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SOCIAL REPRESENTATIONS OF HEALTH PROFESSIONALS ABOUT HIV/AIDS: A COMPARISON BETWEEN MEN AND WOMEN

Yndira Yta Machado

Master in Nursing from the State University of Rio de Janeiro (UERJ). Scholarship note 10 FAPERJ. Faculty of Nursing, State University of Rio de Janeiro - UERJ, Rio de Janeiro (RJ), Brazil

Denize Cristina de Oliveira

PhD in Public Health from the University of São Paulo. Professor in the Postgraduate Program in Nursing at the State University of Rio de Janeiro - UERJ, Rio de Janeiro (RJ), Brazil.

Eliane Ramos Pereira

PhD in Nursing - UFRJ. Professor of Progr. Postgraduate Health Care Sciences at Federal Fluminense University, Niterói (RJ), Brazil.

Ana Paula Munhen de Pontes

PhD in Nursing from UERJ. Director of Teaching, Research and Extension at Hospital School of Valença/ FAA. Valença (RJ), Brazil.

Antônio Marcos Tosoli Gomes

PhD in Nursing from UERJ. Professor in the Postgraduate Program in Nursing at the State University of Rio de Janeiro - UERJ, Rio de Janeiro (RJ), Brazil.

Sergio Corrêa Marques

PhD in Nursing from EEAN / UFRJ. Professor in the Postgraduate Program in Nursing at the State University of Rio de Janeiro - UERJ, Rio de Janeiro (RJ), Brazil.

Rômulo Frutuoso Antunes

Nursing student. CNPq Scientific Initiation Scholarship. Faculty of Nursing, State University of Rio de Janeiro - UERJ, Rio de Janeiro (RJ), Brazil.

Corresponding author:
Yndira Yta Machado
E-mail: yndiramachado@gmail.com

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ABSTRACT: The study aimed to analyze social representations of HIV/ Aids from a gender perspective. This was a descriptive study, based on the Theory of Social Representations, using a structural approach. It was developed with 214 health professionals who worked in reference services in the cities of Rio de Janeiro and Niterói. Questionnaires were applied for characterization of the participants and for collection of free evocations of the inductive term "HIV / Aids". Data were analyzed with the aid of SPSS software for statistical characterization of the group and EVOC 2005 for prototypical analysis of social representations. The results point to divergences in the representations of HIV/Aids between the sexes; greater general positivity, with elements from the reified universe and meanings related to coping with the disease in males; and a more negative trend, accompanied by elements of permanence of the original representations of HIV/Aids, with affective elements in the representation of the female group. It is concluded that it is not possible to affirm the existence of distinct representations between the sexes, but some representational content marked by a general gender orientation.

KEY WORDS: Aids; Gender identity; HIV; Health professional.

REPRESENTAÇÕES SOCIAIS DOS PROFISSIONAIS DE SAÚDE SOBRE HIV/AIDS: COMPARAÇÃO ENTRE HOMENS E MULHERES

RESUMO: O estudo objetivou analisar as representações sociais do HIV/ Aids sob uma perspectiva de gênero. Estudo descritivo, fundamentado na Teoria das Representações Sociais, utilizando a abordagem estrutural. Foi desenvolvido com 214 profissionais de saúde que atuavam em serviços de referência nas cidades do Rio de Janeiro e Niterói. Aplicaram-se um questionário de caracterização dos participantes e outro para a coleta das evocações livres ao termo indutor "HIV/Aids". Os dados foram analisados com o auxílio dos softwares SPSS, para caracterização estatística do grupo, e EVOC 2005, para análise prototípica das representações sociais. Os resultados apontam divergências nas representações do HIV/Aids entre os sexos; maior positividade geral, com elementos do universo reificado e significados associados ao enfrentamento da doença no sexo masculino; e uma tendência mais negativa e acompanhada de elementos de permanência das representações originais do HIV/Aids, com elementos afetivos na representação do grupo do sexo feminino. Conclui-se que não se pode afirmar a existência de representações distintas entre os sexos, mas alguns conteúdos representacionais marcados por uma orientação geral de gênero.

