

Social representations of HIV/AIDS among healthcare professionals in benchmark services

Representações sociais do HIV/AIDS por profissionais de saúde em serviços de referência

Representaciones sociales de VIH/SIDA por personal de salud en servicios de referencia



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ABSTRACT

This study was based on exploratory research and a qualitative approach within the framework of the Social Representations Theory. It aims to capture the social representations of healthcare providers in relation to HIV/AIDS by describing their structure. The Free Evocations technique was applied on 86 professionals of HIV/AIDS benchmark services in Recife, Pernambuco, Brazil, from 2011 to 2013. Analysis using EVOC 2005 software showed that the possible central core is prejudice in a negative attitude dimension; in the contrast zone, chronic disease translates living with the disease. In the first periphery, treatment and disease in a clinical/biometric conception; in the second periphery, death has a imagistic and negative nature. Positive and negative elements were observed, allowing healthcare personnel to construct meaning attributed to the phenomenon and reflect on their practices.

Descriptors: Social perception. HIV. Health personnel. Nursing.

RESUMO

Pesquisa exploratória, descritiva, com abordagem qualitativa, apoiada na vertente estrutural da Teoria das Representações Sociais. Visa apreender as representações sociais de profissionais de saúde sobre o HIV/AIDS descrevendo a sua estrutura. Aplicou-se a Técnica de Evocações Livres com 86 profissionais de serviços de referência em HIV/AIDS de Recife, Pernambuco, Brasil, no período de 2011 a 2013. A análise pelo software EVOC 2005 apontou como possível núcleo central o preconceito numa dimensão atitudinal negativa; na zona de contraste, doença-crônica traduz o convívio com a doença. Na primeira periferia, tratamento e doença revelam uma concepção clínica/biomédica; na segunda, a morte possui caráter imagético e negativo. Evidenciaram-se elementos positivos e negativos, possibilitando aos profissionais de saúde a construção de sentidos atribuídos ao fenômeno e reflexões sobre suas práticas.

Descritores: Percepção social. HIV. Pessoal de Saúde. Enfermagem.

RESUMEN

Investigación exploratoria, descriptiva, con abordaje cualitativo, basada en el enfoque estructural de la Teoría de las Representaciones Sociales. Tiene como objetivo asimilar las representaciones sociales de personal de salud sobre el VIH/SIDA describiendo su estructura. Se aplicó la Técnica de Evocaciones Livres con 86 personal de salud en servicios de referencia en la materia de VIH/SIDA en Recife, Pernambuco, Brasil, en el período 2011-2013. El análisis realizado por el software EVOC 2005 apuntó como posible núcleo principal el preconceito en una dimensión de actitud negativa; en contraste, la enfermedad crónica muestra la convivencia con la enfermedad. En la primera periferia, tratamiento y enfermedad muestran una concepción clínica/biomédica; en la segunda, la muerte tiene imágenes y carácter negativo. Quedando en evidencia elementos positivos y negativos, dando la posibilidad al personal de salud la comprensión de los sentidos atribuídos al fenómeno y reflexiones sobre sus prácticas.

Descriptor: Percepción social. VIH. Personal de salud. Enfermería.

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■ INTRODUCTION

The human immunodeficiency virus (HIV) and the acquired immune deficiency syndrome (AIDS) are a global threat with epidemiological, social, cultural, economic and clinical repercussions. They demand efforts from all of society and its components, such as healthcare professionals, to prevent their dissemination and help improve the quality of life of sufferers.

In this context, this study presents the HIV/AIDS phenomenon as the object of investigation. Concern in relation to this topic is based on the need to know social representations and their influence on the practices of healthcare professionals based on the symbolic constructions of HIV/AIDS and its sufferers.

In 2012, the global AIDS epidemic affected around 3.5 million people living with HIV/AIDS (PVHA) and resulted in 2.3 million new infections worldwide. On the same year, an estimated 530 to 660 thousand Brazilians were living with AIDS in all age groups, of which 34 thousand were new cases of the disease and 11 to 19 thousand were deaths resulting from the disease⁽¹⁾.

