Abstract

Objectives: To evaluate the quality of life of women with HIV/AIDS in the State of Paraíba and define them as the socio-demographic profile.

Method: This was a descriptive, exploratory and quantitative study, conducted at the Hospital Clementino Fraga, had a population of 33 women with HIV/AIDS, using the form of interviews HATQoL, clinical and sociodemographic, data collection took place in July 2014 after approval of the CEP UFPB.

Results and Discussion: There was concern domains with commitment of confidentiality, financial worry and sexual activity with a possible association with clinical and sociodemographic data obtained, most women: they are aged between 36-42 years acquired HIV through heterosexual sex, unmarried, have children (between 1-2), have low education (less than 9 years of schooling) and low income (up to two minimum wages).

Conclusion: Therefore, it is necessary that the care of these women is conducted by interdisciplinary teams that promote integrated care, gazing beyond the individual needs, aspects related to their quality of life. In this perspective, the nurse plays a fundamental role in promoting quality of life.

Keywords
Quality of Life; Women; HIV; AIDS; Nursing.
Introduction

Quality of life (QoL) is a broad and indeterminate definition term, but it is quite common to have presumptions that relate it to the degree of individual satisfaction with life and existential aesthetics, a kind of balance between personal needs, living conditions and self-perception [1].

The World Health Organization defines QOL as the individual’s perception of life in the cultural context and value systems in relation to the goals, expectations, standards and concerns of each individual. It can also be determined by personal experiences; By the perceptions of the social role, related to the concepts for assessing the current state with regard to the ideal, as well as the priorities of life of each one [2].

It is understood that it is extremely important to evaluate the QoL of people living with HIV/AIDS, because despite the innumerable benefits arising from the emergence of antiretroviral therapies (ART), coping with the infection is still a long and stigmatized process.

Caracilo and Shimma [3] state that it is clear that, after the introduction of antiretroviral therapy in Brazil in 1996, there was a drop in mortality, a reduction in the incidence of opportunistic infections, an increase in survival, and a People living with HIV/AIDS. However, it can be seen that even in the face of a new scenario of this infection, new socio-demographic, epidemiological and clinical factors have emerged that may directly affect the QoL of people affected.

Since the first reports of cases of HIV/AIDS in Brazil in the 1980s, this infection has been increasing considerably, constituting a serious public health problem worldwide.

Current data on the HIV/AIDS situation estimate that approximately 35 million people are living with HIV infection worldwide, of which 490 to 530 thousand are believed to be located in Brazil [4], and it is believed also that 130 thousand people do not know they have the virus. According to the epidemiological bulletin, in the year 2013 alone more than 39 thousand new cases of the disease were reported, totaling a record of more than 657 thousand cases registered only in the country. These data further evidence the pandemic character of the infection, characterizing it as the leading infectious disease worldwide [4].

Although there are a greater number of cases reported in males, the rate of growth of the epidemic is faster among women, thus modifying a reality that prevailed since the beginning of this pandemic.

Data from the Northeast Region are even more worrisome, only in the state of Paraíba, more than 5,000 cases were reported in the period from 1980 to December 2013. According to data from the State Department of Health (SES), up to October 2013, 78 deaths were recorded in males and 32 females [6].

Although there is little information about HIV infection in women, it is believed that they have more difficulty accessing public health services. Diagnosis and treatment occur at more advanced stages of infection when compared to the male population. It is possible that these factors are related to the role of "caregivers" that women play in society, making most of them prioritize the health of their children and family, and therefore, do not perceive themselves at risk. In addition, there is a broad discussion about gender issues about condom use, especially among women who have a stable relationship with a single partner [7, 8].

In view of the above, it is noted that HIV/AIDS has been changing in its epidemiological profile, and the idea of vulnerable groups. Infection can reach all social groups, regardless of class, gender, race, sexual orientation and even age group [9].

In order to evaluate the QoL of women living with HIV/AIDS, in this study, we chose to use a socio-demographic and clinical questionnaire, in addition to HAT-QoL. This is a data collection tool to assess the quality of life of people living with HIV/AIDS, developed in the United States, specifically transla-
ted and adapted for a study of women living with HIV infection in Brazil. This instrument proved to be very efficient, since it evaluates important aspects of the daily lives of people living with the infection, taking into account the concerns of the individual. As soon as possible, it was possible to relate the data obtained by HAT-QoL with clinical and socio-demographic characteristics of the target population. Thus, the following objectives were established: To characterize women living with HIV/AIDS in relation to sociodemographic and clinical profile, and to evaluate the quality of life of this public, through HAT-QoL.

