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SOCIAL INTERACTION OF WOMEN EXPOSED TO HIV/AIDS: A REPRESENTATIVE MODEL

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ABSTRACT

Objective: to present the representative model of the social interaction of women exposed to the Human Immunodeficiency Virus and AIDS based on the meanings attributed by them.
Method: an interpretative and qualitative research study carried out in Rio de Janeiro, Brazil, from 2017 to 2018, through semi-structured interviews with 17 women who made up four sample groups, in the period between June 2017 and January 2018. The framework for data analysis is the Grounded Theory and Symbolic Interactionism, and the study was ethically approved as required by the National Health Council.
Results: for women, the representative model of the social interaction process of exposure to the Human Immunodeficiency Virus and AIDS means “not protecting themselves” and “not being protected by the other”. It is seen as a sloppy, irresponsible and reckless act. The women know the measures to prevent exposure; however, they do not use condoms and acknowledge that they are both exposed and exposing others simultaneously. The central category entitled “Neglecting one’s own life although being aware of exposure to the Human Immunodeficiency Virus and AIDS” stands out.
Conclusion: understanding this social interaction can contribute to the apprehension of the main factors that influence the construction of these meanings by women, thus helping them to give a new meaning to this exposure and allowing them to modify their actions to protect themselves and others against AIDS. Consequently, effective assistance based on preservation of life is encouraged, with a view to comprehensive care to women and reducing their exposure to infection.

DESCRIPTORS: HIV. Acquired Immunodeficiency Syndrome. Women’s health. Qualitative research. Symbolic Interactionism.

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INTERAÇÃO SOCIAL DE MULHERES COM EXPOSIÇÃO AO HIV/AIDS: UM MODELO REPRESENTATIVO

RESUMO

Objetivo: apresentar o modelo representativo da interação social de mulheres com a exposição ao Vírus da Imunodeficiência Humana e Aids a partir dos significados por elas atribuídos.
Método: pesquisa interpretativa e qualitativa, realizada no Rio de Janeiro, Brasil, de 2017 a 2018, por meio de entrevistas semiestruturadas com 17 mulheres que formaram quatro grupos amostrais, no período entre junho de 2017 e janeiro de 2018. O referencial para a análise de dados é a *Grounded Theory* e o Interacionismo Simbólico e o estudo foi aprovado eticamente como exigido pelo Conselho Nacional de Saúde.
Resultados: o modelo representativo do processo de interação social, exposição ao Vírus da Imunodeficiência Humana e Aids significa, para as mulheres, "não se proteger" e "não ser protegida pelo outro". É tido como ato desleixado, irresponsável, imprudente. As mulheres conhecem as medidas de prevenção à exposição, entretanto, não usam preservativos e reconhecem que estão, ao mesmo tempo, expostas e expondo outros. Destaca-se a categoria central: "Descuidando da própria vida apesar da consciência da exposição ao Vírus da Imunodeficiência Humana e Aids".
Conclusão: entender esse processo de interação social poderá contribuir para a apreensão dos principais fatores que influenciam a construção desses significados pela mulher, assim, proporcionando auxílio a ela na ressignificação dessa exposição e permitindo que ela modifique suas ações para a proteção contra a Aids. Desse modo, fomenta-se uma assistência efetiva baseada na preservação da vida, vislumbrando um atendimento integral à mulher e diminuindo sua exposição à infecção.

DESCRITORES: HIV. Síndrome da Imunodeficiência Adquirida. Saúde da mulher. Pesquisa qualitativa. Interacionismo Simbólico.

