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ORIGINAL ARTICLE

QUALITY OF LIFE OF PEOPLE WITH HUMAN IMMUNODEFICIENCY VIRUS AND INTERIORIZATION: MULTIDIMENSIONAL ASSESSMENT

QUALIDADE DE VIDA DE PESSOAS COM VÍRUS DA IMUNODEFICIÊNCIA HUMANA E A INTERIORIZAÇÃO: AVALIAÇÃO MULTIDIMENSIONAL

INMUNODEFICIENCIA HUMANA Y LA INTERIORIZACIÓN: EVALUACIÓN MULTIDIMENSIONAL

Tadeu Lessa da Costa[1], Denize Cristina de Oliveira[2]

ABSTRACT

Objective: to analyze the quality of life of people with human immunodeficiency virus (HIV) in the context of interiorization of the epidemic. ***Method:*** this is a quantitative study, with a non-probabilistic sampling of 150 people infected by the HIV. A socioeconomic questionnaire and the WHOQOL-HIV-Bref instrument for assessing quality of life were used. The statistical analysis used the syntax of the instrument. The research was approved by the Research Ethics Committee of Universidade do Estado do Rio de Janeiro, CAAE 0009.0.325.000-11. ***Results:*** we identified a general positive perception of quality of life and health, by analyzing the corresponding facets. However, through the multidimensional evaluation, we identified an intermediate positioning in the 6 domains of the scale, and the worst score is associated to the domain "environment". ***Conclusion:*** infected people's quality of life is negatively impacted by the existential and material aspects and by the general life conditions, as well as the social relationships. ***Descriptors:*** Quality of Life; Human Immunodeficiency Virus; Acquired Immunodeficiency Syndrome; Nursing.

RESUMO

Objetivo: analisar a qualidade de vida de pessoas com o vírus da imunodeficiência humana (HIV) em contexto de interiorização da epidemia. ***Método:*** trata-se de estudo quantitativo, com amostragem não probabilística de 150 pessoas infectadas pelo HIV. Foram utilizados um questionário socioeconômico e o instrumento WHOQOL-HIV-Bref de avaliação da qualidade de vida. A análise estatística utilizou a sintaxe do instrumento. A pesquisa foi aprovada pelo Comitê de Ética em Pesquisa da Universidade do Estado do Rio de Janeiro, CAAE n. 0009.0.325.000-11. ***Resultados:*** identificou-se uma percepção geral positiva da qualidade de vida e saúde, por meio da análise das facetas correspondentes. Entretanto, pela avaliação multidimensional, identificou-se posicionamento intermediário nos 6 domínios da escala, sendo o pior escore associado ao domínio "meio ambiente". ***Conclusão:*** a qualidade de vida das pessoas infectadas é impactada negativamente pelos aspectos existenciais e materiais e pelas condições gerais de vida, assim como pelas relações sociais. ***Descritores:*** Qualidade de Vida; Vírus da Imunodeficiência Humana; Síndrome da Imunodeficiência Adquirida; Enfermagem.

RESUMEN

Objetivo: analizar la calidad de vida de personas con el virus de la inmunodeficiencia humana (VIH) en el contexto de la interiorización de la epidemia. ***Método:*** esto es un estudio cuantitativo, con una muestra no probabilística de 150 personas infectadas por el VIH. Fueron utilizados un cuestionario socioeconómico y el instrumento WHOQOL-HIV-BREF de evaluación de la calidad de vida. El análisis estadístico utilizó la sintaxis del instrumento. La investigación fue aprobada por el Comité de Ética en Investigación de la Universidade do Estado do Rio de Janeiro, CAAE 0009.0.325.000-11. ***Resultados:*** se identificó una percepción general positiva de la calidad de vida y la salud, por medio del análisis de las facetas correspondientes. Sin embargo, por la evaluación multidimensional, fue identificado posicionamiento intermediario en los 6 dominios de la escala, y la peor puntuación se asocia con el dominio "medio ambiente". ***Conclusión:*** la calidad de vida de las personas infectadas es afectada negativamente por los aspectos existenciales y materiales y por las condiciones generales de vida, así como por las relaciones sociales. ***Descriptores:*** Calidad de Vida; Virus de la Inmunodeficiencia Humana; Síndrome de la Inmunodeficiencia Adquirida; Enfermería.

