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## ORIGINAL ARTICLE

### HOSPITAL AND MEDICINAL CARE FOR THE HIV-SEROPOSITIVE CLIENTELE: SOCIAL REPRESENTATIONS OF NURSING PROFESSIONALS

#### CUIDADO HOSPITALAR E MEDICAMENTOSO À CLIENTELA SOROPOSITIVA AO HIV: REPRESENTAÇÕES SOCIAIS DE PROFISSIONAIS DE ENFERMAGEM

#### ATENCIÓN HOSPITALARIA Y MEDICAMENTOSA A LA CLIENTELA SOROPOSITIVA PARA HIV: REPRESENTACIONES SOCIALES DE PROFESIONALES DE ENFERMERÍA

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#### ABSTRACT

**Objective:** to analyze contents related to the hospital and medicinal care practices observed in the social representations of the nursing team with regard to the person with HIV/AIDS. **Method:** this is an exploratory and descriptive study, with a qualitative approach, based on the Theory of Social Representations, carried out with 40 nursing professionals at a university hospital, with whom an interview was conducted. The study was approved by the Research Ethics Committee of the Federal University of Rio de Janeiro (UFRJ), under the Protocol 1,575. **Results:** the contents addressed knowledge on HIV/AIDS and aspects of the nursing care delivered to the HIV-seropositive person, besides speeches about antiretroviral therapy and the nursing care procedures aimed at it. **Conclusion:** the social representations concerned guided the complexity of nursing care from a psychosocial perspective, taking into account the consequences and needs posed by HIV/AIDS, including the antiretroviral therapy, its progress, difficulties, and adherence strategies. **Descriptors:** Nursing Care; Acquired Immunodeficiency Syndrome; Antiretroviral Therapy; Hospital Nursing Service; Social Psychology.

#### RESUMO

**Objetivo:** analisar conteúdos relativos às práticas de cuidado hospitalar e medicamentoso observados nas representações sociais da equipe de enfermagem acerca da pessoa com HIV/aids. **Método:** trata-se de estudo exploratório e descritivo, com abordagem qualitativa, pautado na Teoria das Representações Sociais, realizado com 40 profissionais de enfermagem de um hospital universitário, com os quais se realizou entrevista. O estudo foi aprovado pelo Comitê de Ética em Pesquisa da Universidade Federal do Rio de Janeiro (UFRJ), sob o Protocolo n. 1.575. **Resultados:** os conteúdos abordaram o conhecimento sobre HIV/aids e os aspectos do cuidado de enfermagem prestado à pessoa soropositiva ao HIV, além de discursos sobre a terapia antirretroviral e os cuidados de enfermagem voltados a ela. **Conclusão:** as representações sociais em questão direcionaram a complexidade do cuidado de enfermagem em uma perspectiva psicossocial, tendo em vista as consequências e necessidades impostas pelo HIV/aids, dentre elas a terapia antirretroviral, seus avanços, dificuldades e estratégias de adesão. **Descritores:** Cuidados De Enfermagem; Síndrome De Imunodeficiência Adquirida; Terapia Antirretroviral; Serviço Hospitalar De Enfermagem; Psicologia Social.

#### RESUMEN

**Objetivo:** analizar contenidos relacionados con las prácticas de atención hospitalaria y medicamentosa observados en las representaciones sociales del equipo de enfermería acerca de la persona con VIH/sida. **Método:** esto es un estudio exploratorio y descriptivo, con abordaje cualitativo, basado en la Teoría de las Representaciones Sociales, realizado con 40 profesionales de enfermería de un hospital universitario, con los que se llevó a cabo una entrevista. El estudio fue aprobado por el Comité de Ética en Investigación de la Universidad Federal de Río de Janeiro (UFRJ), bajo el Protocolo 1.575. **Resultados:** los contenidos abordaron el conocimiento acerca del VIH/sida y los aspectos de la atención de enfermería ofrecida a la persona seropositiva para VIH, además de discursos acerca de la terapia antirretroviral y la atención de enfermería dirigida a esta. **Conclusión:** las representaciones sociales en cuestión dirigieron la complejidad de la atención de enfermería bajo una perspectiva psicossocial, teniendo en cuenta las consecuencias y las necesidades impuestas por el VIH/sida, entre estas la terapia antirretroviral, sus avances, dificultades y estrategias de adherencia. **Descriptores:** Atención De Enfermería; Síndrome De Inmunodeficiencia Adquirida; Terapia Antirretroviral; Servicio Hospitalario De Enfermería; Psicología Social.

