

# HIV/AIDS: meanings given by male health professionals

*HIV/AIDS: significados atribuídos por homens trabalhadores da saúde*

*HIV/AIDS: significados atribuidos por hombres profesionales de salud*

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## ABSTRACT

**Objective:** The objective was to investigate the meanings that male health professionals attribute to HIV/AIDS. **Methods:** It was an exploratory study with a qualitative approach based on the Theory of Social Representations. It was conducted with 14 male health professionals in outpatient units in Recife, Brazil, 2012-2013. A questionnaire and a guided interview were used, which underwent Bardin's thematic-categorical content analysis. **Results:** Representations of HIV/AIDS are related to the social diversity of people living with HIV/AIDS and to the urgent multidisciplinary approach to support treatment adherence. Social prejudice is implicit in the image content of participants, who also emphasized multidisciplinary as a needful support for living with the virus. **Conclusion:** The present research raises reflections about social representations of HIV/AIDS, whose meanings emerge from the reality experienced by the subjects involved.

**Keywords:** Acquired Immunodeficiency Syndrome; Health Professionals; Men.

## RESUMO

**Objetivo:** O objetivo foi investigar os significados que homens trabalhadores da saúde atribuem ao HIV/Aids. **Métodos:** Estudo exploratório, com abordagem qualitativa fundamentada na Teoria das Representações Sociais. Realizado com 14 trabalhadores do grupo masculino em unidades ambulatoriais em Recife, Brasil, entre 2012 e 2013. Utilizados questionário e roteiro de entrevista, cuja análise baseou-se na técnica de análise de conteúdo temática-categorial de Bardin. **Resultados:** As representações do HIV/Aids relacionam-se à diversidade social das pessoas vivendo com HIV/Aids e à abordagem multidisciplinar premente como apoio à adesão ao tratamento. O preconceito social está implícito no conteúdo imagético dos participantes que também enfatizaram a multidisciplinaridade como um suporte indispensável para o convívio com o vírus. **Conclusão:** A investigação suscita reflexões acerca das representações sociais do HIV/Aids, cujos significados emergem da realidade vivenciada pelos sujeitos envolvidos.

**Palavras-chave:** Síndrome de Imunodeficiência Adquirida; Pessoal de Saúde; Homens.

## RESUMEN

**Objetivo:** Investigar los significados que los hombres profesionales de salud atribuyen al VIH/SIDA. **Métodos:** Estudio exploratorio con abordaje cualitativo, basado en la Teoría de las Representaciones Sociales. Se realizó con 14 trabajadores del género masculino en clínicas ambulatoriales de Recife, Brasil, entre 2012 y 2013. Se utilizó cuestionario y entrevista guiada, que fueron sometidos a análisis de contenido temática-categorial de Bardin. **Resultados:** Las representaciones de VIH/SIDA se relacionan con la diversidad social de los que viven con la enfermedad y con el abordaje multidisciplinar como apoyo a la adhesión al tratamiento. El prejuicio social está implícito en el contenido de las imágenes de los participantes que también enfatizaron la multidisciplinariedad como soporte necesario para vivir con el virus. **Conclusión:** La investigación plantea reflexiones sobre las representaciones sociales del VIH/SIDA, cuyos significados surgen de la realidad vivida por los sujetos involucrados.

**Palabras-clave:** Síndrome de la Inmunodeficiencia Adquirida; Personal de Salud; Hombres.

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## INTRODUCTION

The Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) are topics discussed worldwide whose genesis has ascendant epidemiological transformations that require further study in demographic, political, ethical, cultural, psychosocial and health aspects.

Since the early 80s, in the twentieth century, the identification of HIV/AIDS has been a challenge for the global scientific community, as it is considered a public health problem of great magnitude and of pandemic character that involves various social actors, reaching individuals without social, economic, racial, cultural or political distinction<sup>1</sup>.

In 2012, there were approximately 35.3 million people living with HIV/AIDS (PLWHA) in the world, and in Brazil, and 530-660 thousand people of all age groups were affected by the virus. Pernambuco occupied the 10<sup>th</sup> position of the Brazilian states, with a detection rate of 20.9 and mortality rate (6.0) higher than the national average. Of the Northeastern capitals, Recife occupied the second position related to higher incidence rates (39.0/100,000 population)<sup>2,3</sup>.