PALAVRAS-CHAVE: Aids; HIV; Identidade de gênero; Profissional de saúde.

INTRODUCTION

The Acquired Immunodeficiency Syndrome (AIDS), since the identification of the first cases, appears as a serious public health problem with regard to the repercussions of the disease, the growing number of occurrences and the high mortality rates worldwide and strong impact on the countries' economy. Due to the increase in the number of people infected with the Human Immunodeficiency Virus (HIV), several studies have been conducted with the aim of understanding the lifestyle of the affected population in order to propose more effective ways of prevention.[1,2,3]

AIDS was the first disease whose social and medical histories developed together. Before biological research advanced and brought information about the nature of the syndrome, society developed theories based on the data available about people living with HIV, anchored in common sense and explaining, in part, the construction of this social phenomenon, which further contributed to prejudice and discrimination against the group. The information about the transmission and victims favored the emergence of two conceptions - one, moral and social, and the other, biological -, with the evident influence of each one on the behaviors and on the relationships with those affected by the disease.[3]

Since its inception, HIV and AIDS have presented with as sensitive representational objects, that is, strongly marked by social norms and moral values, giving rise to several metaphors associated with the new disease, such as death, punishment and shame. The historical course of the syndrome created a relationship between HIV and behaviors that were not accepted in society, with an association between AIDS and promiscuity or marginalization. For this reason, terms like 'gay cancer" or "gay plague" were reproduced by the country's media, which presented the pathology as something unknown, with rapid progression and high lethality.[2,4]

The political and epidemiological contexts allow demarcating four historical moments experienced by people living with HIV, with regard to the formation of representations, access to care and quality of life, considering their approach to the phenomenon of HIV and Aids[5]: the first, characterized by the beginning of the epidemic (1980s); the second, after the regulation of the law on the universalization of antiretrovirals (from 1996); the third, marked by the significant drop in mortality and the renewed hope for the future (2000s); and the fourth (in recent years), with the chronification of AIDS, in which representations became peripheral to the notion of death, shaping new ways of thinking about pathology and bringing quality of life to the scene of immediate concerns.[3]

Brazil has stood out in the fight against AIDS, showing concern with the quality of the assistance provided to people living with HIV. In this context, the country stood out in relation to the availability of alternatives for treatment and control of the virus, especially after the introduction of free access to Antiretroviral Therapy (ART) as part of the Brazilian health policy[6].

In view of the heterogeneous nature of the epidemic and its complexity as a public health issue, the Theory of Social Representations (TSR) brings a path for understanding the collective knowledge built about the syndrome. In this context, Moscovici[7] presents the following definition: "social representation is a modality of particular knowledge that has the function of developing behaviors and communication between individuals in the context of everyday life".

Establishing a connection between the gender perspective and social representations implies thinking about the conception of human nature, which is not only due to a biological determination, but also to a social, historical and cultural construction.[8] The notions of gender, which are not a specific object of the present study, but may subsidize it, are implicit in the discussion, in the forms of social, cultural and linguistic construction that are part of the process of differentiation between women and men who provide assistance to people living with HIV.

For some authors, gender relations refer to the way in which cultures organize the hierarchy between people according to sex, they are mediated by the power relations existing in different social contexts. The understanding of what "being a man" or "being a woman" means is defined in cultural terms based on prevailing models of masculinity and femininity that culminate in standards and norms that must be followed by individuals. Such norms and representations integrate a symbol and value system that determines the interpersonal attitudes to be adopted and expected socially, classifies the subjects according to biological sex, stratifying individuals in the face of their sexual, anatomical and psychological characteristics, influencing the form of identity of gender.[9,8]

In this sense, this article aimed to analyze social representations of HIV/Aids from a gender perspective.