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## INTRODUCTION

Thirty years after the onset of the epidemic of the human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), we realize changes in the social representations constructed with regard to the disease and affected people, despite the fact that we still observe many of those constructed in its early days. Representations taken, sometimes, as somebody else's health problem, to which the subject does not believe to be vulnerable. However, we cannot forget mentioning that representational changes are found out, even more intensely after the deployment, in 1996, of the Brazilian policy for the free and universal distribution of antiretroviral therapy (ARVT). This policy provides that all people with HIV and people with AIDS will receive, for free, from the Unified Health System (SUS), all medicines required for their treatment.<sup>1</sup>

Participating in the actions taken at all phases of the epidemic, nursing professionals care for these individuals both to keep their health status and for dealing with the already established disease; among the latter cases there are hospitalized persons seropositive for HIV.

This study is justified because we hope that the contents regarding the hospital and medicinal care practices contained in the social representations of the nursing team about the care provided to the HIV-seropositive person allow us to understand the guiding principles of these professionals in their respective actions. We can, as a consequence, think through the symbolic elements involved in the design of a good quality nursing care for the person living with HIV/AIDS and, thus, better serve this clientele.

From this perspective, this study aims to describe and analyze the contents related to the hospital and medicinal care practices observed in the social representations of the nursing team with regard to the care provided to the person with HIV/AIDS. Understanding that

[...] social representations are always a product of interaction and communication and they take their shape and specific configuration at any time, as a consequence of the specific balance of these processes of social influence.<sup>2:21</sup>

## METHOD

This is an exploratory and descriptive study, with a qualitative approach, grounded on the Theory of Social Representations. The

scenario consisted in a public university hospital, in the city of Rio de Janeiro, which has a Specialized Care Service (SCS) aimed at HIV/AIDS. We selected the sectors of Infectious and Parasitic Diseases, Medical Clinic, Pneumology, and General Intensive Care Center, taking into account the elements implied in the process for constructing a social representation, namely: focus and pressure for the inference.

The subjects were 20 nursing assistants and 20 nurses who met the inclusion criteria: work on one of the selected sectors; and care for or, in any other circumstance, have already cared for HIV-seropositive person. We complied with the requirements for conducting a research with human beings provided for the Resolution 466/2012, from the National Health Council, and the study was approved by the Research Ethics Committee of the Federal University of Rio de Janeiro (UFRJ), under the Protocol 1,575.

For collecting data, we used two instruments: a questionnaire with socio-professional data; and a semi-structured interview script with questions related to the care for HIV-seropositive people. The questionnaire had questions such as: sex; age; professional category; length of professional practice with HIV-seropositive people, among others. The interview script had questions aimed at the images, attitudes, and information related to the care for HIV-seropositive people. The interviews were recorded and transcribed.

For analyzing data, we used the lexical analysis, by means of the software ALCESTE (Lexical Analysis by Context of a Set of Text Segments), version 4.7. This software is a tool frequently used in studies on social representations and it enables a qualitative textual analysis through statistical association, measured by the chi-square test ( $\chi^2$ ). For this, it uses a comparison of lexical profiles, based on the "lexical distance", so that a greater closeness takes place when there are more identical lexical roots. Thus, the analysis was performed by forming elementary context units (ECUs) and classes. The classes consist of ECU sets defined so that the inter-class variance is maximized, at the expense of intra-class variance, with regard to the lexemes that these ECUs cover.<sup>3</sup>

It is worth stressing that we included socio-professional variables for analysis, such as: sex; age; professional category; length of professional practice.

RESULTS

Contents regarding the practices of hospital and medicinal care had higher statistical association to professionals: who are nursing practitioners; aged between 35 and 44 years; who practiced the profession for over 20 years; and those who worked with HIV-seropositive people for less than 15 years.

