


Quality of life and its representations for people living with HIV: Consensus and dissent

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ABSTRACT

Objectives: to analyze consensus and dissent from social representations of the quality of life of people living with HIV in medium and large municipalities. **Methods:** qualitative research, supported by the Theory of Social Representations - processual approach. A total of 68 people living with HIV participated in the study. A characterization questionnaire and semi-structured interviews were used. Analysis performed by SPSS and Iramuteq software. **Results:** Consensus refers to the perception of quality of life, family relationships and prejudice. Medium-sized municipalities perceive quality of life based on knowledge about the disease, the process of adaptation to ART, sexual practices and social and family support. Larger municipalities, on the other hand, refer to life habits, physical activity, family and the normalization of daily life. **Final Considerations:** differences in the social representations of quality of life were observed in the two groups analyzed, referring to cultural and socio-historical constructions typical of the ways of life and relationships experienced by the groups studied.

Keywords: Quality of life, HIV, Acquired Immunodeficiency Syndrome, Lifestyle, Social representation.



INTRODUCTION

In Brazil, the Human Immunodeficiency Virus (HIV) was first identified in the early 80s, with cases reported in the cities of São Paulo (1980) and Rio de Janeiro (Valadão et al., 2022). In the following years, the epidemic showed significant geographic expansion, reaching all regions of the country in a heterogeneous way (Agostini et al., 2019).

Despite the recognition that the increase in survival time positively influences people's lives, it is understood that this factor alone is not directly related to the improvement in the quality of life (QoL) of people living with HIV, since the diagnosis implies changes in various aspects of life, such as sexual, emotional and social. Thus, when discussing QoL in a broader way, it is necessary to understand it as a dynamic and changeable process, which includes the continuous interactions between the individual and the environment, therefore, socioeconomic, demographic, cultural, psychological, and spiritual conditions are intrinsic factors in this assessment (Marques et al., 2020).

Quality of life has become a useful variable to determine the global impact of diseases and health treatments from the perspective of the individual. Its measure is potentially useful for application in clinical and psychosocial research to demonstrate the possible benefit and impacts of therapeutic interventions (Domingues; Olive tree; Marques, 2018).

This research aims to analyze the consensus and disagreements of the social representations of the quality of life of people living with HIV in medium and large municipalities.

METHODS

This is a descriptive study with a qualitative approach, based on the Theory of Social Representations (SRT), using the procedural approach to analyze the consensus and dissent of the social representations of the quality of life of people living with HIV.

The study was carried out in outpatient HIV/AIDS care units in the cities of Rio de Janeiro, Macaé and Rio das Ostras. The total number of participants was 68 subjects, and 34 participants from the city of Rio de Janeiro (large); 17 participants from Macaé and 17 from Rio das Ostras, totaling 34 interviews in medium-sized municipalities.

The study participants are people living with HIV assisted at the HIV/AIDS outpatient clinics chosen for this study. The inclusion criteria were: being at the time of data collection waiting for the consultation or exams; be 18 years of age or older; and be in mental and autonomous conditions that would allow participation in the study. A non-probabilistic, convenience sample was adopted, chosen from information provided by the health units on the number of clients under follow-up, composing the study universe. The norms established by Resolution No. 466/12 of the National Health Council, which provides for the guidelines and norms that regulate research involving human beings, were



observed, and was approved by the Research Ethics Committee of the three municipalities studied. The participants read and signed the Informed Consent Form (ICF).

For data collection, a questionnaire to characterize the participants and a semi-structured interview script were used. The data were analyzed with the aid of *SPSS and Iramuteq* software.

The comparative analysis was developed with the Descending Hierarchical Classification (DHC) technique, applied to the two corpora, one composed of interviews from the large municipality and the other from the medium-sized municipality. These corpora were submitted to analysis separately, resulting in two sets of classes that express the representational contents of the quality of life of each subgroup of municipalities analyzed.