INTERACCIÓN SOCIAL DE MUJERES EXPUESTAS AL VIH/SIDA: UN MODELO REPRESENTATIVO

RESUMEN

Objetivo: presentar un modelo representativo de la interacción social de mujeres expuestas al Virus de la Inmunodeficiencia Humana y al SIDA a partir de los significados que ellas les atribuyen.
Método: investigación interpretativa y cualitativa realizada en Río de Janeiro, Brasil, entre 2017 y 2018, por medio de entrevistas semiestructuradas con 17 mujeres que conformaron cuatro grupos muestrales, entre junio de 2017 y enero de 2018. El marco referencial para el análisis de los datos está compuesto por la *Grounded Theory* y por el Interaccionismo Simbólico, y el estudio contó con la debida aprobación ética según lo exigido por el Consejo Nacional de Salud.
Resultados: para las mujeres, el modelo representativo del proceso de interacción social, con exposición al Virus de la Inmunodeficiencia Humana y al SIDA significa "no protegerse" y "no ser protegida por la otra persona". Se considera como una acción descuidada, irresponsable e imprudente. Las mujeres conocen las medidas de prevención para evitar la exposición; sin embargo, no usan preservativos y reconocen que están expuestas y exponiendo a los demás simultáneamente. Se destaca la categoría central: "Descuidar la vida propia a pesar de ser conscientes de la exposición al Virus de la Inmunodeficiencia Humana y al SIDA".
Conclusión: entender este proceso de interacción social podrá contribuir para aprehender los principales factores que influencian la elaboración de estos significados por parte de las mujeres, proporcionándoles así ayuda para atribuir un nuevo significado a esta exposición y permitiendo que modifiquen sus acciones para protegerse del SIDA. De este modo, se fomenta una asistencia efectiva basada en preservar la vida, vislumbrando atención integral a las mujeres y reduciendo su exposición a la infección.

DESCRIPTORES: VIH. Síndrome de Inmunodeficiencia Adquirida. Salud de la mujer. Investigación cualitativa. Interaccionismo Simbólico.

INTRODUCTION

The Human Immunodeficiency Virus (HIV) infects a significant percentage of the world population, with some reductions in the number of new cases in a large part of the planet. A 23% reduction is estimated between 2010 and 2019[1]. In 2019, 38 million citizens were HIV positive and, worldwide, 1.7 million citizens were infected with HIV[1].

In Brazil, with an 18.7% reduction in the number of cases from the late 2000s to 2020,342,459 HIV infections were reported, with greater concentration in the Southeast and South regions[2].

The female population is nearly 34.3% of all the people infected from 1980 until June 2020[2]. In Brazil, there is a gradual attenuation in the number of AIDS cases in women, but men, on the other hand, have increased statistics and there are currently 23 HIV-positive men for every ten women[2].

Thinking about the female vulnerability context is still a global health challenge. To study HIV and the gender issues related to women's exposure, it is necessary to go deeper into sociocultural and psychosocial issues, beliefs, sociodemographic data, attrition potentials and vulnerabilities, as well as into biological issues, such as greater susceptibility to contamination and to the virus[3].

Health promotion is an indispensable resource to encourage actions that are consistent with reality, considering the context of individual lives[4]. Public investment in improving women's perception about their vulnerability is indispensable, with actions that go beyond the traditional prevention strategies. In addition to that, it is essential that possible social alienation barriers are overcome for women to recognize themselves as protagonists in promoting their health.

Therefore, the public policies for HIV/AIDS prevention and health promotion need sensitization strategies about vulnerability, risk and exposure. Currently, the Brazilian official documents, which present preventive guidelines, consider the life context to devise actions; although also under the perspective of individual responsibility to comply with the preventive measures, with a focus on the technologies. Thus, limitations are revealed regarding the approach based on the broad concept of vulnerability and human rights, culminating in obstacles to a participatory policy with social control[5].

Considering the current context of the epidemic and asking about the women's actions, as well as the issues related to health promotion and HIV/AIDS prevention, the following guiding question was defined: what are the characteristics of the social interaction process of women exposed to HIV/AIDS based on the meanings attributed by them?

Symbolic Interactionism analyzes the diffuse relationship between society and the individual, how symbols are developed and how the mind behaves, based on everyday facts of life and philosophical insight. In social interactions, individuals predict each other's behavior and sometimes act driven by these behaviors[6]. Individuals are then allowed to interact socially and to get to know the world, in addition to learning to relate to others in their surroundings.

The current state of the art in the area of women's vulnerability to HIV focuses on the incidence of cases, predictors and associated factors, and on management in specific populations. These populations are primarily drug users, lesbian women and sex workers, and there is also focus on the clinical and therapeutic issues of people living with HIV. However, the knowledge gap is evidenced in the discrepancy between the discussion of the scientifically-elaborated concept of vulnerability and its understanding through the actions of the female population, in general, in the prevention of exposure to HIV and in health promotion.

Understanding this social interaction process may contribute to the knowledge and analysis of the main factors that influence the construction of these meanings by them. This knowledge fosters the ability to assist women in resignifying this exposure, allowing them to modify their actions regarding protection against AIDS. This approach will contribute to the provision of effective care, preserving life in a humane way, envisioning comprehensive care for women and reducing their

exposure to the risk of HIV infection. Thus, this study aims at presenting the representative model of the social interaction of women exposed to the Human Immunodeficiency Virus and AIDS, based on the meanings attributed by them.

