked lives are discarded. This process occurs when a woman, a citizen and a holder of rights, starts to be considered a life that does not deserve to be lived, whose elimination through negligence or even murder is simply filed or forgotten without punishment (Agamben, 2004).

Final remarks

In this study, we extended the condition of *naked life*, formulated by Agamben, to women with HIV/AIDS, poor and black women, who reported paths crossed by violence, exclusion, exploitation, and gender inequalities. Not all women with HIV/AIDS can be included in this condition, and Brazil remained, until 2016, a reference for HIV/AIDS, investing billions of reais in medicines and in a network of services to carry out diagnosis, treatment, and monitoring of patients. However, when the focus of HIV/AIDS care focuses only on clinical aspects when the principles of integrality and equity are broken when the life situation is so precarious that AIDS becomes a secondary problem, and when the patients leave the service, these women may be in the condition of mere "naked life." Killable, superfluous, and disposable life.

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WHO - WORLD HEALTH ORGANIZATION; UNODC - UNITED NATIONS OFFICE ON DRUGS AND CRIME; UNAIDS - JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS. *WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users: 2012 revision*. Geneva: WHO, 2012.

Authors' contributions

All the authors conceived and designed the project, analyzed and interpreted the data, wrote the article, carried out its critical review and approved the published version.

Received: 03/05/2018

Resubmitted: 06/22/2020

Approved: 07/31/2020