For the qualitative analysis of the groups, a comparative procedure of the results of the DHC was developed. With this procedure, it was possible to capture the different specificities of each social group studied, segmented by the size of the municipalities – medium and large. The construction of the comparative procedure was based on the premises proposed by Doise (1972) regarding the need and interest in studying representational dynamics exactly where they are produced, that is, in the context of social relations, which are justified and anticipated by the former.

The stages of this comparative analysis were as follows: 1) The corpora of medium and large municipalities were submitted to lexical analysis separately; 2) a detailed reading of each class was carried out, seeking to understand the semantic contents together; 3) the classes were observed according to the variables associated with each class, by the highest value of χ^2 ; 4) the classes were observed with the reduced forms with higher association values; 5) the classes were observed according to the text segments (TS's); 6) the axes of the divisions of the CHD were named, according to their context; 7) naming of classes, according to their context and the axes from which they resulted; 8) the description of the classes was carried out; 9) for the comparative analysis, the vocabularies, semantic contents and variables with the greatest association with each class were taken; 10) construction of a first spatial view of the main similarities and differences of the two analyses; 11) comparison through vocabulary indicators, TS's and variables, to recognize the main similarities of the contents of the classes in the two groups; 12) comparison through vocabulary indicators, TS's and variables, to recognize the main differences in the contents of the classes in the two groups.

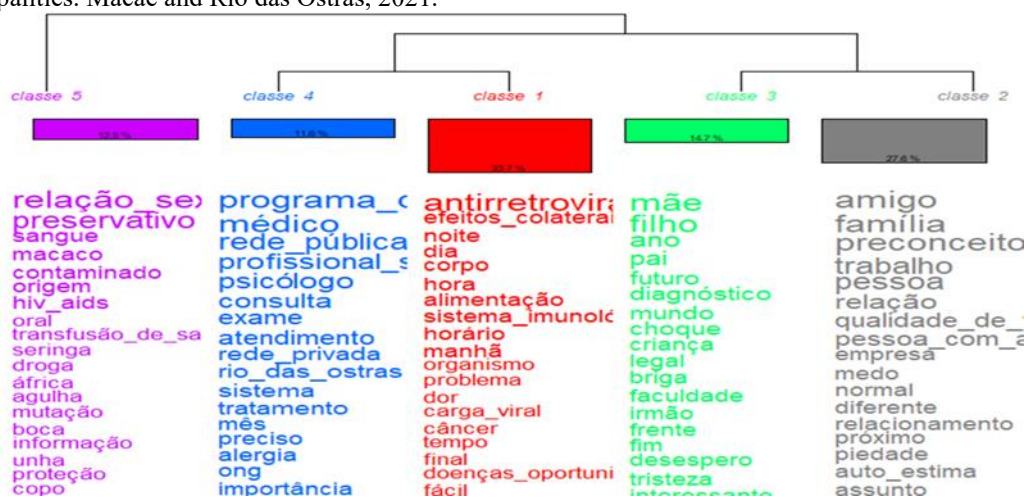
After the development of the stages described, it was possible to identify the differences and similarities between the subjects of the medium and large municipalities of the State of Rio de Janeiro.

RESULTS

The sociodemographic and clinical characterization of the participants reveals that the majority of the group is composed of women, aged between 18 and 38 years (medium size) and 39 to 59 years old (large size); high school education level (9 years of schooling) (medium size) and higher education (large size); in a situation of job stability; monthly personal income of up to R\$ 1,000.00 (medium size) and from R\$ 2,001.00 (large size); they are divided between not having a religious orientation and professing the evangelical religion; he has a partner; according to sexual orientation and mode of HIV transmission, homosexual (large size) and heterosexual or did not want to answer (medium size); they never use condoms; with a diagnosis time of less than 6 years; use ART and duration of ART use less than 4 years; they do not consider themselves sick; have a good perception of their own health.

The results of the lexical analysis of the interviews in medium-sized municipalities revealed 5,357 forms, with 75,445 occurrences; 3,089 reduced forms, with 2,090 active forms of words and 848 supplementary forms. The formation of the dendrogram of the DHC of these municipalities involved 2,126 TSs, with a use of 89.84% of the total TSs, generating five classes, as shown in figure 1.