The emergence and the dynamics of evolution of disease reverberated on the institutions and health professionals, entering in the daily life of health services in Brazil, with important consequences for public policies and for the constitution of care practices<sup>4</sup>. In this context, it is extremely important studies that seek meanings about HIV/AIDS from the Social Representations of health workers, particularly male ones.

The Social Representations were conceptualized from a French study of psychoanalysis published in 1961, whose reflections became a basis for a theory of social psychology, which was widespread in various areas of knowledge, through the construction of categorical elements guided in the everyday reality of individuals in a given population<sup>5</sup>.

Social Representations (RS) emphasize holism and conceive common sense through the interactions between the beliefs, values and communication, linked to the social reality. They are intended to abstract the meaning of the world and to picture the world significantly through order and perceptions inserted in it, making what is unfamiliar into something familiar<sup>5</sup>.

Social representations are considered complex phenomena that encompass informative, cognitive, ideological, attitudinal, imagery elements, among other elements that are organized and allow characterizing a given reality. Social representations also reflect the way a person thinks about a particular object, which can be an individual, a phenomenon, a concrete or abstract material, an idea or a theory<sup>6</sup>.

The development of this theme occurred due to the opportunity to clarify the social representations of HIV/AIDS built by the male group, enabling the completion of gaps in studies related to care for PLWHA and the possible influence of cultural and social

aspects of men, which empower hegemonic interpretations that can affect the care process.

The use of the theoretical framework of social representations in researches conducted by health professionals has been intensified, often involving issues related to diseases and ways of care<sup>7</sup>. The deepening of the SR phenomenon around AIDS in the professional context of health workers can cause social implications in the process of configuring their practices, especially with regard to the care of HIV/AIDS<sup>8</sup>.

Hence the interest in conducting a study based on the Theory of Social Representations, as there are few works on this theme in the national literature. Therefore, this study had the following question the guiding principle: what are the meanings given by male health workers about HIV/AIDS?

Based on the foregoing, this study aimed to investigate the meanings that male health workers attribute to HIV/AIDS.

## METHOD

This is an exploratory study with a qualitative approach based on the Theory of Social Representations. We considered the procedural approach outlined by Denise Jodelet. This approach is considered the most classic follower of the guidelines proposed by Moscovici<sup>6</sup>.

The survey was conducted in six outpatient units included in hospital services, with a Center of Testing and Counseling (CTA) and five Specialized Assistance Services (SAE) in the city of Recife, Pernambuco, Brazil.

The study population consisted of male health professionals working in the selected reference services. To select the sample, the following criteria were met: professionals who have been working for at least six months in these services, who were actively working during data collection, and who had interest and availability to participate in the proposed study. Thus, considering the elected criteria, the sample consisted of fourteen male health workers.

Data collection was conducted from January 2012 to August 2013, through a questionnaire with information about the research participants and the interview technique from a script with questions concerning the objective of the study.

Please note that the data were collected in the study locations, usually at the beginning or end of patient care, through scheduling according to availability of professionals. We used a digital recorder to capture the workers' speech.

Later, we transcribed the interviews in full and they were coded according to the professional category, in order to maintain the anonymity of the participants. Thus, medical professionals have been identified by the letter "M" followed by numbers, from one to eight. Example: the first medical professional who attended the interview was coded as follows: "M1"; the second doctor, "M2" and so on. The nursing technician was represented by the code

"NT" and was also followed by numbers from one to three. Others who professionals had only one representative were named by the first letter and number one. Therefore, the psychologist was presented by "P1", the dentist "D1" and the pharmacist "F1".

The empirical material was analyzed according to the thematic-categorical analysis technique proposed by Bardin, which consists of a set of methodological tools applied to several speeches, allowing the researcher to analyze what is latent, not apparent and the unprecedented potential of the message<sup>9</sup>.