METHOD

A qualitative and interpretive research study, based on the theoretical and methodological assumptions of the Grounded Theory[7]. This an analytical methodology, with sociological origins in North America, which deals with the understanding and interpretation of social reality and of socially-constructed meanings. A theory emerges from the analysis of qualitative data from the comparison of incidents, the proposal of concepts and the raising of hypotheses, which, when compared to more incidents, deepen their theoretical properties. This procedure is called constant comparative analysis[7–8].

Data collection was conducted in public spaces such as beaches, parks and public squares and in the streets, from June 2017 to January 2018. This strategy allows not restricting the approach to women, resorting to ample and open spaces. It is added that, despite being a public scenario, the privacy and secrecy of the interviews were preserved, opting to conduct the interviews in more isolated places and at a distance from other people.

In the first sample group, the participants were Brazilian women, living in Rio de Janeiro and aged over eighteen years old. Women with speech or psychological disorders were excluded. It was believed that, starting in a broader way, this group of women would indicate the next group conformation to understand the phenomenon. This sample group consisted in five women with high schooling level and who stated living in stable relationships.

It is through the process of comparative analysis of data, which are collected, codified, analyzed and compared at the same time, that the interpretation of social experience is made. Constant return to the material for this comparison is defined as data circularity. This is an intentional procedure of theoretical sampling, a process in which the relationship between concepts and assumptions shows the researcher the need to seek other interviews for data collection and select new participants belonging to other groups or situations to obtain an analysis material that is comprehensive enough to elaborate a rich discussion, confirming hypotheses emerging from the analysis[8].

From this perspective, after collecting the data from the first sample group, it was noticed that the women had access to information about exposure and prevention to HIV and that their social interactions could be strongly influenced by the stable relationship. Thus, it was hypothesized that women with low schooling and without a stable relationship could attribute different meanings to exposure to HIV/AIDS, drawing another line of action. Therefore, four women with these characteristics were included for the second sample grouping.

In this process, the Methodological Notes[7] were consulted and then it was established that schooling and the experience, or not, of a stable relationship did not modify the process. Thus, the third sample group was assembled, with four women with high schooling level, regardless of whether they had a stable relationship or not, working in the health area, to reflect on the hypothesis that women with more specific knowledge would have more preventive lines of action. However, even exercising professions in the health area, the phenomenon remained the same in shape. In an attempt to expand the possibilities of modifying the phenomenon studied, a fourth sample group was assembled, consisting of four women, regardless of their schooling level (low or high), type of relationship (stable or not) and activity performed. However, the researchers intentionally sought older women who, for having experienced the advent of AIDS, could contribute to the comparative data analysis and to the construction of the representative model.

When there was no new data, showing theoretical saturation, collection in each group was interrupted because there were no more highlights in the elaboration of the concepts. In theoretical saturation, it is observed that the data collected are sufficient to construct the representative model[8]. Once this process was completed, the group of research participants consisted of 17 women aged between 22 and 63 years old, who were interviewed for data analysis.

The women were approached in person and intentionally. The objectives, methods and ethical issues related to the research were explained. In case they agreed and understood about their participation, they were asked to sign the Free and Informed Consent Form (FICF). Subsequently, the semi-structured recorded interview was carried out according to the woman's availability, in a place chosen by her, where her privacy could be preserved, allowing only the presence of the participant and the interviewer. The data collection script was a semi-structured interview and the triggering question for all four sample groups was the following: what does exposure/being exposed to HIV/AIDS mean to you? This question was also enriched with a number of topics throughout the interview, such as: individual, programmatic and social exposure related to HIV/AIDS; vulnerability x risk; behavior change based on the meaning; line of action; preventive measures based on the meanings; and previous experiences with HIV/AIDS. The audio of the interviews was recorded in digital format and the interactions lasted a mean of 40 minutes.

The interviews were transcribed, in full, for the comparative analysis, which took place, as already mentioned, synchronously and based on Symbolic Interactionism and on the Grounded Theory. The stages were conducted as established by the classical strand[7]. Open, selective and theoretical codings were performed in the inductive, comparative and emergent manners. Once the central category was identified, the search in the literature was conducted and the research report was elaborated. During this process, diagrams were built until a final decision was made. Finally, the diagram was presented to three participants for validation.