Figure 1: Descending Hierarchical Classification Dendrogram by semantic content of the lexical analysis of medium-sized municipalities. Macaé and Rio das Ostras, 2021.



Source: Iramuteq software, 2021.

In order to better understand the internal divisions of the material during the CHD, it was chosen to be called "Social representations of quality of life for people living with HIV and their interfaces", followed by axis 1, entitled "Memories and knowledge of HIV transmission"; in the next division of the corpus, axis 2 was generated, "Relations, social determinants and public policies in improving the quality of life of people living with HIV". This was subdivided into two parts: "Policies of care for people living with HIV and their repercussion on quality of life" and "Affective and social aspects for quality of life".

The classes were named according to the division of CHD observed: Class 5: Sexuality, prevention practices and memories of HIV/AIDS; Class 4: Quality of life and its interface with health services; Class 1: Antiretrovirals and their interface with daily life and quality of life; Class 3: Interpersonal and family relationships and their interfaces with quality of life and Class 2: Prejudice, social support and their facets with HIV.

Figure 2 presents the results of the lexical analysis of the large municipality, which identified 3,639 TSs, that is, 80.08% of the total material analyzed, generating four classes. The corpus was composed of 7,091 forms and 125,712 occurrences; word stemming obtained 4,337, containing 4,128 active forms of words and 8 supplementary forms.

Based on the internal divisions proposed in the analysis, it was called "Social representations of quality of life for people living with HIV and their interfaces", followed by axis 1, "Constituent factors for quality of life"; this was subdivided into "Quality of life: from the present to the future in living with the syndrome" and "The affective and social dimensions of quality of life for people living with HIV". Axis 2 was called "Public policies and the support of the multiprofessional team in the process of living with HIV".

The classes were named as follows: Class 4: Predictors of quality of life; Class 3: Interpersonal and family relationships and their interfaces with quality of life; Class 2: Prejudice, social support and its facets with HIV and Class 1: Quality of life and its interface with health services.

Figure 2: Dendrogram of descending hierarchical classification by semantic content of the lexical analysis of the large municipality. Rio de Janeiro, 2021.



Source: Iramuteq software, 2021.

The results of the two analyses show consensual content and divergent content. The comparison of the classes shows that the consensual elements of the two analyses (medium and large) were related to the health services and the multiprofessional team; to the social and family relationships in the routine of people living with HIV. While the class: Prejudice, social support and its facets with HIV was shared by medium and large municipalities.



The analysis of divergent contents was carried out considering the specificity of each subgroup of municipalities. It is observed that sexuality, prevention practices and memories of HIV/AIDS and antiretrovirals and their interface with daily life are specific to medium-sized municipalities, while the predictors of quality of life only appear in large municipalities.

CONSENSUS ON SOCIAL REPRESENTATIONS OF QUALITY OF LIFE IN MEDIUM AND LARGE MUNICIPALITIES

The classes identified as consensual to large and medium-sized municipalities are: Classes 4/1 – Quality of life and its interface with health services; Classes 3/3 – Interpersonal and family relationships and their interfaces with quality of life and Classes 2/2 – Prejudice, social support and their facets with HIV.

Quality of life and its interface with health services (Classes 4 and 1)

Class 4 of medium-sized municipalities and class 1 of large municipalities were called "Quality of life and its interface with health services", due to the similarities presented and which will be described and discussed below. The classes were composed of 221 TSs (class 4), representing 11.57% of the total *corpus* analyzed, and 790 TSs (class 1), which comprises 27.11%.

The similarities of the variables associated with the two classes are: employment, religion, considering oneself sick, and personal income. It is observed that the similar variable was considering oneself sick with $x^2 = 6.41$ and $x^2 = 21.97$, in both sets of municipalities. With regard to the variables with different responses, the Catholic religion ($x^2 = 8.12$) associated with medium-sized municipalities stands out, and not having a religion ($x^2 = 14.2$) in the large one. Another variable with different answers is unemployed ($x^2 = 20.97$), which is associated in large municipalities, and employed/working ($x^2 = 8.2$), associated with medium-sized municipalities; in addition to personal income of R\$ 1,000.00 ($x^2 = 18.22$) associated with the large municipality and more than R\$ 2,000.00 ($x^2 = 3.79$) with the medium-sized municipality, marking the socioeconomic differences between the municipalities.