METHODOLOGY

This is a descriptive exploratory study, with a quantitative and qualitative approach, based on TSR. The structural approach or Central Core Theory of the TSR was used, which emphasizes that the organization of a social representation is presented around a central core, composed of one or more elements, which give meaning to the representation.[10]

The study was developed in outpatient care units for HIV/AIDS patients in the cities of Rio de Janeiro and Niterói and involved 214 health professionals - 172 female and 42 male - who worked directly in the care of people living with HIV. Data were collected using a questionnaire to characterize participants and free evocations applied between the years 2012 and 2013. Participants were asked to produce five words or expressions that would come to mind after hearing the inductive term "HIV/AIDS".

Data were analyzed with the aid of the software *Ensemble de Programmes Permettant L'Analyse des Evocations* (EVOC), version 2005. The analysis of evocations, also called prototypical analysis, is one of the most widespread techniques for structural characterization of a social representation; it is configured as a data presentation convention that allows the projections of the study participants to be apprehended quickly, objectively and spontaneously, minimizing the possibility of conventional and targeted discursive expressions.[11]

The two importance criteria adopted for the distribution of terms in the quadrants were: average frequency of occurrence of the words (f med) and average order of evocation (AOE), which, at their intersection, determine the limits of each quadrant. These indicators are calculated as follows: f med = total of evoked words divided by the number of different words above the minimum frequency; individual AOE = average with inverse weighting from 1 to 5 of the words evoked by each subject, considering the order in which they were evoked by the subjects; group AOE = simple average of the total of individual weighted averages.[12]

In the table of four houses, the upper left quadrant, called the central nucleus, comprises the words that presented the highest frequencies and were most readily evoked (lowest AOE values), constituting the most stable and permanent part of a representation. The lower left quadrant, called the contrast zone, encompasses the words with less frequency and which were also promptly evoked, and may show variations in the centrality of the representation for specific groups. The two quadrants on the right (upper and lower) contain words that had less evocation readiness (higher AOE values) and higher or lower frequencies, being called the first and second periphery, respectively. The peripheral zone expresses the representational elements associated with the immediate context of life, daily reality and social practices, being, therefore, unstable, allowing the inter-individual variability of representation.[12]

The rules and guidelines for conducting studies involving human beings were respected. At the time of data collection, the current resolution was the 196, of October 10, 1996, of the National Health Council. The project was presented to the Ethics Committee of the State University of Rio de Janeiro and approved under protocol number 048.3.2010.

RESULTS

Participants were 172 females (80.4%); among these participants 92 are aged between 46 and 55 years old (43%) and 45 are up to 35 years old (21%); 115 live with a partner (53.7%); 71 are physicians (33.1%), 39 nurses (18.2%), 33 nursing technicians (15.4%) and 20 social workers (9.3%); 103 participants have a specialization degree (48.1%) and 41 have a masters/doctorate degree (19.2%). Regarding the main sources of information about AIDS, 66 participants considered websites in general on the Internet (30.8%), 59 technical manuals (27.6%). The group, therefore, was mostly made up of women, adults, living with a partner, with an high level of education and who access Internet sites and technical manuals as sources of information about the disease.

The comparison of the free evocations of the female and male professionals was made from the tables of four houses.

The product of free evocations constituted a total of 842 words, of which 181 are different. The cutoff points defined for the analysis correspond to: minimum frequency (8), average frequency (f med) (26) and Average Order of Evocation (AOE) (3.0). Based on these indicators, the table was constructed.

Chart 1 shows the results of the prototypical analysis of female professionals.

Chart 1. Table of four houses referring to the evocations of female health professionals to the inductive term "HIV/AIDS". Rio de Janeiro and Niterói, State of Rio de Janeiro, Brazil, 2014

AOE	< 3.0			≥ 3.0		
f med.	**Evoked term**	**f**	**AOE**	**Evoked term**	**f**	**AOE**
≥ 18	prejudice fear prevention care death	76 31 28 28 18	2.303 2.452 2.393 2.929 2.722	adherence-treatment treatment medicine	31 31 20	3.032 3.097 3.100
< 18	sadness suffering disease chronic disease reception attention anguish	17 15 15 14 10 8 8	2.647 1.400 2.000 1.429 2.500 2.625 2.750	rebirth sexuality help hope responsibility condom health counseling affection knowledge	15 14 13 11 11 10 10 9 9 8	3.733 3.429 3.154 3.091 3.182 3.100 3.600 3.222 3.333 4.000

Source: prepared by the authors.