From the three premises of Symbolic Interactionism[6], it is understood that people act coherently with the meanings they attribute to the phenomena in their lives, and this is made possible by social interactions. These actions and meanings are dynamic and interact with each other, and are manipulated and modified by the individuals themselves throughout their lives.

In the logic of a representative scheme of human action under the interactionist perspective[9], upon reaching certain situation (in this study, exposure to HIV/AIDS), people define it for themselves, determine goals, apply appropriate perspectives, assume the place and the role of other people in the situation, define for themselves the social objects present there, base their actions on previous experiences, and think about the future looking at themselves in the situation. From their actions, other individuals, based on their own interpretations, make sense of the situation and also act openly. This open action of others leads the individual to reanalyze the situation, attribute new meanings to their actions, review values and perspectives, and may or may not change their line of action.

The project was elaborated in accordance with the current Brazilian ethics and research laws and resolutions. This study was approved by the Research Ethics Committee of *Universidade do Estado do Rio de Janeiro* (CEP/UERJ).

To preserve anonymity and confidentiality, the individuals were identified with a code consisting of the letter G and sample group number, as well as the interview number, for example: G1E2, G2E1, G3E2.

RESULTS

Attributing meaning to exposure to HIV/AIDS: Not protecting themselves and not being protected by the other

The communication means, the schools and the health services disseminate diverse information about exposure to HIV/AIDS. By adding this knowledge to their own history, that of family members and friends, women attribute meanings to the complex interaction of the virus and disease with human relationships. Being exposed to the virus means not being careful, not protecting themselves, being sloppy, irresponsible or even reckless.

For the interviewees, "not protecting themselves" means not using condoms during sexual intercourse for the prevention of diseases and contact with contaminated blood or needles, both regarding sharing needles by drug users and occupational risk. This dimension incorporates the sense of lack of care and caution with themselves, even when aware of the risk.

[...] *whoever gets the disease now, I think they're being negligent because now there are methods to help people with prevention* (G2E3).

[...] *I've already been sexually exposed. I didn't take care of myself because I already had sex without a condom* (G4E1).

The dimension called "not being protected by the partner" means that the partner is positive and does not say so due to unawareness, to shame or to a deliberate intention of transmitting the disease. For them, this represents a breach of the couple's trust, since the expected attitude is to preserve the other's life. An important point is that the statements show that women expect attitudes from their partners to preserve their lives; however, at no time do they show concern with protecting their partners.

[...] *and the other having the virus and passing on to the other person. Not saying so, not talking to the other and pass on this virus* (G1E3).

[...] *it's not written on anyone's forehead. And those who have it won't tell you that they have AIDS*, *they won't be concerned about protecting you* (G4E3).

Knowing what must be done so as not to be exposed to HIV/AIDS

According to the values and meanings attributed to exposure to HIV/AIDS, women know how to protect themselves, how not to be exposed to the virus. For them, regardless the type of partner, it is indispensable to use condoms, as well as Personal Protective Equipment (PPE) in the professional practices.

For them, they are measures that must be adopted in all situations as ways of self-care and of taking care of the other.

[...] *I think that the person must use a condom and take care of themselves. But we're all exposed to the disease, no one is exempt. Since the moment you don't prevent and don't take care of yourself, no one is exempt from getting the disease* (G2E1).

[...] *there are methods to help us prevent and prevent the other* (G2E3).

[...] *exposure is very big but, when you work with Personal Protective Equipment, this gives you some safety* (G3E1).

In addition to that, the interviewees defined conservative behavioral measures as protective against exposure to HIV/AIDS. The women reported the importance of knowing their partner and having intimacy for greater "control" over exposure.

[...] *I really believe that, when you're with someone you already have intimacy and a relationship with, you have more control, you know the person more, you trust them* (G2E1).

[...] *when you know the person's history, you can get a little better sense of who you're dating* (G2E2).

[...] *I think that the main thing would be choosing the partner. Being more careful about who you're relating with* (G3E2).

In relation to protecting themselves, not being exposed, the women acknowledged the social objects involved in exposure to the disease. The individual's culture, schooling level and the socioeconomic issues, in addition to the person's life phase, influence exposure to the disease, whether due to youth or to low access to information.

[...] *I think that the socioeconomic aspects are very important. I think that people with low incomes and low schooling would have less access to the information and then they'd have more chances of getting infected* (G1E1).