The two classes discussed deal with the institutional health support network for people living with HIV in the municipalities. The context of the health professionals' work, especially the figure of the physician and the psychologist, appears prominently in the discourse of these groups. These classes ratify the importance of care and treatment in the public health network, as a predictor of better quality of life, as can be evidenced in the following WH's.

What helps the most in my quality of life today is because I have a doctor who takes care of my health, I have the STD/AIDS Program that is accompanying people with AIDS, and it is free. (interview 1095; municipality of Macaé; female; age 18-38 years; high school; employed; does not use ARV; does not consider himself ill).



Another relevant aspect to be highlighted concerns the interpersonal relationship established between users and health professionals. The care provided is evaluated as satisfactory, since the professionals, especially doctors and psychologists, develop active listening, establish dialogue and show affection and affection.

The care offered by the public health network was positively evaluated, with helpful professionals who safely guide patients in relation to their diagnosis and treatment, as well as the availability of free antiretroviral therapy. This positive evaluation is maintained, even among patients who reported having contact with other health services in the private network. As a negative aspect, failure in the organization of the program was reported, especially in the large municipality, but the positive evaluation is dominant in the discourses.

Interpersonal and family relationships and their interfaces with quality of life (Classes 3)

Classes 3 of the two analyses were called "Interpersonal and family relationships and their interfaces with quality of life". They are composed, respectively, of 280 STs (14.66%) in medium-sized municipalities and 386 STs (13.25%) in large municipalities.

Regarding the confluences of the associations of variables with classes, females stand out, with a higher $x^2 = 32.93$ in a large municipality and a smaller one in a medium-sized municipality ($x^2 = 6.63$). The variables related to the time of diagnosis and time of use of ARV have different responses in the groups. In medium-sized municipalities, the time of diagnosis is up to six years ($x^2 = 18.34$); use of ARV for up to four years ($x^2 = 18.6$). For the large municipality, the time of diagnosis is greater than 14 years ($x^2 = 8.87$); use ARV for more than 11 years ($x^2 = 7.5$). This opposite configuration of the time of diagnosis and the time of use of ARV is important because it expresses the subjects' greater experience in dealing with the disease in the large municipality and expresses the process of interiorization, which followed the appearance of the first cases in large cities. These attributes have potential repercussions for the daily lives of these groups, as well as for the way they represent quality of life.

It is important to emphasize in these classes how the affective and social aspects are verbalized in each group. These relationships, especially family relationships, are similar in terms of the bond established, the relationship between father, son, brother, which incorporate the socio-affective dimensions. Therefore, these classes present elements of day-to-day living, of conviviality and that encompass various feelings, such as suffering and fear of the revelation of the diagnosis, prejudice, death, loneliness, religiosity and hope for the future.

Quality of life is not only related to a long life, since living with HIV is facing several difficult situations in daily life, including discrimination, segregation, the rupture of affective and family relationships and difficulties in the exercise of sexuality, as shown in the WS below.



Currently my social support is my mother; My mother supports me a lot, she always picks on me, my family. (interview 0075; municipality Rio de Janeiro; male; age 18-38 years; high school; employee; uses ARV; does not consider himself ill).

It is important to highlight, in the discourses of the interviewees from the large municipality, religiosity as a pillar for coping with HIV and the obstacles arising from this serological condition. Spirituality provides a different way of seeing the disease, through belief in God and faith, helping in the acceptance of the diagnosis and in the experiences related to the infection.

In the past I had faith, I had faith that I was going to be healed, I had this promise from God that I was going to get married, that I was going to have children, so some part of me had this tranquility. (interview 0162; municipality Rio de Janeiro; female; age 39-59 years; higher education; employee; uses ARV; does not consider himself ill).

In view of this, in the family context and in social life, HIV/AIDS is represented as a disease that brings suffering, fear of discovery and prejudice. Quality of life, in turn, is represented by the support of family and friends, in the group to which they belong, and through religiosity, which presents itself as a relational facet with the divine.