Chart 2 shows the representational structure of HIV/AIDS built by male health professionals, composed based on the evocations of 42 subjects. 214 words were evoked, among which 89 were different. The minimum frequency defined was 3, being excluded from the composition of the table of four houses those evoked in less than this number. After defining the minimum frequency, the average frequency was calculated, resulting in 6, and an AOE of 3.0.

Chart 2. Table of four houses referring to the evocations of MALE health professionals to the inductive term "HIV/AIDS". Rio de Janeiro and Niterói, State of Rio de Janeiro, Brazil, 2014 (Continuation)

AOE	< 3.0			≥ 3.0		
f med	**Evoked term**	**f**	**AOE**	**Evoked term**	**f**	**AOE**
≥ 6	prejudice treatment exams care prevention	14 12 7 6 6	2.571 2.917 3.000 1.833 2.333	medicine adherence-treatment	14 10	3.357 3.600

(Conclusion)

< 6	disease	5	2.200			
	suffering	5	2.600			
	sexuality	5	2.600			
	patient	5	3.000			
	virus	4	1.750	hope	5	4.200
	epidemic	4	2.000	death	4	3.500
	opportunistic disease	4	2.500	condom	4	3.750
	fear	4	2.750	cure	4	4.750
	autoimmune disease	3	1.333	depression	3	4.000
	pain	3	2.000			
	chronic disease	3	2.333			
	denial	3	2.667			
	sadness	3	3.000			

Source: prepared by the authors.

DISCUSSION

In the comparison of the two central quadrants, the words *prejudice, prevention* and *care* are common elements to the central nuclei of the two representations, therefore consensual to both groups.

Note that *prejudice* had the highest frequency of evocation in the two groups analyzed and the lowest AOE in women, being the third in this indicator in men. These data point out that the prejudice associated with the virus and the disease presents itself as the permanence of the original representations, maintaining its function of structuring the representation of health professionals, not varying in relation to sex, as other research points out.[13]

The terms *prevention* and *care* were also common to both groups, highlighting that, among women, *prevention* has the third highest frequency and the second AOE; among men, it does not stand out for its frequency, but it is the second AOE. In turn, the word *care* was the most readily evoked by men, and in women, it has the third highest frequency, revealing its importance in both groups. The two terms indicate a unique structuring dimension of this representation, one related to reified knowledge that seeks to avoid contagion and/or care as a strategy for preserving body and mind stability.

The terms specific to each group present in the supposed central nucleus of the representation point to what distinguishes the groups, which may reveal different representations[12,10]. It is observed that the central nucleus of the female participants presents the specific terms *fear* and *death*, while in the male gender, the elements of *treatment* and *exams* are perceived as belonging to this group.

Regarding the specific terms of the female group, *fear* and *death* stand out, characterized as negative, revealing an affective dimension and a second imagery dimension of HIV/AIDS. Both elements are also remnants of the first representations of AIDS[13], pointing to the fear of the unknown and the death threat posed by the disease, from its beginnings to the present day, causing HIV infection to generate a process of stigmatization and discrimination. It appears that HIV/AIDS is associated with the idea of death in an unrestricted way among men, women, young people, older people and even for those under treatment, a fact that reveals the strength of the anchoring of this representational element.[14]

For male professionals, the words *treatment* and *exams* are presented as exclusive and are characterized as positive and coping elements of the disease, reaffirming the incorporation of reified knowledge about HIV/AIDS[13].

The two terms signal a psychosocial construction that has already incorporated the possibility of coping with the disease and its control, as strategies to combat death.