In the ECUs, we selected 50 short forms, those with higher chi-square ( $x^2$ ) values: antiretroviral agents ( $x^2 = 168.50$ ); transvestite ( $x^2 = 58.28$ ); side effect ( $x^2 = 49.92$ ); treatment ( $x^2 = 46.89$ ); know ( $x^2 = 34.83$ ); guidance ( $x^2 = 29.45$ ); talk ( $x^2 = 26.93$ ); difficult ( $x^2 = 25.02$ ); and survival ( $x^2 = 24.91$ ).

Through the analysis of groups of short forms present in upward hierarchical classification (UHC), we find out that the contents are divided into the classes generated by the software which served as a guide to the formation and the name of categories: “Care in the hospital context” and “Care guided by antiretroviral agents”. The first covers knowledge on HIV/AIDS and aspects of the care provided to the HIV-seropositive person during the hospitalization process, while the second covers the antiretroviral therapy (ARVT) and the care procedures focused on their adherence (Figure 1).

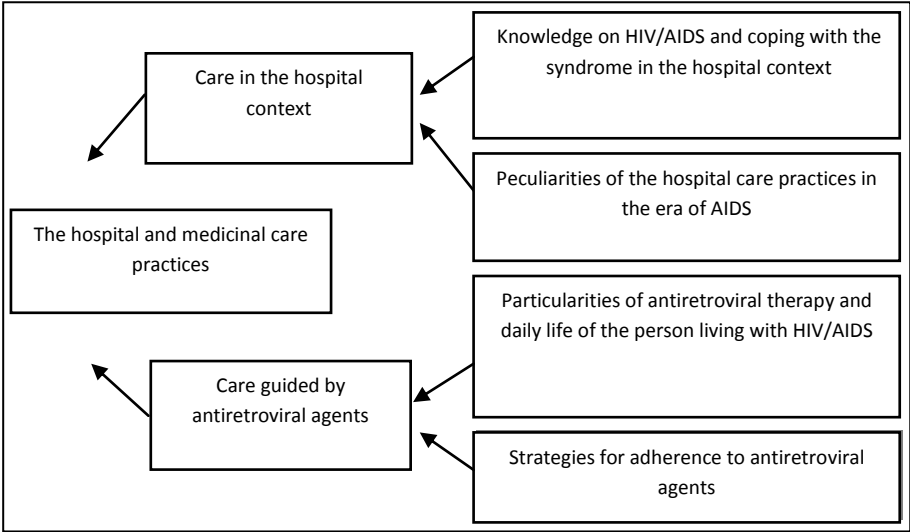


Figure 1. Categories and subcategories of contents regarding the hospital and medicinal care practices. Rio de Janeiro, 2013.

♦ Care in the hospital context

- Knowledge on HIV/AIDS and coping with the syndrome in the hospital context

Respondents addressed in their representations the importance that the nursing team improves itself with regard to the process of caring for HIV-seropositive people, in order to obtain knowledge, such as new medicines and biological aspects, and even psychological and relational aspects. That is so because respondents believe that, this way, they would provide a more skilled care, acquiring means to meet user’s needs, something which becomes of paramount importance for a more effective relationship. And, yet, there would be a need to have knowledge on the expected and adverse effects of the medicines used, possible opportunistic infections, and technological advances, in order to appropriately guide users and, whenever possible, minimize or understand unwanted sensations deriving from the disease and treatment:

*At the onset, it is actually more*

*complicated. It demands much effort from the professional. In addition to effort, it demands dedication. There is the issue of empathy. It also demands knowledge. Nursing professionals must always be trained with regard to the issue of HIV/AIDS, the new treatment, but also the way of approaching and the difficulty of this approach. (Respondent 09;  $x^2 = 33$ )*

Moreover, respondents associate to their representations the idea that users more informed about HIV/AIDS, by having greater awareness of its consequences, were more attentive and showed greater adherence to ARVT, and, hence, they had a better quality of life, keeping themselves under outpatient follow-up, without hospitalization:

*I realize that the HIV-seropositive client has some knowledge about HIV/AIDS through the transmission mode which led her/him to be affected by HIV/AIDS, she/he is more attentive to health, takes the antiretroviral agents, and has a healthier life. (Respondent 27;  $x^2 = 15$ )*