Prejudice and social support as facets of quality of life (Classes 2)

Classes 2 of the medium-sized municipalities and the large municipality were called "Prejudice and social support as facets of quality of life". The classes were composed of 527 TSs (medium size), representing 27.59% of the total *corpus* analyzed, and 790 TSs (large size), which comprises 27.11% of the material analyzed.

In the associations of variables to classes, heterosexual orientation associated with medium-sized municipalities and homosexual/bisexual in large municipalities stand out. The highest personal income is common to both classes, with $\chi^2 = 9.33$ in the medium-sized municipality, while in the large-sized municipality $\chi^2 = 4.47$; as well as the variable time of ARV use more than 11 years ($\chi^2 = 4.99$ and 2.88 , respectively in large and medium-sized municipalities; and non-use of condoms with $\chi^2 = 2.81$ and 2.33 in medium and large municipalities).

One of the aspects addressed in the evaluation of the quality of life of people living with HIV encompasses social support, mainly due to the situations of prejudice that still characterize reactions to seropositivity and that can affect the support network. The fear of prejudice and isolation as self-protection sometimes make individuals hide the diagnosis or cut the bond with family members, generating even more suffering, isolation due to the reduction of the support network.

I think there are people who just say that you are a person with AIDS or that you know a person with AIDS already move away. That's prejudice, that's how people are. Currently my relationship with my family is good. (interview 1073; municipality of Macaé; female gender;



age 39-59 years; elementary school; employee; does not use ARV; does not consider himself sick).

The manifestations of prejudice in the world of work can cause suffering to this group in its sociability dimension, as they seek to keep their HIV seropositivity secret due to the fear of exclusion from work and the judgment of colleagues, avoiding questioning this aspect.

About the quality of life at work, the situation currently is if you tell people that you are a person with AIDS, prejudice appears; people don't know what this situation is, what it's like to live with HIV/AIDS. (interview 0120; male; age 18-38 years; higher education; employee; uses ARV; does not consider himself ill).

The two classes reveal the strategies for coping with prejudice, observed in both medium and large municipalities. These strategies are differential and adaptive in the face of positive or negative attitudes of the support network when confronting the disease. But they are also permeated by the memories of HIV/AIDS that bring the fear and prejudice experienced in the past to the current reality.

DISAGREEMENTS IN THE SOCIAL REPRESENTATIONS OF QUALITY OF LIFE IN MEDIUM AND LARGE MUNICIPALITIES

The classes identified as specific to each group of municipalities analyzed configure the disagreements in the social representations of quality of life and will be presented. The classes that make up the dendrogram of medium-sized municipalities are: Class 5 – Sexuality, prevention practices and memories of HIV/AIDS; Class 1 – Antiretrovirals and their interface with daily life and quality of life. The large municipality has only one specific class: Class 4 - Predictors of quality of life.

DISAGREEMENTS OBSERVED IN THE SOCIAL REPRESENTATIONS OF QUALITY OF LIFE IN MEDIUM-SIZED MUNICIPALITIES

Sexuality, prevention practices and memories of HIV/AIDS (Class 5)

Class 5 of the analysis of medium-sized municipalities called "Sexuality, prevention practices and memories of HIV/AIDS" is composed of 239 WH, which comprises 12.51% of the total corpus analyzed. The variables with the greatest association with the class are: non-use of ARV ($x^2 = 19.88$); evangelical religion ($x^2 = 11.03$); time of HIV diagnosis of up to 6 years ($x^2 = 6.94$); marital status without a partner ($x^2 = 3.84$); and personal income of up to R\$ 1,000.00 ($x^2 = 3.14$).

Participants from medium-sized municipalities reveal that they are aware of the form of sexual transmission of HIV and describe having contracted the virus from sexual partners due to the non-use of prevention methods. Lack of information does not seem to be the main factor associated



with contagion, although it still exists, and is responsible for triggering the increase in risk behaviors, such as the practice of unprotected sex.