In this sense, the organization of content comprises three phases: pre-analysis, material exploration and treatment of results followed by inference and interpretation. In the first phase, the documents are selected, allowing for the systematic exploration and formulation of hypotheses, objectives and indicators about the research object. The relevance of the theme, the consistency and the representativeness of the researched material must be considered<sup>9</sup>.

In the following sentences, the exploration of data was performed by encoding and decomposition thereof. Therefore, treatment and interpretation of the results must be meaningful and valid, and require the description of the contents to facilitate the understanding of what was analyzed<sup>9</sup>.

It should be emphasized that the content of Social Representations is valuable, because they are symbolic and constituted by perceptual and cognitive elements. The conversation is a key element of the consensual universe, adding value to such representations. Actions and words produced by individuals have a meaning, intention or purpose that instigate research. Thus, the words stimulate responses in face of the multiple contexts of a reality<sup>5</sup>.

In this study, the exploration of the empirical material was systematically carried out through various fluctuating readings that allowed the construction of provisional hypotheses. Then, we extracted the relevant items of each interview corpus, as well as the convergence of issues related to topics of the script and that have been transformed into meaning units, identified by the numerical coding of interviews and professional category.

The basis of the analysis triggered the construction of categories presented by the expressions of the male health workers, associated with HIV/AIDS, identified as: Representations of HIV/AIDS related to social diversity of PLWHA and Representations of HIV/AIDS on the multidisciplinary approach in support of treatment adherence.

It is noteworthy that, after approval by the Research Ethics Committee (CEP) of the University of Pernambuco through the record 125-A/11, adopted in July 8, 2011, we began collecting data, which occurred after health professionals accepted to participate in the research proposal. They read and signed the Informed Consent Form and the recommendations contained in Resolution N<sup>o</sup> 466/12 were followed<sup>10</sup>.

It is noteworthy that this study was extracted from a multicenter project entitled "The changes in health care and nursing in times of AIDS: social representations and memories of nurses and health professionals in Brazil", register number 16755, funded by the *Conselho Nacional de Desenvolvimento Científico e Tecnológico* (National Council for Scientific and Technological Development - CNPq), and whose production was obtained through scholarship cooperation provided by the *Aperfeiçoamento de Pessoal de Nível Superior* (Coordination for Training Higher Education Personnel - CAPES).

## RESULTS AND DISCUSSION

Participants were fourteen male health workers, ten physicians, three nursing technicians, one dental surgeon, one psychologist and one pharmacist. Regarding the professional category, there was emphasis on the medical profession, and "Infectious Diseases" was the most explicit expertise between them, with four professionals. In this category, specialties such as pediatrics, psychiatry, cardiology and occupational health are also included.

In SAE, the minimum multidisciplinary team recommended consists of: experienced general practitioner and/or ID specialist; nurse; nursing auxiliary and/or technician; social worker and/or psychologist, whose duties must include the full attention focused on outpatient care to individual and/or collective people living with sexually transmitted diseases (STDs) and HIV/AIDS<sup>3</sup>.

The workers profile showed that most of them have between 46 to 55 years of age and in the care axis, 42.9% have been working in health field for 6-15 years. It should be noted that many participants have age and length of professional experience concurrent to the period of profound social and epidemiological transformations of the phenomenon of HIV/AIDS, which are characterized by the internalization, pauperization and feminization processes.

It is noteworthy that in 2007 the ambulatory care network to adults living with HIV/AIDS had at least one infectious disease specialist or clinical doctor responsible for assisting in 44.2% of services and 46.1% of these services were composed by doctors with five years or more of experience in the care of PLWHA<sup>11</sup>. Thus, professional experience allows the construction of Social Representations on HIV/AIDS.

We emphasize the importance of characterization of participants to understand the phenomenon presented in this study. The characteristics attributed to the profile provide a look on moral and biological representations built to welcome a new element, AIDS, and are based in the meanings and previous knowledge of social groups<sup>8</sup>. In this perspective, the context in which the representations are developed is responsible for the differences in thinking and understanding the facts as distinct rationales<sup>5</sup>.

It should be emphasized that, through the content analysis of male workers' speeches, we identified representations of HIV/AIDS related to social diversity of PLWHA, and also about the multidisciplinary approach to treatment adherence, presented in following categories.