However, respondents indicated the presence of hospitalized HIV-seropositive people who were not aware of the

complications to which they were exposed, without a concern regarding the development of disease. The interviewed professionals, when knowing the diagnosis, immediately thought of an announced death of HIV-seropositive people:

*The biggest impact, even to me, is the diagnosis. Health care professionals know what are the opportunistic infections. The HIV-seropositive client is unaware of the complications and, initially, she/he has no such worry, because she/he ignores the opportunistic infections which can emerge.* (Respondent 37;  $x^2 = 25$ )

#### ♦ Peculiarities of the hospital care practices in the era of AIDS

In the social representation constructed by respondents, they think that the free distribution of ARVT, in Brazil, culminated in the chronicity of disease, as HIV-seropositive people survive for a longer time, and there is a need to keep treatment for the rest of her/his life. Thus, people live longer and they could be affected by other health problems, such as heart diseases. Because of this, what was previously experienced only in specific sectors is currently experienced in all sectors, as these users are found in many clinics:

*As it is endemic, there are many HIV-seropositive clients hospitalized with complications unrelated to HIV/AIDS. Sometimes, the HIV-seropositive client is hospitalized, takes the antiretroviral agents and she/he is hospitalized due to a complication in the gallbladder or heart disease.* (Respondent 26;  $x^2 = 14$ )

Among these users served, respondents emphasized in their representations that, despite the change in the Brazilian epidemiology profile, homosexuals still account for a large part of the people affected. They also recognized the intense prejudice suffered by this group in the hospital on the part of the other people with HIV/AIDS who are hospitalized. In face of this, the homosexual user often showed up angry and isolated her/himself, something which led respondents to believe there is a need for a specific location to provide this group with care:

*Our greatest difficulty is providing nursing care to the HIV-seropositive transvestite client. He does not feel at ease at the male ward, to the female ward he is not allowed to go, at the ward specific to him, he feels it is difficulty.* (Respondent 11;  $x^2 = 10$ )

Besides, the interviewed professionals reported that the long period, in years, over which they provided assistance to HIV-seropositive people facilitated the work process, as experience generated the

perception of normality assigned to care. Another factor observed in the representations were frequent readmissions of these users, due to opportunistic infections, something which led them to get used to the technical procedures and had greater ease of interaction with professionals.

We also observed in the representations difficulties to provide this clientele with nursing care, however, respondents stated that their determining elements were external to the team, being both in the HIV-seropositive people and in the workplace. As for the person with HIV/AIDS, the hindering elements were their inflexibility and their education level. Inflexibility was observed when there was no acceptance of care or the users refused the medicines. Regarding users' education level, they stated that the higher it was, the larger the number of questions and the level of interference in professional practice:

*It is evident that, at some moments, I feel more or less difficulty, depending on the type of person I provide nursing care. There are people who are more malleable. People coming from a more privileged social class have more years of study, they may be more difficult to be addressed.* (Respondent 09;  $x^2 = 18$ )

Regarding the workplace, they mentioned that the conditions of public health care services – such as the lack of material, instruments, and personnel – hindered the delivery of a good quality care. This interfered with the process and entailed the need to improvise in the absence of indispensable components:

*Because we do everything to have a very good quality, but the conditions of the sector do not enable this condition, because we do not have the appropriate equipment and our devices are outdated, there is a lot of better things available.* (Respondent 22;  $x^2 = 13$ )

#### ♦ Care guided by antiretroviral agents

##### • Particularities of ARVT and daily life of the person living with HIV/AIDS

The major breakthrough in ARVT was highlighted in respondents' social representations, taking into account that it led to a change in the stereotype of users and the difficulty to identify them, because they did not show the signs previously regarded as being characteristic of the disease:

*Currently, the antiretroviral agents constitute a great advance with regard to HIV/AIDS. Many people are HIV-seropositive clients and we do not think they are HIV-seropositive, because they are appropriately controlled.* (Respondent 29;  $x^2 = 22$ )



Besides, they contextualized the use of ARVT in Brazil, regarding it as an example for other countries, due to the free distribution of these drugs:

*No country provides so much information. Only in Brazil antiretroviral agents are free. Brazil is a reference regarding treatment.* (Respondent 33;  $x^2 = 9$ )