HIV/AIDS is easy to transmit through sexual intercourse without a condom, oral intercourse as well. I believe that it is caught through the secretion of sexual intercourse without a condom; using drugs with a needle that other people use at the same time. (interview 1089; municipality of Macaé; male; age 18-38 years; high school; retired; uses ARV; does not consider sick).

This class demonstrates contents related to the importance of knowledge for the adoption of prevention practices, but also to the non-linearity between having knowledge and adopting such practices. Sexual transmission was the most reported form of transmission, with implications for the exercise of sexuality. Quality of life, therefore, is understood as dependent on the degree of freedom and responsibility in the exercise of sexuality.

Antiretrovirals and their interface with daily life and quality of life (Class 1)

Class 1 of medium-sized municipalities, named "Antiretrovirals and their interface with daily life and quality of life", has 643 TSs, which comprises 33.66% of the total corpus analyzed, being the largest class of medium-sized municipalities. The variables with the greatest association with the class were: considering oneself sick ($x^2 = 32.05$); evaluation of good or very good health ($x^2 = 26.82$); always use a condom ($x^2 = 23.95$); homosexuals + bisexuals ($x^2 = 22.07$); transmission of the disease through MSM/homosexual contact ($x^2 = 19.45$); time of HIV diagnosis of 6-14 years ($x^2 = 14.37$); uses ARV ($x^2 = 10.29$).

In order to achieve the longevity predicted by the appropriate use of ART, adherence to treatment must remain adequate over the years. In the testimonies, the participants reveal feelings related to the use of antiretrovirals and the practices of a healthy eating routine and physical activity in order to preserve their quality of life.

The relationship established with ARV is marked by ambiguous feelings, as the medication is something that promotes control and living with HIV, without AIDS. At the same time, something that causes damage associated with difficulties in adhering to ART due to the side effects caused, the amount of medications and schedules, sometimes segregating these patients and placing the disease as a secretion, negatively influencing quality of life.

Currently, I honestly only have the benefits, because I don't have any side effects. The only thing is that I only remember later that I have to take that antiretroviral at night; I take it once a night just before bed. (interview 0162; female; age 39-59 years; higher education; employed; uses ARV; not considered ill).

For those who did not take any antiretroviral, starting to take almost 20 pills a day of antiretroviral messes with the psychological. I had to always be worried about whether it's time to take antiretrovirals; you have side effects. (interview 1069; municipality of Macaé; female gender; age 18-38 years; high school; employed; uses ARV; does not consider sick).



The subjects refer to the concern with the adoption of healthier habits developed through attitudes and behaviors recommended by science, related to food, sleep, physical activities, in addition to the appropriate use of antiretroviral drugs.

This class was associated not only with the use of ART, but with treatment in a broader conception, involving several dimensions that contribute to a good quality of life, even in a situation where the infection exists. The most positive associations related to the use of ART were characterized by the understanding of the need to readapt to the adoption of new daily habits, with the insertion of the continuous use of medications, in addition to the maintenance of other healthy behaviors. In addition, the greatest difficulties reported by the participants were linked to pharmacological side effects and the maintenance of a routine use of medications.

DISAGREEMENTS IN THE SOCIAL REPRESENTATIONS OF THE QUALITY OF LIFE IN THE LARGE MUNICIPALITY

Predictors of quality of life (Class 4)

Class 4, resulting from the analysis of the large municipality, called "Predictors of the quality of life of people living with HIV", is composed of 926 TSs and 31.78% of the total corpus analyzed, making up the largest class in this municipality. The variables with the greatest association with class are: good/very good health assessment ($x^2 = 14.82$); male sex ($x^2 = 12.92$); not using ARV ($x^2 = 9.72$); age group from 18 to 38 years ($x^2 = 8.39$); not having a partner ($x^2 = 7.39$); and personal income from R\$ 2,001.00 ($x^2 = 6.96$).

The predictors of quality of life identified in this analysis are related to healthy lifestyle habits, such as healthy eating, physical activity, regulated living, in addition to leisure, work and the maintenance of a belief in the divine.