### Representations of HIV/AIDS related to social diversity of PLWHA

In this category, participants relate the diversity of HIV seropositive individuals to the social reality they experience and the possible influence treatment adherence. In addition, there is a profile of PLWHA expressed in the minds of professionals that may promote a prejudice established by society in general.

The statements revealed some aspects of individuals affected by HIV/AIDS who, throughout history of the epidemic, embodied the living conditions of PLWHA and the images inherent to the behavior and physical changes caused by the disease. This picture of PLWHA is evidenced through some lines:

*At that time [...] people who had the most severe symptoms were thin, had red eyes, their appearance was more like an AIDS patient (NT1).*

*There is still that idea of an ugly man, thin, that remained in the people's mind, that's what everyone thinks it's still related to AIDS, and that this situation has not changed and that patients, all patients with HIV are like Cazuza, like Betinho [famous Brazilian personalities who died with AIDS], in the end of life. (M1).*

*[...] lower and middle class, predominantly low class, thin body type, others with skin lesions, added to weight loss and depression. (M2).*

*[...] before, AIDS had a face, the face of that seriously ill patient, with hair loss, with skin lesion, an emaciated person. That was the face of AIDS. It has changed, today the face of AIDS has adverse effect, lipodystrophy, dyslipidemia. (M3).*

Based on these speeches, one can see that although there are new therapeutic resources and greater possibility of survival related to quality of life, the initial stereotype of the epidemic of the "person with AIDS", the image of seropositive individuals for HIV persists as a person in terminal stage and with physical characteristics of weight loss and weakness<sup>12</sup>. In the social imaginary, the subject affected by the disease is morally judged, in a negative way<sup>13</sup>.

Other statements, however, reinforce the idea of the expansion of the virus in the population, which affected groups of elderly people, children and adolescents, and there is a distinction in the epidemiological profile of PLWHA raised at the beginning of the epidemic and revealed in some speeches:

*It changed a lot, in fact. AIDS left the gay plague name and now it's perceived as a disease that currently the proportion of men and women infected is almost one to one, in most countries of the world [...] (M4).*

*[...] people found that it was not only gays that could be infected, nor only homosexuals that can be contaminated with the HIV virus when children began to born positive for HIV and it started to appear positive women. (NT2).*

*[...] we see more people of the lower middle class [...] today we have HIV patients among elderly [...](NT3).*

*[...] it was migrating to the poor population, then to women and, with the advent of Viagra, it has spread to the elderly, and then to these elderly's wives and today everybody is in the same boat. (M5).*

*[...] although it is more prevalent in all groups, in all social classes, the lower classes are suffering more [...] I see patients, I have already realized it, they are victims of a whole system, a whole context, a broad social context [...]. People have become infected because they live, I will say this, a miserable life. Here we end visits crying for the misfortune that reaches some people's lives. Having HIV is just another incident in a life of misery. [...] (M1).*

Some speeches relate to the inefficiency of control practices towards the epidemic of the disease in Brazil, which is manifested by poverty and an increase of infection in different social groups, such as young people and women.

It is known that HIV/AIDS phenomenon emerged in the country in 1982, in a striking, mysterious and terrifying way, due to the rapid lethality and extreme bodily disfigurement. It has emerged at a time of control of infectious and parasitic diseases that, in the social imagination, were common to poor countries and regions<sup>4</sup>.

Thus, the setting of this epidemic indicates that those most exposed to infection live in poverty, social exclusion and/or belong to minority groups such as women, homosexuals and drug users. This reality reinforces the need for professionals to perform preventive measures that can minimize prejudices and break taboos<sup>14</sup>.