In Brazil, 39,185 cases of AIDS were notified and the incidence rate was 20.2 cases for every 100,000 inhabitants in 2012. The mortality coefficient was 5.5 for every 100,000 inhabitants, of which 4.0 were in the north-east. Although this region has the lowest incidence rate (14.8) with 20.3% notified cases of the disease, Pernambuco ranks 10th among the 27 Brazilian states, with a 20.9 detection rate, considered one of the highest rates in relation to the national average (20.2/100,000 inhabitants), and a higher mortality coefficient (6.0) in relation to the national average⁽²⁾. Data of the Ministry of Health show that, of all the north-eastern capital cities, Recife, the capital of Pernambuco, ranks second (39.0/100,000 inhabitants) in the list of highest incidence rates in 2012. This same year, the national gender ratio was 1.7 new cases in men for every woman's case⁽²⁾ and the north-east represented 1.6 of this ratio in 2010⁽³⁾.

The evolution of AIDS emerges in different population groups, subject to distinct and vulnerable risk conditions or characteristics of HIV infection. Collectively, this is a crucial moment of the global HIV/AIDS epidemic⁽²⁾ characterized by the need for changes of attitude in society, greater protection in all social groups, the application of political and therapeutic directives, confrontation of social and structural barriers of diagnosis and care, and the stigma and discrimination associated to HIV, all of which represent huge challenges⁽⁴⁻⁵⁾.

The dynamics of this phenomenon, both globally and in Brazil, suffered epidemiological and social transforma-

tions in recent decades, revealing an interiorization profile; migrating from the middle and upper classes to the lower classes; from artistic and cultural scenarios to marginalized groups such as homosexuals, sex workers and drug users. It also affected social groups considered not vulnerable to the syndrome, such as heterosexuals, monogamous women, the elderly and children⁽⁶⁾.

Based on this premise, the representativity of HIV/AIDS in the global epidemiological profile and the need to know the social processes that involve individuals, collectivities and their relationship with the disease justify conduction of a study on the social representations of HIV/AIDS. Moreover, healthcare professionals are fundamental actors in this process, as they can help make significant changes in the behavioural pattern of patients, family members and society.

Social representation is defined as a form of knowledge produced socially that can determine the common reality of a social group⁽⁷⁾. Considering that social thought consists of common sense and the way in which individuals and groups see the world, the dynamics of interaction among subjects can determine their social practices. In this context, we are capable of altering our behaviour according to the internal representation we fabricate or inherit from society⁽⁸⁻⁹⁾.

It should be noted that social representations are important for the professional approach to HIV/AIDS, as they enable the apprehension of processes that construct a social meaning of the object in daily relationships with the subjects, thus building a symbolism that supports healthcare practices. Furthermore, they allow the elaboration of practical knowledge that adheres to value, standards, beliefs and recollections that are shared by the group, and the scientific knowledge that is translated into social and professional representations⁽⁶⁾. The daily practices of these groups are influenced by their perceptions of AIDS through constructions, representations and stereotypes contained in the subjectivity of these associations⁽¹⁰⁾.

A deeper insight into the phenomenon of social representations surrounding AIDS, in the context of healthcare providers, can have social implications in the configuration of practices, especially in relation to people living with HIV/AIDS⁽¹¹⁾. In light of the verticalized nature of healthcare process, the work of health professionals, especially nurses, requires the advancement of critical and reflexive clinical practices that allow the participation of the individual in the construction of subjectivity⁽¹²⁾.

People living with HIV/AIDS need a different perspective and it is up to the nursing professionals to have the sensitivity to perceive feelings, attitudes and beha-

viour and to provide information on the disease, its appropriate treatment and overall care. These professionals should also strengthen the bond with these sufferers and help them find strategies to adapt to this reality⁽¹³⁾. They should develop the rational, sensitive, affective and intuitive dimensions to help patients and provide care that is compatible with the different needs of individuals, families and collectivities.⁽¹⁴⁾

The investigation of social representations can arouse an interest in conducting studies on other domains based on understanding the totality of social phenomena and their development. This study may contribute to improving the practices of healthcare professionals who provide care for people living with HIV/AIDS at all care levels. Considering the importance of acquiring knowledge on the actual representational phenomenon and on HIV/AIDS, it is important to develop this topic. Consequently, this study is based on the following guiding question: what is the social representations framework among healthcare professionals in relation to HIV/AIDS?

The aim of this study is to capture the social representations of healthcare professionals on HIV/AIDS, by describing their framework.

■ METHODOLOGY

This is a descriptive, exploratory study based on a qualitative approach and inserted in multi-centric research titled, "The transformations of healthcare and nursing in times of AIDS: social representations and recollections of nurses and healthcare professionals in Brazil". This study was supported by the Social Representations Theory that embodies the Central Core Theory proposed by Jean-Claude Abric, when determining the organization and constitution of social representation, which presents several elements surrounding the central core, granting it a meaning⁽⁸⁾.