The possibility of conceiving positive expectations and enjoying good health translates into better acceptance of the condition of seropositivity and greater adaptation, which ends up reflecting on the quality of life. By analyzing the class in question, there is a tendency already evidenced by other studies to present the representational aspects of AIDS linked more to life and future perspectives, surpassing, at least partially, the presence of representation in death.

The most important factor for the quality of life of people with AIDS today is prevention, maintaining a healthy life, doing physical activity. (interview 0164; municipality Rio de Janeiro; male; age 18-38 years; high school; employee; does not use ARV; does not consider sick).

Quality of life is also expressed by good nutrition, physical activity and work, aspects pointed out as part of a functional dimension of the social representations of the quality of life of people



living with HIV. It is noteworthy that good nutrition was also associated with self-care mode, such as that which replaces unhealthy habits, even in patients who are not using ARV.

Another important aspect for people living with HIV is work, since it is what ensures subsistence, in addition to being an environment of social interaction and one of the ways used to categorize individuals in society as productive or unproductive.

What is most important in quality of life today is that you have a good diet, that you can move on with your life, take your life into the future. (interview 0090; municipality Rio de Janeiro; male; age 39-59 years; higher education; employee; uses ARV; does not consider sick).

People living with HIV seek strength to accept their condition and take spiritual care of themselves, providing feelings of faith, hope and peace, being a predictor of good quality of life.

Hold on to some religion, at least something to believe the future will be better. I understand quality of life as physical activity, food and leisure. I think these are fundamental things today for you to have a quality of life. (interview 0011; municipality Rio de Janeiro; male; age 18-38 years; higher education; employee; does not use ARV; does not consider sick).

This class refers to the quality of life represented by multidimensional attributes of the daily life of people living with HIV, mainly related to objective indicators expressed in health-protective lifestyle habits.

DISCUSSION

In the context of HIV/AIDS, the concern with the concept of QoL refers to a movement within the human and biological sciences towards valuing parameters that are broader than just symptom control, mortality reduction or increased life expectancy, in which understanding QoL and its expression in symbolic constructions is fundamental. Thus, understanding the relationship between living with HIV and QoL implies apprehending the way they are structured and define their social practices and behaviors (Antunes et al., 2022).

The implications of living with HIV go beyond physical and biological impairment. Psychological and social difficulties are also observed, which are factors that influence living with this condition. The stigma and prejudice experienced, or even the fear of experiencing them, can lead to social and family isolation, compromising the social support network and health monitoring (Marques et al., 2020).

Also from this perspective, social relationships may also be threatened due to the fear of suffering discrimination and prejudice, for example, at the time of disclosure of the diagnosis. Thus, the individual chooses not to reveal his or her HIV-positive serology, adopting behaviors of social isolation and withdrawal (Oliveira et al., 2023).



This fact is presented in an integrative review of social representations of people living with HIV in which it portrays stigmas and prejudices, social dimensions, social vulnerability and health conditions (Juliano; Andrade; Thobald, 2022).

Another study demonstrated the diagnostic representations of 14 HIV-positive patients in the city of Rio de Janeiro. The representations were divided into two groups: pessimistic representations whose content refers to stigmatized diagnosis, AIDS appearance, contaminating potential, diagnosis of imminent death, diagnosis as a punishment; and optimistic representations in which participants refer to their quality of life as appearing healthy and dissociation between being the carrier of the virus and having AIDS (Muniz; Brito, 2022).

Thus, the social representations of the quality of life of people living with HIV are important due to the need for subjects and groups to keep themselves informed about their health, the process of becoming ill with HIV and the strategies to cope with this process, ensuring a better overall quality of life for the group. An integrative review study reveals that understanding HIV from the perspective of social representations favors reflections on the disease and its repercussions on daily life. Anchoring through this process allows the understanding of the perceptions and singularities experienced by people living with HIV/AIDS and contributes to a change in behavior and the reduction of the harmful effects of the disease (Fonseca et al., 2023).