AIDS triggers a complex set of physical effects and prejudiced attitudes in the social environment of affected people, permeated by fear of contamination and the moral judgments linked to disease<sup>15</sup>. Considering the social prejudice as an explicit feature in society and incorporated by several social actors, including by health professionals, it is possible to identify it in some reports:

*[...] for these patients it is very difficult sometimes because they arrive in the medical office and when they say that they are HIV positive are not met even though they are healthy, even if they have no pathology installed (DS1).*



*We find a lot of prejudice from other doctors [...] not all of them, but some do not seek to solve the patient's problem, and some other try to refer them to another doctor [...] (M6).*

*[...] a patient who needs an urgent surgery [...], but since this patient has HIV, they postpone it the maximum they can to avoid operating this patient (M1).*

*One of the things we see, [...] is drug users, especially injectable crack. It is difficult to deal with them, regardless of HIV or AIDS, health professionals may have a greater prejudice or resistance work with them [...] (M6).*

*[...] social classes differ in levels but they converge when there is abusive and irresponsible sexual practice (M7).*

*[...] the opinions remain biased, in the sense that the HIV patient is mostly gay, promiscuous or drug user or a person who is harshly judged and empathy takes a long time to emerge towards patients with AIDS [...] about prejudice within the medical community itself, regarding sexuality and homosexuality [...] (M4).*

In view of these speeches, exclusion and discrimination of PLWHA were clearly evidenced in the daily lives of health workers who participated in the study, whose meanings of the phenomenon have been developed in a historical, affective and evaluative approach, comprising the genesis of representations.

It is worth mentioning that at the beginning of the epidemic, the representation of AIDS by health professionals was manifested by fear, prejudice, exclusion and death, set by negative senses that portray a social stance experienced by PLWHA against the disease<sup>15</sup>. Given this premise, we can infer that it is not always possible to break free of all conventions or eliminate all prejudices. Therefore, the representations can be treated as a real process<sup>5</sup>.

During the investigation, it was found that the profile of PLWHA is still determined by characteristics related to sexual behavior and that they are vulnerable to discriminatory manifestation of society in general. On that basis, it is embedded the revelation about the diseases linked to sexual behavior, which are morally reprehended and culturally registered as illnesses that people seek and deserve to have it<sup>13</sup>.

Given these facts, silence is a way of denying the positivity of HIV and the existence of AIDS and homosexuality, preserving the individual and families of coping and recognizing the difference. There is a fear of revealing this condition to family and friends, and also of judgments that may occur. Such feelings are added to prejudice, which is a product of a disease still associated with stigmas and stereotypes<sup>12</sup>.

Stigma is related to judgment, definition of stereotypes, separation, loss of status and discrimination, in which power

is exercised. This condition affects socially disadvantaged population groups, hinders or inhibits access to various structural, interpersonal and psychological resources that could be used to avoid or minimize health problems. Stigma also impairs the effectiveness of interventions<sup>16</sup>.

Stigma and discrimination related to HIV persist as the main obstacles to an effective response to global struggle against the virus, and the presence of discriminatory acts in the treatment and access to health care for people affected is common<sup>2</sup>.

Stigma is a social behavior that induces the person with HIV to walk a silent, lonely path, heading for insulation. The moral vision can turn the disease into a social stigma causing submission or revolt in PLWHA<sup>6</sup>. Thus, some testimonials illustrate this processes of excluding oneself or being excluded by others that many PLWHA experience, making them susceptible to social isolation:

*[...] patients want that absolutely nobody knows that they have HIV. (P1).*

*[...] it is difficult for families to accept it; it is difficult for the patient to accept it. Patients are very biased in relation to their own condition (M1).*

*There is still a lot of prejudice. Prejudice is, to me, what most kills in the HIV/AIDS condition. It's what most causes exclusion and grievance on the patients themselves. (F1).*

*Since it is a stigmatizing disease, prejudice is very strong and it is a chronic disease that is not easy to treat. It is still a challenge for the physician, for the multidisciplinary team and especially for the patient (M4).*

With regard to family relationships, research noted the difficulty that the patient with HIV faces to reveal the diagnosis to the health team, for fear of exposure in the community, which leads them to seek care in services far from their families and social life<sup>15</sup>. The lack of trust shown by patients related to the guarantee of secrecy of their condition remains a challenge, as evidenced in the statements below:

*[...] some patients were from other places, there were a lot of gay men, the came from interior cities of the State, from other States, and many were supported neither by family nor by friends. It was very difficult; many people did not want to be seen with the HIV-positive patients (M4).*

*[...] often, the very patient's family does not know they have HIV, sometimes have been infected for three, four, five years, taking medication and everything and the family does not know, because often the patient thinks it is not good to say to the family they are sick. (P1).*

As the statements above, when discovering that they are infected with HIV, people feel different from the others because

they socially build a body contaminated by an endogenous agent and assimilate moral values and judgment determined by society<sup>13</sup>.