**Method**

It is a descriptive and exploratory study of a quantitative nature. The data collection took place in July and August 2014, in the outpatient setting of the Clementino Fraga Hospital, located in João Pessoa, specialized in the care of people living with HIV/AIDS, having as a population women with HIV/AIDS infection.

To select the sample, the following criteria were chosen: to be a woman with HIV/AIDS infection regardless of the stage of infection; Be over 18 years of age; Being in clinical-outpatient follow-up of the Reference Hospital; Have a fixed residence in the State of Paraíba; Being in ART for at least 3 months, the sample being obtained by random sampling for accessibility. Of the public invited to participate in the interviews, there were only two refusals, these women reported fear that others would discover them as having the infection. Then, at the end, a sample of 33 women, randomly selected, were obtained while awaiting medical consultation.

For data collection, a brief questionnaire was drawn up with the purpose of tracing the clinical and sociodemographic profile of this group; and then applied the HAT-Qol instrument, structured to assess the quality of life of these women. The clinical and socio-demographic profile questionnaire contained questions that addressed the following aspects: age, family income, ethnicity, marital status, complete years of schooling, sexual orientation, form of exposure to the virus, number of children, viral load CD4 cells.

The HAT-Qol instrument, short for “Qualit of life”, was originally developed in the United States for studies with HIV-positive individuals and was validated in Brazil to be applied in a study with a sample of women with positive serology for HIV/AIDS in the State from Sao Paulo.

This instrument is very efficient because it evaluates important aspects of the daily lives of people living with the infection. It consists of 34 questions distributed in nine domains: general activity, contentment with life, health concerns, financial concerns, medication issues, HIV awareness, concern about the confidentiality of the disease, relationship with the physician and sexual activity. For each question the following response options are given: all the time, most of the time, part of the time, little time or never.

The research project was registered in the Brazil Platform, then analyzed by the Ethics and Research Committee of the UFPB, under CAAE: 30883114.3.0000.5188, respecting the normalization of Resolution 466/12 [10], which refers to the ethical aspects that should be observed in research involving human subjects.

For the application of the instruments, the technique of individual interviews was used in a reserved environment, free of people that could interfere with the participants’ responses and privacy. Having been, all participants, previously clarified about this research and agreeing to sign the Free and Informed Consent Term, following the requirement for research involving human beings.

In order to analyze the data of the HAT-Qol instrument, values from 1 to 5 were assigned to the answer options offered for the questions, where the “all time” option was worth 1 and “never” was
worth 5. Except in the areas of General Activity and Health Concern that the assigned values were inverted, therefore, it never came to value 1. After this assignment of values, a summation of the questions concerning each domain was performed, transforming these values into indexes, scoring them on a scale of 0 to 100, where 100 refers to the best index. Thus, we considered that those domains that presented results below 50.

All the data obtained in this investigation were typed and stored in spreadsheets of Microsoft Office Excel 2003. After coding the variables in a dictionary, a database was elaborated that was fed using the technique of validation by typing. After typing steps and data consistency were completed, they were imported into the Statistical Package for Social Sciences (SPSS) application version 20.0.

**Results**

The results are presented in the form of tables and are related to sociodemographic, clinical characteristics and scores of the domains of Quality of life according to HATqOL.

**Sociodemographic and clinical characterization of people living with HIV/AIDS**

The mean age of study participants is 39 years, with a minimum age of 24 and a maximum of 59 years. Most 23 (69.8%) have less than 9 years of schooling. The data also revealed that the majority of the population was defined as brown 24 (72.7%) and the indigenous minority 1 (3.3%), according to Table 1. Regarding the number of children, 29 (87.9%) have children and the majority have up to two children, 16 (55.2%). They assumed sexual exposure to the virus 29 (87.8%) of the women interviewed. Regarding the current marital status and sexual choice, the largest portion of the sample was defined as single 15 (45.5%) and heterosexual 26 (78.8%). A large part of the sample also had a CD4 + T cell count at levels higher than 350 cells/mm³ and undetectable viral load. *(Table 1)*