[1]Nurse. PhD Professor in Social Psychology at the Nursing and Obstetrics course of Universidade Federal do Rio de Janeiro (UFRJ). Macae (RJ), Brazil. Email: tadeulessa@yahoo.com.br; [2]Nurse. PhD in Public Health. Full Professor at the School of Nursing of UFRJ. Rio de Janeiro (RJ), Brazil. Email: dcouerj@gmail.com

INTRODUCTION

The epidemic of human immunodeficiency virus (HIV) and the disease it causes, the acquired immunodeficiency syndrome (AIDS) currently present significant figures, with around 34 million people living with this virus around the world.[1] In Brazil, from 1980 to the end of 2011, 253,703 deaths were officially indicated to be caused by this health problem, with an estimated existence of 656,701 AIDS cases notified until June 2012.[2]

Since the second half of the 1990s, the disease acquired new outlines, with innovations that started occupying a space within the scientific community and in the public health policy agendas. The introduction of the highly active antiretroviral therapy (HAART) stood out, which enabled a significant reduction in mortality and the inabilities triggered by the disease, culminating in a substantial increase in the survival of HIV-infected people.[3,4]

Despite the therapeutic advances mentioned, many questions remain as major challenges to be faced. Among these aspects we find the increased quality of life of people living with HIV/AIDS, a key element for designing the global political and institutional responses to AIDS.[5] If there was, on the one hand, an increased lifetime of these subjects, on the other, we observe the multiple psychosocial implications of this disease, as well as the consequences that the treatment itself brings on to the existential conditions and the health of infected people.[6,7] From this perspective, currently, a challenge shown up to the HIV/AIDS field is understanding the way how the quality of life of people living with this health problem is set and the possible strategies to improve it. However, if the need for studying the quality of life has been increasingly recognized, we may say that there's no consensus about its conceptualization among the various authors involved, due to its complexity.

The inclusion of the concept of quality of life into the health care sector was faced with other tangential constructs. Some of them would be distorted, reflecting, primarily, a focus on the dimension: *biological and functional*, such as health status, functional status, and impairment/disability; *psychological*, such as well-being, satisfaction, and happiness; and *economic*, based on the preference theory.[8] There're researchers who regard as impossible conceiving quality of life without a cultural bond, while others believe in an abstract level, in the existence of a "cultural universal" of quality of life, in which people feel good psychologically, socially included, and functionally competent.[9]

The World Health Organization (WHO), aiming to provide means for the development of an adequate instrument for assessing quality of life, defined it as the individual's perception of their life status in the cultural context and the system of values in which she/he lives and with regard to her/his objectives, expectations, standards, and concerns. It's a broad spectrum concept which incorporates in a complex manner physical health, psychological status, level of independence, and people's social relationships, as well as their interfaces with important characteristics of their environment.[10]

We regarded as key aspects in this construct: subjectivity; multidimensionality; and the presence of positive and negative dimensions (bipolarity).[8] Thus, the quality of life would cover the very health field delineation, being complemented by factors regarded as external (social cultural, economic, physical, geographical, and health care). This, with the addition of aspects named as inherent to the subjects (biology, lifestyle, and health behavior, personality, motivations, values, and preferences).[11]

OBJECTIVE

- To analyze the quality of life of people with HIV in an epidemic interiorization context.

METHODOLOGICAL PATH

This is a descriptive study, with a quantitative approach, having as subjects people with HIV/AIDS. Data collection was conducted in a specialized care service (SAE) on HIV/AIDS in a midsize town of the northern region of the state of Rio de Janeiro. The sample was non-probabilistic, based on convenience, selected through the information, made available by SAE, that there're 979 patients undergoing follow-up. We made the calculation of finite sample through a pilot study with 45 subjects, obtaining a prevalence of 11% and assuming a confidence level of 95% and 5% of error with regard to the average. Thus, we delimited in 131 the number of participants in the research.

The inclusion criteria were: being at SAE at the data collection time; having ≥ 18 years of age; having positive serology for HIV; showing mental conditions which could enable participation in the study; and agreeing to

participate in it. The data collection period was between May and October 2011.