However, they pointed out that ARVT must be used for a long time, being compared to the treatment for chronic diseases, such as hypertension. Thus, they understood that various limitations were posed to the HIV-seropositive person, due to the large amount of medicines and the overlap of schedules. Furthermore, the existence of several side effects of these medicines made impossible the person's usual daily life, because they restricted activities until the person was adapted and/or these effects were minimized:

*When you know HIV/AIDS, you know that the future is in pain and prevention all the time. HIV-seropositive clients need to be careful not to acquire infections, relapse, and they need to live with the side effect of antiretroviral agents, which restrict and hinder daily life.* (Respondent 33;  $x^2 = 5$ )

Respondents represented that the adherence to treatment led to greater survival for people, which would be evidenced by the outpatient follow-up instead of hospitalization:

*Those who actually adhere to treatment, these we do not know. They come to the doctor's ward once every three months, to pick up the recipe.* (Respondent 15;  $x^2 = 12$ )

Given this, they sought explanations for the abandonment of ARVT by some users. One reason they realized was related to clinical improvement, because, in the absence of clinical signs and symptoms, the user could think she/he is no longer in need of using medications, suspending treatment. Another reason detected is the long duration of treatment and its rules:

*There are some antiretroviral agents that the HIV-seropositive client feels very difficult to adapt to. It is very difficult, this is an aspect. On the other hand, she/he thinks there is no need, she/he starts taking the antiretroviral agents and gets better, I am good, I do not need, that is the second reason.* (Respondent 15;  $x^2 = 28$ )

In addition to these reasons for treatment dropout, respondents represented as obstacles the presence of several side effects more frequently observed (such as nausea, vomiting, and malaise) and other long-term ones, yet little known, such as lipodystrophy (abnormal distribution of body fat).

The interviewed professionals also

associated non-adherence to users' socioeconomic conditions. Such conditions could vary from the impossibility to take the medication along with food appropriate to the difficulty of going to the health care service to get ARVT due to the distance from their residence:

*The third reason, some antiretroviral agent have to be taken along with food, with full stomach, and many HIV-seropositive clients cannot afford taking these antiretroviral agents with food, with food rich in fat or another type of food.* (Respondent 15;  $x^2 = 18$ )

#### ♦ Strategies for adherence to antiretroviral agents

In the social representation constructed by respondents, the role of the nursing team showed up quite relevant in the guidance regarding ways to mitigate the side effects of ARVT, something which greatly contributed to adherence. They stated that the bitterness and large size of pills made it difficult, too, their acceptance and they sought strategies to facilitate it:

*They refuse a lot due to vomiting and diarrhea. There are people who can not eat antiretrovirals. Then, look for ways to give before, with or after food.* (Respondent 30;  $x^2 = 36$ )

However, the strategies also aimed to help users to hide their status of living with this syndrome, such as removal of label from the vials, due to the social exclusion involved. They sought, this way, to avoid distancing from relatives and friends of HIV-seropositive people:

*So, they need to recognize the antiretroviral agents by color, but they are taught to recognize the antiretroviral agents by color and size.* (Respondent 15;  $x^2 = 21$ )

## DISCUSSION

Through the social representations of respondents, we understand the importance of the scientific knowledge acquired by nursing professionals to make the good quality of hospital and medicinal care to come true. This knowledge allows us to reach safety in the actions taken, the power of argument, the holistic care and the deployment of actions aimed at the user's benefit.

Among the actions aimed at the quality of life of the HIV-seropositive user we observe health education, with the objective of informing her/him on the disease, as well as on the progress and possibilities for their treatment. To do this, the nursing professional needs to be able to provide all

appropriate information regarding user's uncertainties, since it is believed that only by feeling adequately informed the user will reach the awareness needed to become a participant in the responsibility for her/his treatment exerting her/his autonomy.<sup>4</sup>

The moments of dialogue must take place at the time the diagnosis is disclosed and they are useful to lead the user to understand the process involved and its role regarding health and quality of life. Thus, it is important that health education has individual and different moments for each user, because the cultural influences, style, and living conditions differ from person to person and the user needs to feel comfortable to express their doubts, distresses, and feelings.