**Table 1. Sociodemographic and clinical characterization of women living with HIV/AIDS, João Pessoa (PB), 2014.**

<table>
<thead>
<tr>
<th>Variable</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age group (years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24-30</td>
<td>5</td>
<td>15.2</td>
</tr>
<tr>
<td>31-36</td>
<td>2</td>
<td>6.1</td>
</tr>
<tr>
<td>37-42</td>
<td>15</td>
<td>45.5</td>
</tr>
<tr>
<td>43-48</td>
<td>5</td>
<td>15.2</td>
</tr>
<tr>
<td>49-54</td>
<td>3</td>
<td>9.1</td>
</tr>
<tr>
<td>&gt;54</td>
<td>3</td>
<td>9.1</td>
</tr>
<tr>
<td>Years of study</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-3</td>
<td>5</td>
<td>15.2</td>
</tr>
<tr>
<td>3-6</td>
<td>9</td>
<td>27.3</td>
</tr>
<tr>
<td>6-9</td>
<td>9</td>
<td>27.3</td>
</tr>
<tr>
<td>9-12</td>
<td>5</td>
<td>15.2</td>
</tr>
<tr>
<td>12-15</td>
<td>2</td>
<td>6.1</td>
</tr>
<tr>
<td>15</td>
<td>3</td>
<td>9.1</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>5</td>
<td>15.2</td>
</tr>
<tr>
<td>Yellow</td>
<td>3</td>
<td>9.1</td>
</tr>
<tr>
<td>Brown</td>
<td>24</td>
<td>72.7</td>
</tr>
<tr>
<td>Indigenous</td>
<td>1</td>
<td>3.3</td>
</tr>
<tr>
<td>Children</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>29</td>
<td>87.9</td>
</tr>
<tr>
<td>No</td>
<td>4</td>
<td>12.1</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>15</td>
<td>45.5</td>
</tr>
<tr>
<td>Married</td>
<td>4</td>
<td>12.1</td>
</tr>
<tr>
<td>Life partner</td>
<td>5</td>
<td>15.2</td>
</tr>
<tr>
<td>Separate</td>
<td>3</td>
<td>9.1</td>
</tr>
<tr>
<td>Widow</td>
<td>6</td>
<td>18.2</td>
</tr>
<tr>
<td>Number of children</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 0 to 2</td>
<td>16</td>
<td>55.2</td>
</tr>
<tr>
<td>3 0 to 4</td>
<td>11</td>
<td>37.9</td>
</tr>
<tr>
<td>Orientação Sexual</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heterossexual</td>
<td>26</td>
<td>55.2</td>
</tr>
<tr>
<td>Homosexual</td>
<td>3</td>
<td>9.1</td>
</tr>
<tr>
<td>Exposure form</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual</td>
<td>26</td>
<td>87.8</td>
</tr>
<tr>
<td>Blood/Injecting Drug User</td>
<td>2</td>
<td>6.1</td>
</tr>
</tbody>
</table>
Assessment of quality of life according to HATQoL

Most scores indicated that the responses ranged from "most of the time, and all the time," except for the variables of the General Activity and Health Concern domains that showed an inverted sum and most of the answers were "never".

Factor analysis within each domain shows that all facets of the "Satisfaction with life" domain presented high scores. Regarding the "Financial Satisfaction" domain, there are low scores in all facets, highlighting the facet 4.2 "I was worried if I would have to pay my bills". In the field of "Concern for health" it is observed that the majority of the women do not show concern with the clinical questions nor with the "death".

The domain "Regarding HIV medication" shows that most interviewees have difficulty adhering to antiretroviral therapy despite being aware of the reasons for using the drugs.

Most women interviewed are concerned about confidentiality except for family members, as for "Trust in the doctor" most interviewees have high facet scores on good relationship with the doctor and relationship of trust and respect. However, in the field "Sexual activity" it is observed that the majority have difficulty in getting aroused and reaching orgasm.

The domain "HIV awareness" shows that most people are "all the time" worried about the vulnerability behavior adopted in the past. (Frame 1)

The quality of life evaluation of women living with HIV/AIDS, according to HATQoL, presented higher scores in the areas of "Trust in the Doctor" and "General Activity". It is observed that the domain "Sexual activity" presented the lowest score in relation to the other domains. (Table 2)

It is important to note that most of the domains of Quality of Life, according to the HATQoL, presented high scores, except the areas referring to "Financial Concern" and "Sexual Activity".