Data collection took place, initially, with the application of a questionnaire with socioeconomic and clinical data. Then, for the quantitative assessment of quality of life, we used the instrument specifically developed for this purpose by the WHO, namely, the WHOQOL-HIV, in its abbreviated version (Bref), with 31 questions. This is a module designed through the transcultural methodology, including facets aimed at the people with HIV/AIDS and, therefore, with greater content validity and sensitivity.[12]

The WHOQOL-HIV-Bref has its 31 questions, or facets, distributed between 1 overall perception component and 6 domains for assessing quality of life: physical; psychological; level of independence; social relationships; environment; and spirituality, religion, and personal beliefs.[13,14] It has been translated and validated in Brazil; the psychometric characteristics and the instrument's transcultural perspective have shown to be satisfactory with regard to the Brazilian context.[14] It also presents appropriate reliability and internal consistency for the targeted scale and domains (0.87-0.94).[15]

The questions included in the said instrument are structured under the Likert's scale form, with 5 appropriate gradations, according to the domains and facets. It's worth highlighting that the WHOQOL-HIV, as suggested by the WHO, was filled in by the research subjects themselves, unless when they were unable to do so, due to the difficulty for reading. On these occasions, the researcher provided the filling in, according to the respondent's responses.[13]

The analysis of information with regard to the clinical and socioeconomic questionnaire took place, statistically, through central tendency measures and percentage distribution, using the software SPSS, version 17.0. Data from the WHOQOL-HIV-Bref were analyzed, initially, too, according to the distribution of the subjects' responses to questions in terms of absolute and relative frequency.

The analysis of data from the said instrument complied with the WHO guidelines contained in the document *Syntax for SPSS*.[16] Thus, the questions' scores within each domain of quality of life are used to calculate the domain's score, and this is the average of the questions' scores. The average values of the domain's scores were, then, multiplied by 4, so that the domains' scores were comparable by means of the scores used in the WHOQOL-100, with oscillation of values between the minimum of 4 and the maximum of 20.

For characterizing the level of quality of life identified through the application of the WHOQOL-HIV-Bref in each of its domains, we used the proposition laid out in previous studies with HIV-positive population.[17] This way, the score range between 4 and 9.9 would be regarded as lower position, from 10 to 14.9 as intermediate, and from 15 to 20 as higher.

We complied with the Resolution 196/96, from the Brazilian National Health Council (CNS), and the study was approved by the Research Ethics Committee of Universidade do Estado do Rio de Janeiro (UERJ), under the Protocol 017.3/2011 and the CAAE 0009.0.325.000-11. The subjects read and signed the free and informed consent term.

RESULTS

Regarding the subjects' characterization, there was an equitable distribution of the 131 participants with regard to gender, with 51.9% of men and 48.1% of women. Age ranged from 20 to 67 years, with an average age of 40.1 years; the predominant age group was from 20-49 years (80.1%). As for the education level, we identified a predominance of incomplete Primary School (33.6%) and complete Primary School (27.5%).

For marital status, there were records of close percentages in the categories of the group single or without a steady partner (41.2%), and married, living with a partner, or individuals in a marital-like relationship (46.6%). Taking into account the variable exposure category, most participants stated having acquired HIV through sexual intercourse (97%) and, regarding sexual orientation, the majority reported being heterosexual (78.6%) and 21.4% homosexual or bisexual.

Regarding the employment status, we observed, mainly, the category self-employment (25.2%), followed by work under the Brazilian regime of the Consolidation of Labor Laws (CLT) (24.4%) and 16.8% of unemployed people. The predominant individual income range was from 1.1 to 3 minimum wages (MWs) (37.4%) and, then, that earning up to 1 MW (29.8%).

Regarding clinical data, the time of diagnosed HIV seropositivity ranged between the minimum of < 2 months and a maximum of 28 years, with an average of 7.4 years, and 80.9% of subjects have ≥ 2 years of diagnosed disease. Most participants (77.1%) were already receiving HAART, with use between

the minimum of < 1 month and a maximum of 27 years, with the average of 7.2 years.

Then, the subjects' positions with regard to the facets of the instrument employed are shown, being grouped by domains. And, as undertaken in a previous study[18], they were also subdivided into two tables (Tables 1 and 2) according to the biggest prominence in the evaluation by most individuals due to their positivity, intermediate position, or negativity.

In the component overall perception, most subjects regarded their quality of life as good or very good and they showed to be satisfied or very satisfied with their health. As for the physical domain, we perceived that it's among those with a lower number of facets with positive position of subjects, with only one question. Thus, most subjects expressed a positive evaluation due to the absence or no influence of pain on their activities deemed as needed. Most respondents also regarded the presence of energy as sufficient to daily life, but with a borderline relative value (Table 1).

For the psychological domain, most subjects reported feeling good about themselves and enjoying life, very or extremely. Most of them reported being able to accept their physical appearance and have a good concentration in everyday life. At the level of independence domain, most of them had a more positive positioning. This way, we obtained predominant positive perception with regard to mobility, the ability to fulfill daily life activities, and the work capacity (Table 1).