The judgments chain associated with living with HIV is a challenge for PLWHA, for families and for health teams due to psychological changes and difficulties in treatment adherence. Thus, health professionals often experience some barriers related to work and social life with PLWHA, as described by the following deponents:

*[...] it has already happened to me more than once: I find a patient in the shopping center and the patient deviate from me [...] that reflects the degree of discomfort of people with their own state of seropositive for HIV. The sick person still hasn't managed to accept themselves and is afraid that people recognize them as being in such condition. (M4).*

*There was so prejudice in relation to patients with AIDS, there was prejudice to people who worked with AIDS. So in my social life when someone asked me: what do you do? I use to say that I worked with children. [...] (M3).*

*[...] when someone says that has HIV, it's always very dramatic for the patient, for family, for friends, at work. The person still has to hide that is HIV positive at work. I still see it as a very stigmatized disease, with much prejudice. (M8).*

With regard to the removal process of PVHA that occurs in institutions, when there is confirmation of the diagnosis of the disease, it can occur through various mechanisms mediated by a form of violence, by suspecting of their ability to produce workforce, which contributes to feelings of pain and social isolation<sup>13</sup>.

In this perspective, the social isolation of PLWHA is a challenge for health professionals, who should welcome, host, support and enable the social inclusion of the infected person, through strategies that improve their self-esteem and adherence to social groups<sup>5</sup>.

### **Representations of HIV/AIDS on the multidisciplinary approach in support of treatment adherence**

In this category, we included the speeches of male workers participating in the study on the multidisciplinary approach. The initial process of this theme highlights the importance of the interaction of the health team on the care context that the interviewees idealize as a feasible strategy for improving the quality of life of PLWHA, confirming the advances in health care. Reports point that this strategy should be adopted by the outpatient care services for PLWHA:

*When you deal with other people you will always seek to learn with the multidisciplinary team, you are always being enriched. (M6).*

*[...] We need to see more than the disease itself, it is not only about medical prescription of tests and results, because we know that everything can affect treatment adherence in the long term. (M3).*

*[...] we still need to work harder at the level of prevention and early diagnosis of the disease, I think maybe we can work more effectively, being closer to patients at their home, in their community, to better monitor treatment adherence [...] (M8).*

Regarding these statements, respondents recognize the need for efforts of the multidisciplinary team to improve care directed to PLWHA in the various levels of health care. The care process involves factors related to maternity, religion, lifestyle and psychological conditions, which must be identified to enable appropriate and effective interventions<sup>17</sup>, as evidenced in the following excerpt:

*We need to have a professional relationship. And in this relationship we get to know the patient more deeply and start to see the differences thereof. So this facilitates you to take care and treat the patient [...] (NT3).*

Regarding the barriers faced by professionals, study on adherence to antiretroviral treatment highlights the abandonment associated with psychological difficulties or due to side effects, which require professional intervention with emphasis on the promotion of self-care and comprehensive health care, since good treatment adherence is related to the quality of life of PLWHA<sup>17</sup>.

In South Africa, poverty, mobility and poor infrastructure have built barriers that affected the adherence to HAART, manifested by increased fatigue of patients, and higher food costs, limiting access and causing intolerable side effects in taking medication on an empty stomach. Moreover, institutional factors related to prolonged wait during consultations, overcrowding in attendance, lack of privacy, as well as religious beliefs, stigma and fear of discrimination resulted in low HIV tests and low adherence to antiretroviral treatment<sup>18</sup>.