**Discussion**

The feminization of the HIV/AIDS epidemic has been observed for some time. In 1985, the proportion was 26.5 men for every woman with HIV/AIDS; In 2005, the ratio was 1.5 men for each

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**Table 2. Distribution of the scores of Quality of life domains of women living with HIV/AIDS according to HATQoL, João Pessoa (PB), 2014.**

<table>
<thead>
<tr>
<th>Domains</th>
<th>Number of items</th>
<th>Average</th>
<th>Median</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Activity</td>
<td>6</td>
<td>83.8</td>
<td>87.5</td>
<td>25</td>
<td>100</td>
<td>10.8</td>
</tr>
<tr>
<td>Satisfaction with life</td>
<td>4</td>
<td>70.5</td>
<td>75.0</td>
<td>8.5</td>
<td>100</td>
<td>25</td>
</tr>
<tr>
<td>Concern about health</td>
<td>4</td>
<td>60.1</td>
<td>60</td>
<td>0</td>
<td>100</td>
<td>31</td>
</tr>
<tr>
<td>Financial Concern</td>
<td>3</td>
<td>42.6</td>
<td>30</td>
<td>0</td>
<td>100</td>
<td>29.7</td>
</tr>
<tr>
<td>Regarding HIV medication</td>
<td>5</td>
<td>72.8</td>
<td>74</td>
<td>0</td>
<td>100</td>
<td>20.2</td>
</tr>
<tr>
<td>HIV Awareness</td>
<td>2</td>
<td>68.0</td>
<td>66.7</td>
<td>0</td>
<td>100</td>
<td>23</td>
</tr>
<tr>
<td>Concern about secrecy</td>
<td>5</td>
<td>55.0</td>
<td>40</td>
<td>0</td>
<td>100</td>
<td>26.4</td>
</tr>
<tr>
<td>Trust in the doctor</td>
<td>3</td>
<td>94.7</td>
<td>90</td>
<td>0</td>
<td>100</td>
<td>33</td>
</tr>
<tr>
<td>Sexual activity</td>
<td>2</td>
<td>31.6</td>
<td>30</td>
<td>0</td>
<td>100</td>
<td>20.3</td>
</tr>
</tbody>
</table>

Source: Research data, 2014.
woman. The increase in HIV/AIDS cases in the heterosexual male population has contributed to the spread of the disease in married heterosexual women or in a stable union. This has become a worldwide concern, especially in women of childbearing age due to the possibility of vertical transmission of HIV/AIDS [11]. So soon, what was once an epidemic of specific epidemiological characteristics of certain groups of risks now takes on new characteristics and takes on great proportions, passing through a process of feminization, internalization and pauperization.

Parker and Galvão [12], affirm that in no other country in the world, the feminization of the epidemic occurs as markedly as in Brazil. Female vulnerability to HIV, as well as to other sexually transmitted infections, is associated with biological, social and cultural characteristics [13, 14].

From the biological point of view, women’s vulnerability is associated with the fact that women present the physiology of the genital tract bigger and thicker than the male genital tract, and it is also the site of semen deposition that is characterized as a larger secretion of the body Potential when related to vaginal secretions.

Knowing that, historically, the social role of women has always been of submission to the male and family figure. Until they got the right of access to studies, voting and work, it was many decades of struggle for the feminine affirmation in society. Although many social advances have been conferred on women, we are still faced with a culturally sexist society where the predominance of gender inequalities gives this group less value in the labor market, in political representations and in family relations [15, 16].

According to a study conducted in Paraná, with a sample of 169 people and the use of the HAT-QOL instrument, it was observed that the predominant age group was between 30 and 39 years old, corresponding to 45.6% of the studied population [17].

In the present study, it was observed that the predominant age group was between 36 and 42 years, most of whom are currently single. However, in their speeches, during interviews, the greater part of the interviewees reported having acquired the infection with a partner with whom they had some family bond. This fact is also evidenced by the fact that the vast majority of the women participating in the study had between 1 and 2 children.

It also occurs in the country’s population, the people of Paraíba are the result of strong miscegenation. Thus, the population is essentially mestizo, and the group of the declared pardos crosses the 50% of inhabitants of the State of Paraíba. Another curious fact, revealed, is that 31.6% of the Paraíba population remains studying for less than 11 years [18].