Concerning the facets of the social relationships domain, the positioning of most participants also showed a positive way. This is so because there was a predominance of those who regarded themselves as satisfied with social relationships, as a whole.

The domain environment is that with the lowest amount of facets whose subjects' positioning is favorable. In descending order, participants regarded in a positive way the access to health services, housing conditions, and availability of information needed in everyday life, and the latter two showed borderline values.

For the domain spirituality, religion, and personal beliefs, we observed that 81.7% perceived a meaning for her/his own life. On the other hand, fear with regard to the future showed a borderline value, with subgroups having different perceptions.

Table 1. Distribution of answers regarding the WHOQOL-HIV-Bref with a predominantly positive assessment. Town in the northern Rio de Janeiro state, 2011.

Facets of quality of life - WHOQOL-HIV-Bref	n	%
Overall Perception		
Quality of life (good or very good)	86	65.7
Health (satisfied or very satisfied)	72	55
Physical Domain		
Pain (physical) as an impediment to do what is needed (nothing or little)	81	61.8
Sufficient energy in daily life (very or completely)	67	51.1
Psychological Domain		
Satisfaction with yourself (satisfied or very satisfied)	85	64.9
Enjoy life (very or extremely)	84	64.1
Acceptance of physical appearance (very or completely)	75	57.3
Concentration (very or extremely)	69	52.6
Level of Independence Domain		
Walking ability (good or very good)	97	74
Ability to fulfill daily life activities (satisfied or very satisfied)	81	61.8
Work ability (satisfied or very satisfied)	79	60.3
Social Relationships Domain		
Personal relationships (friends, relatives, acquaintances, colleagues) (satisfied or very satisfied)	86	65.6
Support from friends (satisfied or very satisfied)	82	62.6
Acceptance by people you know (very or completely)	81	61.9
Environment Domain		
Access to health services (satisfied or very satisfied)	85	64.9
Conditions where you live (satisfied or very satisfied)	73	55.7
Information required on a daily basis (very or completely)	67	51.1
Spirituality, Religion, and Personal Beliefs Domain		
Meaning in your own life (very or extremely)	107	81.7
Fear of the future (little or nothing)	66	50.4

Thus, for the physical domain, we observed as mean or more negative the assessment of subjects with regard to discomfort due to any unpleasant physical problem resulting from HIV and dissatisfaction with sleep (Table 2).

As for the psychological domain, we obtained, with unfavorable perception, the facet aimed at the experience of negative feelings, such as bad mood, despair, anxiety, or depression, in which most participants considered to have experienced them, from sometimes to frequently. It's noteworthy that 29% experienced such feelings frequently, very frequently, or always.

Regarding the level of independence domain, the only facet with a mean or more negative positioning refers to the need for medical treatment in daily life. Regarding the social relationships domain, only the facet linked to sexual life prevailed between mean and low satisfaction.

As for the environment domain, it's that with the largest number of facets with the subject's positioning at the mean or lower points. So, we observed in this condition the perception of the facets: money to meet the needs; leisure activities; transportation mean; environmental health; and safety in daily life.

Concerning the domain spirituality, religion, and personal beliefs, two of its facets showed borderline values for defining the mean or negative position: discomfort due to accountability on the part of other people for HIV seropositivity; and the concern with death. Thus, it denotes subgroups with non-consensual perceptions on such phenomena.

Table 2. Distribution of answers regarding the WHOQOL-HIV-Bref with mean and negative assessment. Town in the northern Rio de Janeiro state, 2011.

Facets of quality of life - WHOQOL-HIV-Bref	n	%
Physical Domain		
Discomfort due to have (or have had) an unpleasant physical problem related to the HIV (mean, very, or extremely)	71	54.2
Dissatisfaction with sleep (mean, dissatisfied, or very dissatisfied)	67	51.1
Psychological Domain		
Experience of negative feelings (bad mood, despair, anxiety, depression) (from sometimes to frequently)	93	71
Level of Independence Domain		
Need for medical treatment in daily life (mean, very, or extremely)	91	69.4
Social Relationships Domain		
Sexual life (mean, dissatisfied, or very dissatisfied)	89	67.9
Environment Domain		
Money enough to meet needs (regular, very little, or nothing)	117	89.3
Opportunities for leisure activities (mean, very little, or nothing)	101	69.5
Transportation mean (mean, dissatisfied, or very dissatisfied)	80	61.1
Healthy physical environment (climate, noise, pollution, appealing things) (mean, very little, or nothing)	74	56.5
Safety felt in daily life (mean, very little, or nothing)	68	51.9
Spirituality, Religion and Personal Beliefs Domain		
Discomfort by accountability of people due to the HIV (mean, very, or extremely)	70	53.4
Concern with death (mean, very, or extremely)	66	50.4