The disclosure of information regarding, specifically, HIV/AIDS becomes more effective when it takes into account the aspects of social representations – namely, the knowledge, perceptions, and attitudes – of the people on whom health education will be focused. The first aspect will allow coping with some resistance which, perhaps, makes people more accessible to messages. The understanding of HIV/AIDS greatly influences on the quantity and quality of information obtained, and it also reflects on the attitudes taken. In turn, the attitudes reveal the process for behavioral changes adopted by people, and, thus, the information provided may be more or less adequate to progress in this process.

In this sense, it is worth mentioning that respondents restricted, in their representations, their actions to the transmission of information and, this way, we cannot conceive health education as effective. In order to come true, it requires the training of individuals and groups to transform reality and not just the persuasion process or the transfer of information.<sup>5</sup> It consists in a social practice which contributes to the formation and development of a critical awareness of people with regard to their health problems and encourages the search for solutions and the organization for collective action.

It is emphasized that, for achieving comprehensiveness in health care actions there is a need to incorporate the renewal of their practices. For this, we must appreciate attention and lead care to emerge as a basic dimension for the health care policy which is actively provided in the daily life of services.<sup>6</sup>

It is considered that the chronicity of AIDS, controlled by the introduction of ARVT, is an important factor observed in the social representations constructed by the group

interviewed, since it brings the need for changes regarding knowledge, values, attitudes, and individual and collective behaviors. Thus, there is a change from the representation where living with AIDS means closeness to death, being marginalized and discredited, to a representation where AIDS is seen as a chronic disease, compared to hypertension and diabetes mellitus, with personal, collective, and government incentives aimed at redirecting life with HIV.<sup>7,8</sup>

Studies on social representations show that the introduction of ARVT caused, among other changes, the displacement of death from the core of the social representation of health care professionals, whereas the treatment has taken a leading role in this representation. Thus, we may claim that such representations acquire a more functional and less normative nature<sup>8</sup>, with a direct influence on hospital and medicinal care aimed at the HIV-seropositive person. Still, in face of the chronicity mentioned, the respondents' representations indicate the impacts found out in health care services, where there is an increasing number of hospitalized HIV-seropositive individuals due no more to opportunistic infections, but to secondary pathologies, such as heart diseases.<sup>9</sup>

It was found out that, despite the changes in the epidemiologic profile of AIDS and in the understanding that all people are vulnerable to HIV, the social representations of nursing professionals still show a greater discrimination against certain social groups affected by the epidemic. Among these groups, there are the homosexual individuals, who suffer discrimination even in the hospital environment, when in contact with other users with HIV/aids.<sup>10</sup>

Although veiled, discrimination can also be inferred from expressions verbalized by the professionals themselves, since their representations do not greatly differ from the current social representations. Given this, it is up to them to search strategies for a care which respects the behaviors and values specific to each group, so that they feel embraced.<sup>10</sup>

We identified that the attitudinal aspect of representations of nursing professionals was guided by eases experienced in care. These eases increased during the interaction with users, when technical, cognitive, and psycho-affective skills were acquired in order to help coping with certain situations. And, as a consequence, the stress felt by interacting with these users could be decreased, since

professionals could feel safer and more prepared to care for people.

In the representations which emerged, it was found out that the difficulties were distributed 5 five categories: fear of contagion; persistence of prejudice; barriers to relationship; unacceptability of discrimination; and engagement and empathy. In the first category, there are feelings related to fear of being contaminated by HIV while providing care. In the second, there is intolerance felt by the professional when recognizing users as belonging to risk groups, although recognizing that, currently, all people are vulnerable to contamination. The third covers the effects of feelings reported in the first two categories. The fourth includes practices affirming the respect and acceptance of the HIV-seropositive user. The fifth covers attitudes establishing the effective communication as essential for effectuating nursing care.<sup>11</sup>

Although not directly referred to, difficulties may also be associated to power relations established between professionals and users. This aspect becomes clear in the representation when presenting a higher education level as something which hinders care, since in this situation the user leaves the place of subordination to technical knowledge and starts having intellectual instruments to dispute. Thus, she/he abandons the passive position and takes an active position in the care process.