Considering the functions of the central nucleus, the importance of comparison is pointed out to identify one or more representations[10,12]. In this study, two very specific orientations stand out. The first is indicative of a representation marked by a negative affective-attitude-imagery orientation towards HIV/AIDS, a characteristic of the female sex; and the second is structured by a positive attitude-conceptual orientation of coping with the disease and the virus.

Taking into account the conceptual propositions of the gender approach, subjectivity and objectivity guide the understanding of what constitutes being a woman or man, culturally defined and observed in other studies, based on models of masculinity and femininity that are expressed in a symbolic system and specific values related to AIDS.[9,8]

The comparison of the representational contents can also be made from the terms and dimensions present in the other quadrants. In the first periphery, *adherence-treatment* and *medication* are common in the representations of the two groups, and the *treatment* element is specific to women. The three terms reveal the psychosocial incorporation of the possibility of facing the disease through specific treatment and the importance of adherence to its continuity.[15]

These representational contents were incorporated into the social representation of HIV/AIDS with the institution of the Brazilian public policy of universal access to ART, in 1996, which resulted in a reduction in mortality from HIV, increasing survival and giving the disease a chronic character.[14] As of 2013, it was defined the immediate start of ART for all people living with HIV after confirming the diagnosis, regardless of the TCD4+ count. This change in the treatment policy enabled greater control of the still existing mortality and associated morbidity, improved immunological indicators and better response to opportunistic infections, promoting quality of life for this group and may also have an impact on the psychosocial construction of the disease.[6]

These epidemiological and social changes in the syndrome demonstrate its strong dynamism and the population vulnerability to the disease, requiring its psychosocial construction and reconstruction. The advances in treatment, the significant improvement in the quality of life and life expectancy of those infected and the increase in the knowledge and experiences of health professionals contributed to new perceptions of society about the pathology over time.[16]

In relation to adherence to treatment, it has stood out among researchers and health professionals as a primary factor for the control of the disease[17]. In fact, it promotes an improvement in the quality of life of people living with HIV and represents a challenge to control the disease and to maintain the immune balance. The experience of professionals with people with HIV constituted practical knowledge, incorporated into the representation, the importance of adhering to treatment to maintain the stability of this group.

Psychosocial support plays an important role in mitigating negative consequences of stressful events related to infection, which can contribute to coping with HIV. Therefore, understanding how such support relates to the experience of the disease can collaborate in coping, adaptation and quality of life for HIV-positive users, helping, in turn, in therapeutic adherence and disease control.[18]

The elements common to the two groups studied in the second periphery are *hope* and *condoms*. They are marked by a positive attitude about the virus and the disease, in support of people living with HIV, with a humanistic character. They also suggest a view of the health-disease process involving subjectivity and the perception of the need for a social support network for those who live with the disease, in the form of promoting a dialogical relationship between health professionals and people living with HIV.

The main strategy for HIV control is the development of disease prevention measures that include health education actions, wide access to self-care supplies, such as male and female condoms, and also anti-HIV testing.[19] As for prevention, condom use is the main practice to avoid transmission of the virus to non-infected people, as well as contagion with different subtypes of the virus among people who previously had HIV. Moreover, it is considered a healthy lifestyle habit that reduces the risk of acquiring other sexually transmitted infections.[20]

The Brazilian stance, since the launch of the National Policy For Combating the HIV/AIDS Epidemic, in the 1990s, has focused on prevention through the promotion of safer sex and overcoming contexts of vulnerability, in opposition to measures that potentially violate the exercise of sexual rights, such as stimulating abstinence and reducing partners. Thus, the promotion of condom use as a method of protection remains, even today, as the main strategy of prevention policies in the country.[21]

The specific terms of the second periphery of female professionals are *rebirth*, *sexuality, help, responsibility, health, counseling, affection* and *knowledge*, referring to different ways of coping with the disease when the professionals develop care. In this regard, one must reflect on the elements of a humanistic character present in this representation, which are of fundamental importance in the search for quality of life for people living with HIV. The dialogical actions of health education aim to raise greater awareness, individual and collective, about responsibility for health, especially for young people who were born in times of AIDS, with accessible treatment and a possible coexistence with the virus, tending to naturalize it.