The result of domain scores for the analysis of the 31 facets of the instrument WHOQOL-HIV-Bref and its overall perception component are presented in Table 3. We also computed the Cronbach's alpha value to measure the internal consistency of items of the scale and of each domain.

Table 3. Distribution of statistical parameters related to the domains of the WHOQOL-HIV-Bref. Town in the northern Rio de Janeiro state, 2011.

Domains of the WHOQOL-HIV-Bref	n	Mean	SD	Median	Minimum	Maximum	Cronbach's alpha
Physical	131	13.81	3.54	14	4.0	20.0	0.7
Psychological	131	14.37	3.11	15	5.6	20.0	0.7
Level of independence	131	14.00	3.09	14	6.0	20.0	0.6
Social relationships	131	14.49	3.42	15.2	5.0	20.0	0.7
Environment	131	12.69	2.49	12.5	7.5	18.5	0.7
Spirituality, religion, and personal beliefs	131	13.98	3.77	15	5.0	20.0	0.6
Overall perception of quality of life	131	14.40	3.57	14	4.0	20.0	0.8

We obtained a Cronbach's alpha value of 0.9 for all 31 items of the WHOQOL-HIV-Bref and values ≥ 0.7 in the physical, psychological, social relationships, environment, and overall quality of life domains. Only in the spirituality, religion, and personal beliefs domain the value was 0.6.

The average scores of the domains quality of life showed distributions regarded as intermediate, between 10 and 14.9. The domains with values closer to the higher standard were the psychological, social relationships, and the component of the overall perception of quality of life. Concerning the first two areas mentioned, their median values were included into the stratum of higher classification, denoting a tendency to a better perception of them by participants.

The physical and level of independence domains had close mean scores and common median. As for the spirituality, religion, and personal beliefs domain, there was an intermediate score, but a median of 15, something which points out the fact that the key point of data takes place closer to the higher position of the assessment made by subjects. Furthermore, its greater variability reinforces the higher standard deviation value between the domains assessed.

The environment domain was that with the lowest average score and median among the six, as well as that showing the lowest standard deviation. Thus, we point out a group's more negative positioning in a more homogeneous way.

DISCUSSION

The results of the overall assessment of quality of life and health of people with HIV found in this study are similar to those found in Joao Pessoa, Paraiba, Brazil, where the researchers identified, respectively, percentages of 55.9% and 56%. Thus, the fact of being a carrier of that virus wouldn't imply, *per se*, that the subjects couldn't, through their assessment and socially shared beliefs and values, consider the prospect of a good quality of life and health.[19,20]

Given the comparison to other studies[21-23] which employed the same instrument for assessment, the psychological domain was among those with better evaluation. In other studies there was also an unfavorable influence of the facet negative feelings in everyday life. Although with a significant difference between people with AIDS (lower score) and those only symptomatic or asymptomatic, the psychological domain remained among those with higher position for these three subgroups.[22] After the advent of HAART, there was the possibility of the emergence of new elements and a process of change in the representations of AIDS, in the society as a whole, getting away from the idea of an invariably rapid death towards the prospect of chronic health problem, with which it would be possible to live.[4] So this daily experience with the chronic disease would allow designing reinterpretation processes, with the emergence of new anchors and the assumption of a less negative view of living in this context.[7,24,25]

As for the social relationships domain, the result found in this research is similar to that identified in Porto Alegre, Rio Grande do Sul, Brazil[22], where it was, along with the psychological component, among the highest scores of the domains for individuals who are asymptomatic, symptomatic, and those with AIDS. However, it was significantly lower in the third subgroup mentioned. That domain was characterized in the fourth position in decreasing values among the six domains in a large part of similar studies.[21,23] Moreover, if the comparative process is effected among HIV-negative people and other groups of patients with chronic diseases, as other authors in this area[17], we noticed that, even for the result of this study, where the social relationships domain has a more positive assessment about the other ones, it puts itself at lower levels when compared to the last groups of patients, and, with the same pace, we observe a pattern relatively similar to the other domains, and there're, even, some higher ones.