[...] *I had no guidance, I was raised an orphan. I didn't have access to the Internet, newspapers, television. Then, I think I was very exposed* (G4E2).

Recognition and exposure to HIV/AIDS: Unveiling the ideological context

At this moment, women define how they will act and end up not using the barrier method. They recognize that they are exposed and consciously expose themselves when they have a relationship that they consider well-established, when they consider it stable. They trust in mutual fidelity and, consequently, they justify non-protection against HIV.

They report that it pleases their partners, who do not like condoms, when they give up this method. The main reason for using condoms is as a contraceptive method. When a hormonal method is adopted, the condom is no longer used.

However, women recognize that they cannot control their partner's actions when they interpret their own actions based on the actions of other people. They renounce condoms even though they have some doubts in the process of trust: they reflect and identify themselves as exposed to HIV.

[...] *I'm not 24 hours a day with my partner. But I find it difficult, because the condom, among women who have a steady partner, we don't care too much about it* (G1E1).

[...] *I live it myself, he hates condoms. When we started dating seriously, I started taking medication and then we stopped using it* (G1E4).

Another important point to be highlighted is the recognition of the exposure only in their professional life. For those interviewed who work in the health area, the possibility of exposure to HIV/AIDS is not related to not using condoms, because they are married or have been with their partner for a long time.

[...] *perhaps, in my professional life* (if considering at risk). *Because, before AIDS appeared, we didn't have all the care that later we started to have* (G3E2).

Considering the others as more exposed

The women consider the others as more vulnerable to exposure to contamination by the virus through the adoption of "deviant behaviors" or "promiscuity". For them, promiscuity means casual partners, partner turnaround and indiscriminate freedom. They even complement that they are common characteristics found in homosexuals and young individuals. They relate exposure to HIV/AIDS to the way of life adopted by these people.

[...] *those who have casual sex are more likely to get it from sex. Those who don't know the person they're getting involved with* (G2E1).

[...] *I think that homosexuals and gays are more vulnerable. Because, most of the time, they're very relaxed, they have several partners* (G4E2).

[...] *I think that the youth is more exposed, because married people have a fixed partner, right? And they know, they've had exams* (G3E3).

The women also acknowledge the increasing rate of HIV/AIDS infection among older adults. This situation was indicated as lack of habit in condom use and as related to the advent of Viagra, which promoted an increase in sexual activity in this age group.

[...] *older adults were not used to having relations with condoms* (G3E2).

[...] *some time ago, it was the ladies, like me, who discovered that they could have sex; old men started taking the "little blue"* (pill). *And then older couples started to have sex, and the old ladies started to get contaminated* (G3E2).

Another point to be considered is certain perception of a reduction in mortality due to AIDS. With treatment evolution, life expectancy increased. Thus, she attributes to this fact the lack of concern with the disease and the trivialization of the preventive measures, especially by young people, who did not experience the onset of the epidemic.

[...] *Before, AIDS was that severe thing. Today it seems like it's a trivial thing, that you take the medications and you'll live well for the rest of your life* [...] *people are very comfortable nowadays with AIDS* [...] (G3E2).

[...] *today's young people no longer value HIV because they think there are medications and that they can survive. When they knew it was fatal, they took better care* [...] (G3E3).

Unveiling the ideological context

Based on the meanings attributed, women start to reformulate some views, interpret the situation and establish a new course of action, which is to expose themselves to HIV/AIDS. They act through measures aimed at minimizing the probability of contamination. The loyalty pacts/agreements with partners, the adoption of conservative behaviors, such as attending church, and their trust as part of the stable relationship are measured, strongly evoking an ideological context.

[...] *I don't live in this world because I live for the Church. But, that's it, there are a lot of people with this, a lot of people with this problem of HIV infection* (G2E2).

[...] *he was my first boyfriend, he was my first man, he was my husband, got it? And he was no chicken, got it? I know this because of the life we had, we've lived together for 13 years* (G4E2).

Central category: Choosing to neglect one's own life although being aware of exposure to HIV/AIDS

Regardless of whether they have knowledge about exposure and vulnerability to HIV/AIDS, women of different schooling levels, ages and professions end up deciding not to protect themselves. Therefore, the representative model of the process is presented in Figure 1.