In contrast, in the group of male professionals, the words evoked were *death*, *cure* and *depression*. They reveal tensions related to the daily life experienced by professionals in health services (*cure*), associated with affective-attitude elements (*death* and *depression*) present in the original representations of HIV/AIDS[13].

The terms common to the two groups studied in the second periphery are *hope* and *condom*; they are marked by a positive attitude about HIV/AIDS, of supporting people living with HIV, with a humanistic character. They also suggest a view of the health-disease process, involving subjectivity and the perception of the need for a social support network for those living with the syndrome in the form of prevention and dialogue between health professionals and people with HIV/AIDS.

In the comparison of the contrast elements, it was possible to identify, among the common ones, *suffering*, *sadness*, *disease* and *chronic disease*, revealing those affective-attitude ones associated with the reified universe of representation. In the female sex, the specific terms indicate the predominance of positive elements defining care, such as *reception* and *attention*, linked to negative affective-attitude elements, such as *anguish*. In the male sex, there is a predominance of specific terms of neutral figurative elements, associated with the reified universe of representation, such as *sexuality*, *patient*, *virus*, *epidemic*, *opportunistic disease* and *autoimmune disease*, accompanied by negative affective-attitude elements, such as *fear*, *pain* and *denial*.

Therefore, taking into account the contrast elements, one can hypothesize the existence of a subgroup that attributes HIV/AIDS to the meaning of chronic disease, not present in the other quadrants, but which is not associated with sex, since this term is common to both groups analyzed.

The global comparative analysis of representational content reveals an important difference between the two groups studied. It is important to note the most negative trend, accompanied by elements of permanence of the original representations of HIV/AIDS, with others, affective elements, in the representation of the female group and, on the contrary, greater general positivity, with elements from the reified universe and meanings associated with coping with the disease in males. However, gender varies spatially from one culture to another, temporally in the same culture at different historical times and longitudinally throughout an individual's life.[22]

In relation to the common elements between the two groups examined, suffering and sadness are associated with the affective consequences that AIDS causes, including the physical changes caused by immunodepression and medication, in addition to the symbolization of death caused by living with the disease, which, in turn, refers to the feeling of sadness and suffering. Some authors consider that death recovers elements present since the beginning of the epidemic, when the shock of the diagnosis and the uncertainty of the future before the possibility of the end of life brought feelings of fear and sadness.[23,13]

CONCLUSION

In the comparative analysis of male and female health professionals, the divergent content draws attention, allowing to observe certain specificities that point to gender attributes. In the male group, there was, in the possible central nucleus, representational contents of AIDS linked to coping with the disease, as well as other derivatives of professional practices and positive attitudes. The female group built their representations based on references anchored in the past, strongly marked by negative affective elements of life destruction, social isolation and stigmatization.

Thus, there is a difference in the comparison of the content and the representational structures of the two groups, with a more positive attitude towards coping with the disease by male professionals, and a negative affective-attitude positioning by female. These different attitudinal postures express individual specificities, but also of groups formed by men and women, inserted in different socio-cultural and care practice contexts.

A second order of differences found relates, by hypothesis, to anchoring, which in the first group occurs mainly to elements from the beginning of AIDS and in the constituted social memories, whereas in the second, the scientific knowledge associated with the current AIDS configuration as determining trends.

However, it is not possible to affirm the existence of two distinct representations associated with sex, but some representational content marked by a overall gender orientation, given the need for other techniques confirming the centrality of this statement.

It is believed that this research contributes to understand how professionals can interfere with health care and provide reflections that enable professional improvement in order to improve care for people living with HIV. It is also expected that, based on the questions and reflections presented in this study, others can develop by overcoming the theoretical and explanatory limitations of this study.

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