This way, it may also be evidenced by comparing the values found in this research for the social relationships domain with regard to people with HIV/AIDS to those deriving from clients with chronic renal failure on a hemodialysis regime, and the latter ones have higher scores.[26] By comparing to the group of psychiatry, medical clinic, gynecology, and surgery clients[27], we observed, similarly to other study[17], scores equal to or lower than those of seropositive subjects of this research in the physical domain; they're very close, although somewhat higher, for the psychological; and considerably higher in the social relationships domain, having in all groups mentioned a higher position, that is, with an average value of 15.5. This aspect, probably, is associated to the process of stigmatization and discrimination faced by people with HIV/AIDS, different from other patients with various chronic diseases who may, even, lean on a greater family social

support system, among friends, or society as a whole, at the time of diagnosis.[17]

Regarding the physical and level of independence domains, data resemble those found in researches[21] involving people with HIV/AIDS, as a whole, as well as with in other ones with the group of asymptomatic individuals with HIV/AIDS in the research for validating the WHOQOL-HIV-Bref.[14,22] According to these validation studies, there would be a significant difference with regard to the mean scores of these domains in accordance with the occurrence of their unfavorable progression to immunodeficiency, with body repercussions and compromised self-management ability.[14,22]

As for the spirituality, religion, and personal beliefs domain, several conducted investigations have evidenced the influence of these aspects, not just about the construct health, but also on quality of life.[28] It's worth noticing that in a study in the area[22] the authors raised the hypothesis of the occurrence of increased scores in this subscale in a proportional way to an unfavorable progression of HIV infection, and the symptomatic stage seems to be that of greater introspection and questioning about life and its meaning. It's worth highlighting that, as observed in other studies[21,23], we obtained a higher standard deviation value just in this particular domain, and it may be associated to a greater variability in the group's personal beliefs and religious affiliation.

As for the findings related to the environment domain, there was also a similarity to the findings of other authors.[14,21,22] This domain had the lowest mean score among the six domains within the group of asymptomatic HIV-seropositive patients.[22] In turn, within each of the groups of symptomatic subjects with AIDS, the domain with the lowest mean score was the physical one, as described by the same authors. This aspect may suggest a greater focus on the environment domain before the onset of the disease's symptoms, when the main attention would be related to the most affected physical component itself. Furthermore, there's a need for pointing out that, as in other studies[21,23], this domain has emerged as that having the lowest average score among the six. The environment component seems to consist in a cross-section issue among most subjects for whom the quality of life has been evaluated in accordance with the methodology proposed by the WHO. Thus, we evidenced a lower mean assessment value in this domain by gynecology and psychiatry clients, and it showed to be lower than that of all domains, except for the physical one, in patients undergoing follow-up in the medical clinic and surgery sector.

CONCLUSION

Given an approach to the phenomenon of quality of life of people with HIV/AIDS in a context of interiorization of the epidemic of the problem concerned, this study used the construct of the group WHOQOL-HIV of the WHO. And, as in other researches in the area, we identified a good perception of quality of life measured in its generic facet, but with intermediate patterns based on classification in the literature for standard multidimensional analysis results. In this sense, the only domain lower than the other ones was the environment, involving structural aspects of life, such as information, access to health services, transportation, leisure, finances, physical environment, and daily life safety. Out of these, the latter five aspects seem to have contributed, to a greater extent, to this result, providing means to a better understanding of the presentation of the said domain.

It's also worth highlighting that, despite a higher value found among the six domains to that of social relations, we recorded that its level is lower than that envisioned in other non-stigmatizing chronic pathologies. And, also, we highlighted the discomfort among the subjects with regard to the accountability assigned by society for having acquired the disease. This way, we think that it was relevant to employ the WHOQOL-HIV-Bref, taking into account that it's a tool originated from the needs and peculiarities arising from the people with HIV/AIDS themselves.

The findings of this study constitute, therefore, additional means to the public health field, for the management and enforcement of nursing care and for planning and assessing public policies aimed at setting the assistance related to the health problem concerned. This, especially, in the context of interiorization of the epidemic, where there's a need for greater investigative investments for understanding the dynamics of structuring and perceiving the quality of life of people infected by the HIV.

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Corresponding Address

Tadeu Lessa da Costa
Universidade Federal do Rio de Janeiro
Av. Aluizio da Silva Gomes, 50 – Granja dos Cavaleiros
CEP: 27930-560 – Macaé (RJ), Brazil