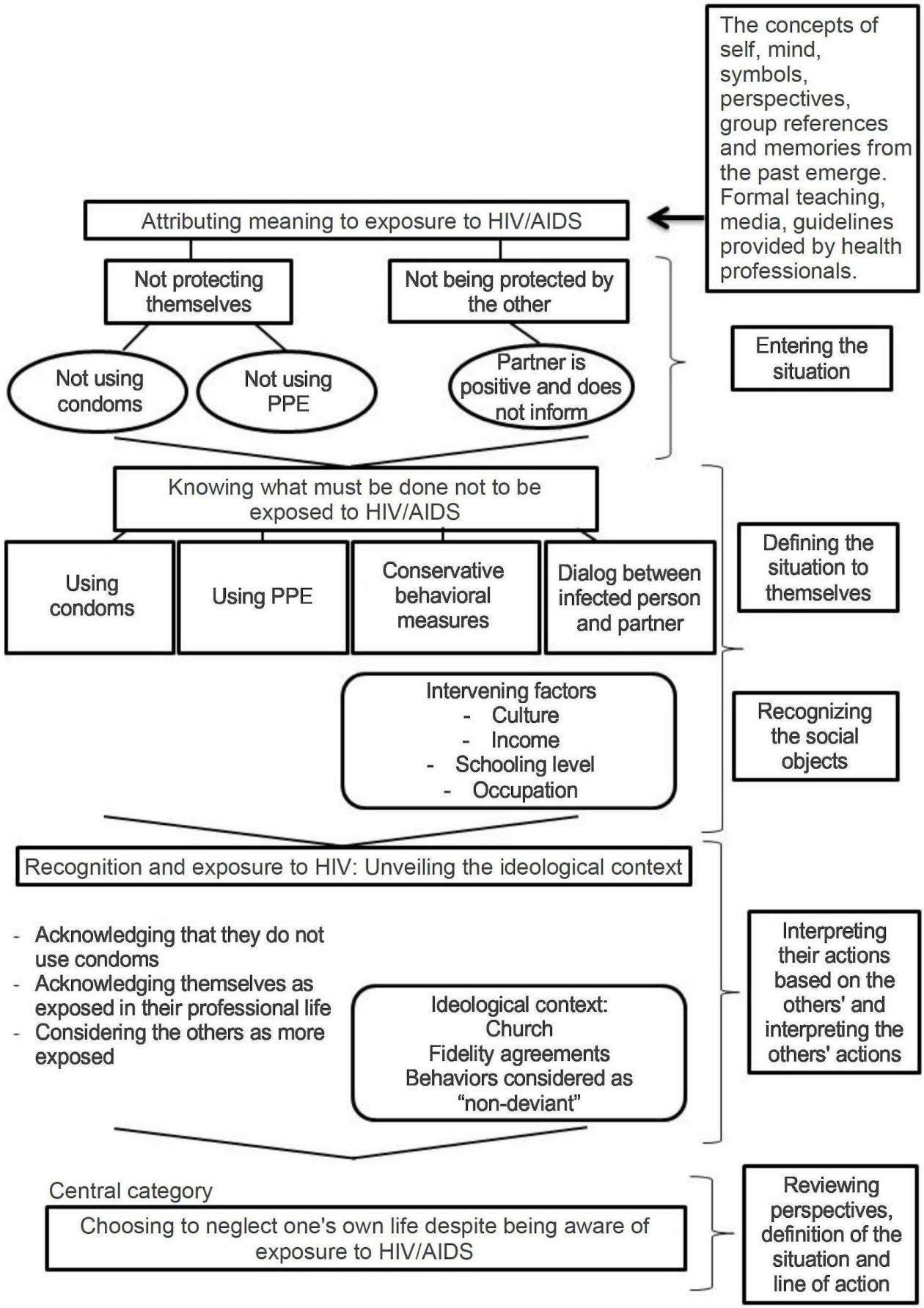

Figure 1 – Representative model of the social interaction process of women exposed to HIV/AIDS. Rio de Janeiro, RJ, Brasil, 2018.

DISCUSSION

Condoms are globally considered as a prevention method to avoid transmission and, consequently, to protect individuals from contracting HIV. In general, the percentage presented in the literature regarding condom use in women is below the expected. Most of the users state not using condoms during their sexual relations although being aware of the risk and knowing about the epidemic[10]. Most women recognize the importance of using condoms, even in stable relationships[10–12].

Women present difficulties in negotiating the use of condoms with their partner, showing that it is up to the man to take the initiative regarding the use of protective measures, often justified on the basis of trust relationships with the partner[11]. Such situations illustrate how women leave the decision to preserve their lives to their partners.