Anchoring can involve the modulation of behaviors, making the environment and certain social objects more familiar and, therefore, subject to greater physical and intellectual domination, with the identification and resolution of emerging issues in the daily life with HIV and AIDS. In this process, it becomes essential for this group to attempt to integrate new, unfamiliar elements, originating from reified knowledge, into a system of pre-existing norms, beliefs, and values and, therefore, less alien to it, as proposed by several basic authors of SRT (Oliveira et al., 2023).

Thus, quality of life is conceptualized in the reified universe from different approaches, it is a complex concept that admits a diversity of meanings, with varied theoretical approaches and numerous measurement methods. The impact of HIV infection can generate changes in several aspects of individuals' lives. Facing this problem, associated with the difficulties that serological status imposes in relation to quality of life, has been one of the challenges faced by people living with HIV and by science (Cecílio et al., 2018).

The social representation of the quality of life observed from the set of subjects studied is constituted by symbolic dimensions related to the following contents: HIV/AIDS control program; antiretroviral drugs; interpersonal, affective and family relationships; sexual and prevention practices; social aspects and prejudice; in addition to a pragmatic dimension related to health promotion practices and the future.



The search for good levels of quality of life and not getting sick involves behaviors that aim to change lifestyle in terms of physical health, psychological state, level of independence, social relationships, and interaction with the environment (Silva et al., 2021). In the results of this research, these dimensions were observed as essential for the promotion and maintenance of quality of life. These contents were built from psychosocial and communication processes developed throughout the AIDS epidemic in Brazil and in the world. These dimensions express consensual representational contents, therefore, shared quality of life by the groups studied.

The consensual contents mentioned showed variations in the comparison between the groups, revealing that some of them are specific to a certain group of people living in large or medium-sized municipalities. These specific contents are: antiretroviral drugs; sexual and prevention practices; pragmatic dimension related to health promotion practices and the future, and family and interpersonal relationships. The understanding of the disagreements made it possible to highlight symbolic constructions specific to each set of municipalities studied.

The differences observed suggest symbolic variations due to the socio-economic-cultural and historical contexts of each city. The quality of life in medium-sized municipalities was observed based on dimensions exclusive to this group, which are not shared with the subjects of the large municipality. They are those related to: use of antiretroviral drugs, maintenance of sexual practices and prevention.

These representational contents allow us to reinforce the importance of these themes for quality of life, permeating concepts and concerns related to the body, illness and its coping, as well as behavioral aspects related to daily practices in the face of the disease. For the large municipalities, they were surrounded by contents specific to the quality of life, revealing a specific dimension, related to the adoption of a healthy lifestyle, with food, physical exercise and the adoption of a positive vision of the future, approaching the concept proposed by the World Health Organization.

CONCLUSION

It is concluded that differences were observed in the contents of the social representations of quality of life in the two groups analyzed, referring to cultural and socio-historical constructions typical of the ways of life and interpersonal relationships of small and large cities. This finding points to the adoption of lifestyles focused on self-care in order to achieve a better quality of life in large municipalities and to cope with the disease and the maintenance of more conservative values with regard to ways of living in medium-sized municipalities.

However, the presence of two distinct representations cannot be affirmed, considering the existence of hegemonic consensual elements in both groups, in addition to the need for other confirmatory techniques of analysis. In this context, the importance of public policies to value the



subjective issues expressed by individual subjects and social groups should be considered, since the understanding of quality of life is not reduced to the biomedical model and is related to the social, cultural and ideological context, if the intention is to produce a positive impact on the lives of people living with HIV.

It is believed that the data presented here and other studies can favor a reflection of health professionals, and especially nursing professionals, regarding their role in the performance of health care, in favor of a more effective nursing care in which the role of each professional is known and recognized.

STUDY LIMITATIONS

The convenience sample that limits the demonstrative effect of the results stands out; technical difficulties still present in some functionalities of the Iramuteq software that prevented even more objective comparisons.

CONTRIBUTIONS TO THE AREA OF NURSING, HEALTH OR PUBLIC POLICY

It is believed that this article can contribute to understanding how health professionals can interfere in the health care established today and provide reflections that enable professional improvement, to improve care and, therefore, the quality of life of people living with HIV.

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