The study scenarios were benchmark services that comprise out-patient and hospital units, including a Testing and Reception Centre (CTA), and seven Specialized Care Services (SAE) linked to the provision of care, prevention and treatment of people living with HIV/AIDS, in Recife, Pernambuco, Brazil. These services provide healthcare to people suffering from HIV⁽³⁾, which, in Brazil, is offered by the Unified Health System (SUS) and governed by the same directives. The SAE are inserted in a heterogeneous complex of services with units that are connected to the units of primary care or out-patient care or specialized care⁽¹⁵⁾.

The sample comprised 86 participants of the services selected for this study and complies with the multi-centric

research sample number of up to 100 healthcare providers. The larger the group of participants, the more stable the results, as they allow a more accurate idea of the reality of the subjects and more reliable estimates of this phenomenon in the population⁽¹⁶⁾.

Inclusion criteria were: permanent staff member of the institution, actively working for at least six months in the development of healthcare practices related to people living with HIV/AIDS. The professional experience of these participants was observed due to the possibility of increased approximation with the phenomenon and the real needs of patients. It is believed that assiduousness at work and background provide professionals with greater knowledge and better adaptation in relation to the daily work dynamics in this field of intervention. Professionals who were on holiday or leave and those who did not meet the criteria and did not accept to participate in this study were excluded.

Data were collected at the study locations from February 2011 to August 2013 with the application of the Free Word Association/Evocation Technique. The adopted instrument was a standardized questionnaire consisting of questions based on free associations. This technique requires that participants answer using three to five words after the researcher's request. The spontaneous nature of these evocations approaches reality⁽¹⁶⁾.

It should be noted that the questionnaires were scheduled during the day shift according to availability of participants and suggested dates and times. The questionnaire was applied individually for 20 to 30 minutes and, at another encounter, participants were interviewed for an average duration of 1 hour.

The evocations were recorded in writing by the interviewers as the participants associated five words and/or expressions to the inducing term "HIV/AIDS", listed in order of importance, from the least to the most important, informing positivity, negativity or neutrality. The instrument also presented a block of personal and socio-professional characterizations on the studied group.

Empirical material obtained from the questionnaire was analysed using the Free Association Technique, commonly adopted for a structural characterization of a social representation⁽¹⁶⁾. EVOC software, version 2005, was used, provided by the involved institutions.

The project was approved by the Research Ethics Committee of the inserted universities, with Certificates of Ethical Appreciation (CAAE) nº 0045.0.325.000-10 and 01080.0.097.000-11. Recommendations of Resolution nº 466/12, of the National Health Council were observed. Participants signed an informed consent statement to safe-

guard confidentiality of data and establish the right to stop participating in the study without prejudice.

Data used in this study are from the Master's dissertation⁽¹⁷⁾ of an Associated Graduate Nursing Programme with the scientific support of a scholarship of the Coordination for the Improvement of Higher Education Personnel (Capes).

■ RESULTS AND DISCUSSION

Initially, participants were briefly characterized to identify their personal, social and professional profiles. Of all the participants, 80.2% were women. In relation to age group, 23.3% were under 35 years of age, 24.4% were between 36 and 45, 39.5% were between 46 and 55, and 12.8% were over 56.

In terms of functions, physicians represented 27.9%; in the nursing team, 16.3% were nursing technicians, 9.3% were nurses, and 2.3% were assistant nurses. Other participants were psychologists (16.3%), social workers (11.6%), dental surgeons (4.6%), pharmacists (3.5%), nutritionists (3.5%), biomedical doctors (3.5%) and others (1.3%).

It was observed that 86% of the studied subjects worked in the SAE, 14% in CTA, 40.7% had been conducting work activities with people living with HIV/AIDS for less than 5 years, 36.7% between 6 and 15 years; 22.1% from 16 to 25 years, and 3.5% had started providing this type of care more than 26 years ago.

The representational structure of HIV/AIDS among professionals was presented in the structured chart (chart 1) using EVOc. The participants evoked a total of 439 words associated to the term HIV/AIDS, of which 145 were different. Minimum frequencies (6.0) and average evoked words (12.0) were presented, together with Rang Moyen (3.0), that corresponds to average word position expressed by the Average Evocation Rank (AER).