As for the form of contamination, the majority of the seropositive affirms to have been by sexual relations. In his studies, Reis [16] states that one of the most critical problems for this group is related to HIV/AIDS prevention with the use of condoms for safer sex. Many women are apprehensive about applying for this method, are afraid of losing their partner, or even financial support.

Through the instrument used, the Hat-Qol, the data referring to the nine domains of quality of life were analyzed, obtaining an average variant among them from 36.1 to 94.7, where the lowest average is related to the activity Sexual concern (36.1), followed by financial concern score (42.6), concern about confidentiality (55.0), HIV awareness (68.0), health concern (60.1), satisfaction with Life (70.5), medication (72.8), general activity (83.8) and confidence in the physician (94.7).

According to a study carried out in the state of São Paulo in 2001, women with HIV infection using the same instrument obtained some low indexes in the quality of life scale, and the results showed that the most affected domains were: financial concerns, Health concerns, concerns about confidentiality and sexual activity [19]. Results that diverge in relation.
to the findings in this study regarding the domain of health concern.

The domain trust in the doctor, who presented higher average, is composed of three questions that assess safety, respect and accessibility to the doctor. Bakken et al [20] state that the relationship between patient and health team directly influences the patient’s clinical condition and strengthens adherence to treatment. Therefore, this score reflects the degree of the physician’s ability to assist the individual in the face of his anxieties and needs, as well as the quality of care.

The second highest average domain (83.8) is related to general activity. In this, the level of physical activity satisfaction and work execution capacity were evaluated. In their speeches, during the interviews, many participants associated the questioning to the side effects caused by ARTs.

The medication-related domain had a mean of 72.8, assessing questions about how they feel about medication use, understanding the importance of treatment, and side effects.

HIV infection alone causes a feeling of incapacity, even for the execution of simple tasks, which is increased, after initiation of HAART, by the side effects caused by the cocktail.

Even knowing the numerous benefits of the introduction of antiretrovirals, for many people, starting treatment with these medications is the most difficult time. This new routine incorporated into your life is often marked by the unpleasant side effects of ART, and may be temporary, with: diarrhea, vomiting, nausea, restlessness, insomnia and vivid dreams; Or in the long term, such as lipodystrophy [21].

However, it was observed that despite the side effects and toxicity of ART described in several literature, the results obtained in this study reflect the organization of reference centers and the positive impact of the introduction of antiretrovirals [22].

Regarding a general view of social life, the satisfaction domain with life obtained an average of 70.5, evaluated from four questions regarding decision-making power, social satisfaction and healthy life.

In his studies, Reis [16], found that the time of adhesion to ART is relevant with respect to the level of satisfaction with life. Thus, the lower the adherence time, the lower the satisfaction level with life.

Aries [23], affirms that during the course of the infection the people who live with it, go through several oscillations in the satisfaction of life. It also emphasizes that these changes may be due to both symptomatology and the effects of medications.

As soon we can consider that the domain satisfaction with life, presented a good average in the scale of quality of life, when associated with the fact that it was previously established as a prerequisite of sample participation, only women who started Treatment for more than three months.

The HIV awareness domain averaged 68.0, and stands out for investigating feelings of acceptance, accountability, and anger related to the risk and exposure behavior adopted in the past. Most women, who participated in this study, reported having acquired the infection through heterosexual intercourse, where they often could not comment on safe sex.

Accepting the HIV diagnosis takes longer to occur than chronic diseases, for example. In addition to absorbing the social representation of prejudice and discrimination that this infection carries with them, for these women, there is still the weight of the rupture of the affective relationship with their partner [24].

Psychologists say that acceptance of the diagnosis is essential for increasing QOL and coping with the new challenges posed by infection. However, it is more difficult for the female population that, in addition to dealing with feelings of betrayal, abandonment and even loss of financial support, if they come without family support and in a situation of abandonment.
Reaching an average of 60.1, the domain concerned with health, evaluated aspects concerning concern with CD4+ cell levels, viral load, and death. This average was obtained because, most of the interviewees had undetectable viral load and CD4+ cell levels above 350 cells/mm³ in the last three months. Many have reported that they do not feel concerned about the results of the laboratory tests, since they follow the treatment.