Regarding the aspects observed in the representations concerning the use and adherence to ARVT, many difficulties are faced by users to effectuate adherence to treatment, corroborating what was observed in other studies. These difficulties are related to the geographical distance from the health care service and the consequent difficulties of access to consultations, in addition to those directly related to the use of antiretroviral agents.<sup>12</sup>

According to studies addressing the non-adherence to ARVT, some aspects identified for this were: the characteristics of pills (size, flavor, and quantity); the intense side effects; the psychological factors related to therapy; the requirements for its intake (different times to administer medication, need for fasting, abstinence from alcohol, need for increased fluid intake); the large amount of pills to be taken. Regarding side effects, those determining non-adherence to therapy, according to users' account, are the gastrointestinal effects, such as vomiting, nausea, diarrhea, and abdominal pains, and

neurological effects, such as headaches and insomnia.<sup>13</sup>

Other causes for treatment dropout indicated in the literature were clinical progress and fear that the others know the diagnosis, due to the strong prejudice. In the first, the individual experiences improvement in signs and symptoms of the disease and believes she/he no longer needs the medicines, because she/he does not understand that it is a long-term treatment, which should not be stopped without medical advice, perhaps because, according to common sense, the medicine has a direct relation to be and seem to be sick.<sup>14</sup> The second factor consists in the wish that the diagnosis is known by a restricted amount of people, feeling obliged to hide, pretend, and lie about important aspects of her/his life.<sup>15</sup> Thus, often, people use complicated strategies to use the medicines, hindering adherence to treatment<sup>14</sup>, such as removing the labels of medicines and avoid taking them in the presence of another person, something which leads to the loss of doses and non-compliance with the therapeutic regimen.

It is worth stressing that the rates of adherence to treatment for chronic diseases are described as low and, when associated to the perception of low life expectancy, they have a greater decrease. However, a good prognosis observed by increasing the count of cells aimed at body defense and maintenance of undetectable viral load, is a factor that can contribute to adherence to ARVT.<sup>16</sup> Besides, we find out that individuals with higher education level and longer treatment adhere more strongly to ARVT, probably due to the fact that they better understand the mechanisms of action of medicines and because they have proven the long-term effects.<sup>17</sup>

The social representations analyzed in this study show by means of which incentives and strategies the nursing professionals change behaviors and lead to a greater adherence to ARVT. However, there is a need for health education with an effective participation of HIV-seropositive users in the planning of strategies and the individualization of the approach so that these users feel safe to expose uncertainties and feelings. However, the development of such educational strategies and the positive outcomes must consider as a starting point the mechanisms for escape, social isolation, and exclusion experienced by the subjects with HIV/AIDS.

## CONCLUSION

This study allows us to conclude that nurses who work with people with HIV/AIDS for less than 15 years have a social representation of the care provided to these users with an emphasis on hospital and medicinal care practices. The social representation constructed by this group is aimed at the transmission of information about the disease and the progress with antiretroviral therapy, in addition to difficulties and strategies for adherence.

The social representation of the nursing care provided to people living with HIV/AIDS in the hospital environment showed to be wrapped by a significant complexity, considering the demands and institutional constraints. Moreover, also play an important role the psychosocial implications of the changes envisioned in the course of the epidemic, since the health care services, programs, and professionals are challenged to propose and execute corresponding responses.

Still, the social representation constructed points towards the need for an effective health education aimed at HIV-seropositive people, as there is ignorance with regard to the consequences and needs derived from HIV infection. Whereas the members of the nursing team are the subjects within the health care team who spend more time caring for these users during hospitalization, it is claimed that they play an important role in health education and they must use the moments close to the user to put knowledge exchange into practice.

In order to lead the educational relationship to obtain good results, we must start from the representations constructed by the subjects, under the burden of not contributing in an effective way so that new information can be analyzed and incorporated into the current social representations, in case they are not taken into account.

Given the above, we conclude that the social representations identified in this study effectively contribute to nursing practice, because they enable us to understand the psychosocial process observed in care, with a hospital-driven and medicinal focus on HIV-seropositive people; we identified the need to devise and put into practice actions more useful with regard to a better quality of care and, as a consequence, a better quality of life of people living with HIV/AIDS.

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