In the context of exposure to HIV/AIDS, there is a responsibility to protect oneself and the other for the preservation of life, which involves ethical, spiritual and cultural issues. Despite the clear importance of self-care, there is certain expectation that the other will assume responsibility or, in case of positive serology, that there is dialog. Concealment by the HIV-positive partner, even if to mitigate the social impact of the infection, is interpreted as a cowardly and harmful behavior to other people[13]. Discovery of the infection is a critical moment, permeated by affliction and fear, marked by the uncertainty of having an incurable disease and, especially, by the fear of abandonment and of virus transmission[13].

In addition to the sexuality issues, the use of alcohol and other drugs was also pointed out. Whether licit or illicit, the literature describes it as a risk factor for HIV and that even triggers negative outcomes for its treatment. The use of drugs before sexual practices is estimated as an enhancer for unprotected sex, providing exposure to HIV/AIDS infection. Despite this relationship, what this study discusses is conservative thinking, which largely attributes exposure to HIV to drug and alcohol users. For example, alcohol is part of the daily life of Brazilian women and, as well as HIV/AIDS, which seems to be “the other person’s problem”, the same seems to happen with the increased exposure resulting from the use of these substances[14–15]. The idea of lack of care and recklessness also appears in the dimension of direct contact with contaminated blood and needles, a form of contagion that is not very prevalent in Brazil, since less than 0.5% of the people report using them in Brazil[16].

In the discourse by the women interviewed in this research, regarding “protection of the other”, the statements brought about a more subjective side, and even romantic, of the idea of protection. For them, when they are in a stable relationship, the fidelity provided by monogamy, the length of the relationship, trust and affection between the couple are sufficient attributes, in their conception, to mitigate the risk of being contaminated by their partners.

Therefore, conservative or non-deviant behaviors are protective factors. This idea reveals the permanence of the old concept of “risk behavior”, which focused on women’s sexuality and promiscuity, that is, the result of an irresponsible practice[3,17]. However, the situation of female vulnerability to HIV/AIDS is no longer characteristic of women who are sex workers and incur in promiscuous behaviors. AIDS also started to affect the heterosexual female population in stable relationships[17]. Thus, the strategies listed as preventive are based on avoiding multiplicity of partners and maintaining loyalty in their stable relationships[17].

The culture of Brazilian society is constituted by stigmas about female and male sexual behaviors that are considered inadequate. It is evident and stated by the interviewees that the individual’s culture, schooling level and socioeconomic issues influence exposure to the disease, in addition to the cultural aspects that permeate sexual activity, impoverishment and the circumstances triggered by this factor, such as reduced schooling, unemployment and low purchasing power[18]. However, in contrast to these assertions, a study conducted with cisgender men who have sex with transgender women in Latin America indicated that schooling and income had no impact on the decision to use or not use barrier methods[19].

However, the authors highlighted that the HIV infection also affects the population of young adults with good schooling levels, whose main infection route is sexual[20]. In addition to that, it is emphasized that knowledge does not ensure responsible sexual behaviors. Changes in customs are brought about through the introjection of the responsibility awakened and adopted by the individual, without being obliged or imposed on them[21].

In relation to the occupational risk, health professionals consider themselves vulnerable to the risk of being infected with the HIV virus due to their professional activity; they understand that there is risk and even verbalize fear of consequences of an accident during their professional activity with biological risk. This fact is mainly supported on their work together with people who live with HIV/AIDS[22]. There is an intense fear about accidents with biological material and there is a variety of protection strategies, such as the excessive use of PPE and the verbal warning to other colleagues that the patient is infected with the HIV virus[22–23]. However, due to an intrinsic relationship with the gender issue, these women reported not feeling vulnerable to HIV in their sexual life, only in their work activity[22–23].

Protective measures based on trust and on the type of relationship with likely fidelity often lead women to abandon condoms and replace them with hormonal contraception[24–25]. However, in contrast to this, there is an estimation of a significant number of people making inconsistent use of condoms in casual relationships[24]. This has evidenced that it is a conscious phenomenon. And, in an attempt to minimize the guilt of their actions even knowing the exposure or to justify themselves, women point to groups as more exposed to HIV/AIDS. This brings to light the understanding of the Human Immunodeficiency Syndrome as a disease of others[12,25], making women feel, in a way, distant from the infection.