In this sense, the arrangement of quadrants comprised: top left quadrant or central core, top right quadrant or first periphery, bottom right quadrant or second periphery and bottom left quadrant, called contrast zone.

The use of EVOc helped to identify the possible central core of HIV/AIDS representation made up of the elements: prejudice, treatment and disease, present in the top left quadrant with frequencies above 12.0 and average evocations under 3.0, corresponding to the most frequent and most promptly evoked words.

This quadrant indicates the stability of the representation, awarding it meaning⁽¹⁸⁾. It signals the most frequent and important elements, and can group less significant terms with synonyms and prototypes associated to the object. It should be noted that not all the terms of this

quadrant are central, but this quadrant does contain the central core⁽⁸⁾.

The representations are presented as "inhibitors of conduct; they permit their justification in relation to social standards and their integration"^(8:168). For the healthcare professionals, considering that this disease is incurable, devastating and of unknown transmission, AIDS was marked by fear, negative fantasies, a feeling of death, discrimination and rejection, as it mostly affects individuals who are stigmatized by society, such as homosexuals, users of injectable drugs and sex workers⁽¹⁹⁾. This affirmation is similar to the approach constructed by society in general about prejudice and, although there is a transformation in the epidemiological profile of the affected groups, prejudice is still explicit according to the social representation.

In relation to the centrality of terms, it is believed that the prejudice evoked by the healthcare professionals of the study emerges as an attitude element directly associated to the imagistic content built by society and maintained since the origin of the disease. This proposition reveals a negative attitude element and seems to incorporate an implicit attribute between the professional categories. This term refers to social prejudice, known as that which others, that is, family members, neighbours, friends and colleagues, associate to HIV/AIDS.

In spite of advancements in public prevention and assistance policies for HIV sufferers in Brazil, confronting AIDS requires the overcoming of prejudice and fear and increased knowledge on the disease. These issues go beyond information, as they demand changes in the way people view the world, their beliefs and the ability to accept the singularity and diversity of others⁽²⁰⁾.

In relation to elements of the central core, the terms disease and treatment have a neutral connotation. Disease refers to identifying the virus as a concrete and imagistic meaning. Treatment is a functional and positive element that defines confrontation of the disease in terms of medication and clinical aspects; it presents a dimension of knowledge about HIV/AIDS and is also reported in the first periphery as adherence to treatment, reflecting the contribution of antiretroviral treatment and the need to ensure disease control. These terms are associated to the clinical/biomedical conceptions that professionals build around the studied object.

In the field of professional practices for HIV/AIDS, the treatment dimension points to adherence to treatment that can strengthen adaptation to the disease. Furthermore, the start of antiretroviral treatment improves the quality and duration of life of people living with HIV/AIDS^(11,5).

On the organization of social representation, there are peripheral elements surrounding the central core that are

AER	< 3			≥ 3		
Av. Freq.	Evoked term	Freq.	AER	Evoked term	Freq.	AER
	Central core			1 st periphery		
≥ 12	prejudice	47	2,128	treatment-adherence	20	3,200
	treatment	22	2,409			
	disease	16	2,063	prevention	16	3,188
Av. Freq.	Contrast zone			2 nd periphery		
< 12	fear	11	2,727	hope	8	3,500
	care	10	2,700			
	struggle	7	2,857			
	suffering	7	2,147			
	abandonment	6	2,833			
	medication	6	2,667			
	chronic-disease	6	1500			
			death	8	3,500	
			overcoming	7	3,286	
			help	7	3,000	
			sadness	6	3,000	

Chart 1. Analysis of the inducing term “HIV/AIDS” of the evocations of healthcare professionals. Recife, Pernambuco, Brazil, 2013. Source: Research data.

expressed as retained, selected and interpreted information, judgements made on the studied object, stereotypes and beliefs⁽⁸⁾. The quadrants arranged on the right correspond to the first periphery (top) and the second periphery (bottom), both of which express the reality that is closest to the individual's experience⁽¹⁸⁾.

In this study, the first periphery consists of the element of treatment-adherence and prevention that have a positive dimension on the knowledge that professionals have in relation to HIV/AIDS. The lexicons hope, death, overcoming, help and sadness were identified in the second periphery and carry a positive and negative connotation. Among the positive expressions, hope and overcoming are supported on an affective/attitudinal dimension that converges with the satisfactory impact of treatment, and help is inserted in the dimension of knowledge. Death and sadness are negative terms, and death is characterized by the imagistic dimension of disease and can be associated to the onset of the epidemic.