This reality is consistent with the Brazilian epidemiological profile, emphasized by the impoverishment of population and illustrated in the following statements:

*[...] My patients who live in interior cities of the State face a constant struggle to get transport with the City Government. [...] Other thing: why are you like this? Doctor, I'm taking the medication properly, but I keep throwing up. Why: Because I have nothing to eat, that's*

*why I lost weight! I have nothing to eat! [...] She wanted to get hospitalized only to eat [...] (M1).*

*The big problem is still the large number of patients who do not adhere to treatment, for various reasons; social, economic and cultural [...] (M8).*

Professionals associate the financial condition of PLWHA to difficulties in treatment adherence. Verbalized situations give a paradox of socioeconomic and political reality in Brazil that directly affects PLWHA and other social groups, and may contribute to increased morbidity and mortality associated with HIV/AIDS.

Studies point the success of adherence to antiretroviral as one of the challenges to control the disease, both for the individuals affected and for the health team, considering that many side effects to treatment counteract the benefits. Thus, effective communication between the professionals involved and the patients may encourage reflection on the complexity of the control and responsibility for the therapeutic success. In this context, the interaction between patient, professional, health system and society is fundamental to the effectiveness of HAART<sup>17</sup>.

With regard to the work of the multidisciplinary team, we highlight the advent of HAART, which implies advances in health care directed to the PLWHA in Brazil and suggests the improvement of multidisciplinary work process by welcoming, counseling and explaining that this adherence is aimed at improving the quality of life of patients. This emphasis was illustrated in speeches:

*Advances, added to each new drug entering in treatment and reflecting also on treatment, multidisciplinary teams of specialized care service that requires multidisciplinary team. You cannot have a SAE service without a multidisciplinary team. So, all this management is important. (M3).*

*[...] treatment adherence groups is an aspect that should be pointed out, because we used to face many difficulties in making patients adhere to medication because of the stigma, depression and other factors, the side effects of medications. And there was a treatment adherence group that acted dynamically, it contributed a lot. (M2).*

*[...] Allowing that a more effective integration between patients could happen, and also between family members and the patient, that would help a lot in the reintegration of this patient [...] (F1).*

Another topic referenced by the participants of the study refers to the need for interaction between the multidisciplinary team, patients and families as an aid to improve living with the virus and for the treatment of PLWHA, as the following statements:

*[...] Today, when the family interacts with the professional and the patient, coexistence becomes better and treatment becomes better. (NT3).*

*[...] if you have no family involvement to provide support to the patient, they will not continue treatment [...] they can even start it, but after a while they will leave. (NT2).*

*[...] When we cannot have the support of the patient's family, the family abandons and everything is more difficult. (M6).*

*I think it's crucial to have a good relationship with patients, with the family, always being available to give the necessary information, answering questions in a way that that family group can understand [...] (M2).*

*It is the professional's responsibility to guide the patient, the family [...] it is very important to have a family member with whom you can count to give these guidelines. (DS1).*

Based on these assumptions, family participation is critical to the effectiveness of treatment adherence. The need for family support is recognized by workers and constitutes a key element for the success of therapy.

Before the above, it is considered that the thinking of individuals occurs through a language and is organized according to a representational and cultural system that determines their behavior<sup>5</sup>. The successful conduction of care for PLWHA requires of professionals involved understanding about the fears, desires, anxieties, and the benefits of treatment, enabling an effective and comprehensive intervention that addresses health promotion<sup>17</sup>.

## CONCLUSION

In examining the symbolic aspect of HIV/AIDS in the point of view of group studied, we realize the sharing of a language, common values and memories, whose meanings may be able to produce certain effects in interpersonal relationships. These results have a real cause, which allows us to understand the social behavior and the judgment of subjects and underlies the reason why we insist on this search.

The study highlighted the meanings of HIV/AIDS identified by socioeconomic and stigmatizing conditions affecting PLWHA. We stressed the need for effective multidisciplinary approach, through treatment adherence groups and family support, which can facilitate the process of social reintegration and treatment adherence.

Despite the limitations inherent in the work context, this study raises reflections on the social representations and the results can be widely appreciated and discussed the scientific and academic community, including the area of nursing. Registered prospects can be extended in other health care services, and also in the health care complex on HIV/AIDS. Therefore, we expected to contribute to the understanding of the representations of HIV/AIDS through the meanings produced by male health workers from the reality experienced in the daily lives of those involved.

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