Young people, homosexuals and older adults were present in the interviewees' statements as strong protagonists of exposure to HIV/AIDS and this shows that these data are well disseminated in society. There are precedents that justify the emergence of a new overview aimed at the issues involving the perceptions of adolescents in relation to their conception of vulnerability to HIV infection. This concern is based on the perspective that young people are invulnerable to contamination[26].

Another point to be discussed is the change in the AIDS epidemic scenario in the country, marked by the advance and increase of Antiretroviral Therapy (ART). This is currently reflected in the drop in the percentages of vertical HIV transmission, in the low morbidity and mortality rates, and in the improvement of living conditions and longevity. Such factors contribute to the change in the stigma of "fatal disease" and to a modification in the profile of the population affected by this infection, indicating the current representation of chronicity of the disease[26–27]. This was pointed out by the interviewees in this research, and these characteristics of a chronic disease acquired by AIDS, due to ART, provided an ever-increasing approximation of AIDS in people's lives. Before, people with the disease were seen as terminally ill; currently, in everyday life, they live as HIV positive[26–27].

Another ideological context is dictated by the Church. In this case, it influences sexual practices according to normative criteria full of moral values, in addition to the belief of divine protection based on faith. Thus, there is an urgent need to understand how social interactions work in the religious sphere, which form a social web loaded with human subjectivity[28–29].

Given these data, and interpreting their actions and the actions of others, women recognize and expose themselves from a context in which traditional gender issues are well established in a macho, sexist, and patriarchal society. From an interactionist perspective, the decision to neglect one's own life is permeated by the socio-cultural and economic scenario in which these women's social interactions occur and consistent with their access or lack of access to social rights. It is conceived that these issues, subjective and social, have direct repercussions on the public policies and health actions[30].

This article contributes to scientific progress by disclosing, in an unprecedented manner, the representative model of the detailed interaction process of women who choose to neglect their own lives, even if aware of the exposure. These conclusions support the conduction of future research studies about the ideological context that influences the increased exposure to HIV in these women.

With regard to the implications for the practice, based on the findings, it is indispensable to encourage educational, preventive, autonomous and reflective actions that distance women from the ideological context of the phenomenon of female vulnerability in relation to HIV/AIDS, which paralyzes decision-making ability to preserve their own life.

Among the limitations of this study, the intimate nature of the issues addressed in data collection stands out, which can interfere in the statements. Despite that, the reports analyzed maintain certain coherence, share similar experiences, and were able to be corroborated in the scientific literature.

CONCLUSION

The representative model presented points to a gap: the antithesis between what women know and how they act. There is lack of appreciation of their own life by women, to the detriment of conservative thinking of non-promiscuous social behavior, non-exposure to drugs and stable relationships, among others. Women leave their partners' behaviors and lives in charge of the care for their own safety. Therefore, they sometimes choose to neglect their own life to please their partners.

Exposure to HIV/AIDS is a risk for others, but it does not show sensitization for themselves. They are concerned about the occupational risk, but minimize risk in the relationship with their partners. Women say that abstract feelings, such as love, feeling faithful and trusting in the partner's fidelity, monogamy and even divine protection, reduce their exposure. They end up adopting risk sexual behaviors in the midst of a conservative ideology, alienating from and for themselves.

It is to be recalled that these decisions, filled with social symbols and objects, were influenced by the patriarchal and sexist context in which these social interactions took place. Therefore, health professionals must seek to understand these women's process of social interaction in order to guide and advise them on changing their behaviors. It is indispensable to empower women so that they decide to protect themselves and take care of their health. It is hoped that this article collaborates to health promotion strategies in this new configuration of the AIDS epidemic.

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NOTES

ORIGIN OF THE ARTICLE

Extracted from the dissertation - Choosing to neglect one's own health although being aware of exposure to HIV/AIDS", presented in 2018 to the Graduate Program in Nursing of the Nursing School at *Universidade do Estado do Rio de Janeiro*.

CONTRIBUTION OF AUTHORITY

Study design: Silva CM, de Oliveira VS.
Data collection: Silva CM, de Oliveira VS
Data analysis and interpretation: Silva CM, de Oliveira VS, Vargens OMC.
Discussion of the results: Silva CM, de Oliveira VS, Claro HG, Vargens OMC.
Writing and/or critical review of the content: Silva CM, de Oliveira VS, Claro HG, Vargens OMC.
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APPROVAL OF ETHICS COMMITTEE IN RESEARCH

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CONFLICT OF INTEREST

There is no conflict of interest.

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