Analysis showed a possible representational change when compared to a more remote period of the disease. These data remit to the assimilation of AIDS as a chronic disease and allow visualization of a distancing from death, manifested as an opposite representation to the primary conceptions synthesized by social groups.

The bottom left quadrant can represent a representational subgroup, showing groups with other ways of thinking about the object⁽¹⁸⁾. Also called the contrast zone, this scheme comprises affective elements such as fear, suffering and abandonment inserted in the attitudinal di-

mension and carries a negative connotation. This way, the phenomenon can be considered as a chronic disease also presented as an element of contrast.

Fear refers to the apprehension of professionals on treatment of the virus and risk of infection, which can be associated to the expression care, signalling the precautions that health providers must adopt. In this perspective, prevention constitutes a peripheral element of a clinical/bio-medical nature that can also reinforce the idea of disease in the possible central core.

Among the elements of contrast, medication converges with the dimension of treatment and is attributed to the use of antiretroviral treatment. It is determined by the imagistic content and is present in the central core. Care, struggle and chronic-disease are reported when confronting the disease, still under the positive perspective of survival. The cognition of care is inserted in the dimension of knowledge and the term chronic-disease deserves special attention, as it requires a deeper understanding of its connotations related to AIDS. This expression does not yet constitute a clinical reality as the survival of people living with HIV/AIDS depends on antiretroviral treatment. Regardless, chronic-disease is configured as a subgroup of the representation of the studied professionals that can incorporate this notion at a central level. This perception of the phenomenon is related to confronting the disease in the sense of maintaining health and prolonging life.

Among the elements that are negatively projected in the quadrants, the peripheral term death and sadness are related to the challenges experienced by these sufferers.

In relation to the affective/attitudinal dimension, contrast evocations expressed by fear, suffering and abandonment can determine an unfavourable connotation in terms of confronting the disease.

In relation to the actual professionals, fear of viral contamination constitutes a challenging reality. It is also probable that they experience some level of suffering when dealing with adversities. Abandonment seems to be another controversial issue due to the exclusion processes that can result from the self-exclusion of sufferers or exclusion from other social groups.

Some representations directly influence practices⁽⁹⁾. The HIV/AIDS diagnosis causes a huge impact on the lives of sufferers and can lead to significant changes in their personal planning of the future. During the health/sickness process, there is some adaptation to living with the disease and the perception of quality of life is reconstructed. AIDS progressively acquired the characteristics of a chronic disease based on overcoming some stereotypes that facilitate living with HIV^(20,15).

In this investigation, medication was a contrast lexicon that reaffirmed adherence to treatment, sustained by adequation to antiretroviral treatment and satisfactory acceptance of the disease. Consequently, this interaction can ensure a better quality of life for the sufferers of this disease.

In general, on the positive aspects, in the peripheral scheme, the lexicons prevention and help reflect the knowledge of health providers in relation to the phenomenon; hope and overcoming are congruent with the idea of living with the disease. The words care, struggle and chronic-disease positively emerged from the contrast zone, being that care is understood under different viewpoints, and can be chiefly associated to the precautions care professionals must take to prevent contamination of HIV.

■ FINAL CONSIDERATIONS

Data obtained from the structural approach showed positive and negative elements in the representational content of HIV/AIDS. In terms of representation, central elements and their direct association to peripheral and contrasting expressions were observed, justifying the relevance of antiretroviral treatment and the possibility of living with the disease. This interface translates the connection between processes supported in the clinical/biomedical dimension apprehended by the participants.

Many elements evoked by the professionals are thought to converge toward a favourable adaptation to the

HIV seropositive condition, related to a greater chance of survival. These results enable healthcare professionals to understand meanings attributed to the phenomenon and allow new reflection on their practices, which are still linked to values and historical and affective conceptions.

Results of this investigation can be useful to strengthen healthcare actions directed at patients living with HIV/AIDS, and to overcome prejudice and stigmas that can influence professional practice. These results can also reveal representational characteristics that can modify care-related conduct.

It should be emphasized that the professionals in this study work in benchmark HIV/AIDS services inserted in hospitals, allowing the presumption of an association with the therapeutic conception based on the clinic and biomedical model incorporated to their professional education and care practices.

Study limitations included the need to expand research to other care services, including primary care. In academic terms, the study can contribute to discussions and encourage new investigations on social representations in the fields of healthcare and nursing.

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