Another area analyzed was the concern about confidentiality, averaging 55.0, it was observed that a large part of the women who participated in the present study, showed great concern about the secrecy related to the disease and treatment, except in the family environment.

During the data collection phase of this study, we obtained two refusals. Despite being previously clarified as to the ethical precepts of the research, these two women reported feeling fear that other people would discover that they are living with HIV, mainly because they live in inner cities of the state with low population density.

The fear of suffering stigma, prejudice or discrimination makes communicating the diagnosis to others in social life a difficult decision, this act is often still avoided and postponed. This fact, which can lead to negative impacts both in adherence to treatment, and in the frequency of consultations, laboratory tests, and distribution of medications; Compromising the quality and efficacy of the treatments [21].

The domain related to financial concern, with an average of 42.6, refers to the second worst result obtained in the analysis of the scores. Composed of four questions that investigate the concern of living with a certain income, with the possibility of not being able to pay the bills and if there is possibility of buying things that please them. When we ask the questions of this domain we are faced with a reality, many of the women living with this infection live with up to a minimum wage and are not included in the labor market, being restricted only to domestic activities.

When compared to other studies, similar results were observed related to this domain. Some researchers affirm that the low income associated to low schooling reflects the new epidemiological scenario of the epidemic and further denote the pauperization of the infection [16, 7].

Finally, the domain sexual activity, obtained a mean of 31.6, being characterized as the score with lower mean. This domain investigated the difficulty of feeling aroused and reaching orgasm during sexual practices.

Historically, HIV infection was associated with the practice of unsafe sex and its diagnosis at the death sentence. Although there are few studies related to the sexual behavior of people living with HIV/AIDS, a statistically significant difference was observed in the mean obtained in this domain when compared to other studies that used the same instrument. In their study, Galvão et al [19] found an average of 52.5 in this same domain. REIS (20) observed an average of 62.7 in the sexual activity domain.

Paiva et al [25] report that obtaining such low averages directly reflects the fear of becoming pregnant, increasing viral load, and the fear of the condom breaking, further compromising the sexual behavior of people living with HIV/AIDS.

In addition, diagnosis of HIV alone can cause cessation of sexual activity and suspension of the affective life; ARVs also include as a side effect libido loss and self image distortion [26].

Conclusion
Since the beginning of the epidemic, HIV/AIDS infection has been associated with stigmas that persist to the present day. After the emergence of alternatives of continuous treatment, the infection assumed a chronic character, being able to dissociate itself from the idea of death. Not unlike its beginnings, receiving the positive diagnosis for the infection brings with it countless negative biopsicosocial consequences, since they can provoke
important impacts in several domains of quality of life.

Therefore, for effective intervention in improving the quality of life of the patients, it is necessary a prior knowledge of the determinants and variables that can negatively influence the quality of life of people living with HIV/AIDS.

When using the Hat-Qol instrument to assess the QoL of the women who participated in the present study, it was observed a significant commitment in areas of concern with secrecy, financial concern and sexual activity. However, this compromise can be associated with the data obtained in the socio-demographic profile, since most of the women were between 36 and 42 years old, reported having acquired HIV through heterosexual relations, are currently single, have low level of schooling (3 to 6 years and 6 to 9 years), low income (up to 1 to 2 minimum wages), and, have children (1 to 2 children).

For this, being a cross-sectional study, had as a limiting factor the fact that the data collection occurred at a single moment of time, and it was not possible to establish a temporal relationship between the events.

According to the present study, it is possible to affirm that Paraiba women living with HIV/AIDS do not present a quality of life impairment, since most scores obtained excellent averages.

In this way, it is fundamental that the professionals who integrate the health team are aware of the long historical process of the HIV/AIDS epidemic, as well as the changes in face of the new perspectives of life, not just addressing the issues of fear, prejudice and discrimination. For this, it is necessary that the care of these women be carried out by interdisciplinary teams that promote integral care, contemplating, besides the individual needs, aspects related to this reality.

Thus, it is concluded that, when integrating the health team, nursing plays a fundamental role in promoting the quality of life of people living with HIV/AIDS, from diagnosis to possible coping strategies. The nurse must have critical thinking to assess and identify the factors that influence the quality of lives of these people, as well as to create the possibility of access to health services.

References


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