Psychosocial impact of HIV/aids diagnosis on elderly persons receiving care from a public healthcare service

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Abstract

The current increase in the number of elderly people infected with the human immunodeficiency virus (HIV) represents a major challenge to healthcare professionals, public policies and the general population, in terms of the need to discuss the role of sexuality and sexual practices in the aging process and the impact of these issues on health promotion for the elderly. The aim of the present study was to identify the psychosocial impact of HIV/Aids diagnosis on elderly persons receiving care in a public healthcare service, based on the perception of the individuals themselves. A qualitative research study of an exploratory nature was performed, based on individual semi-structured interviews with HIV-positive elderly patients, living in the mid-west macro-region of Minas Gerais. Analysis of the results suggested that, according to the 14 patients interviewed, HIV diagnosis involves changes in the way they relate to people; in self-care; in sexual practices; in the performance of daily activities and in the possibility of continuing to participate in social groups. The patients reported embarrassment, fear of rejection and discrimination, and experiences of isolation and facing prejudice. Based on the results, it can be concluded that most of the problems faced by older people are linked to socially constructed stigmas and stereotypes associated with the disease and the efforts made by such individuals to keep the diagnosis a secret.

Key words: HIV/aids. Acquired Immunodeficiency Syndrome. Aging. Sexuality.

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INTRODUCTION

Population aging is a worldwide phenomenon with regional traits, including differences linked to gender, income, education and access to health services. In developed countries, the characteristics of the elderly population have been most effectively analyzed by public sectors in order to establish strategies that can improve services for this segment of the population.[1] Concomitant to population aging is a process known as "epidemiological transition", which represents the changing patterns of morbidity and mortality, in which chronic diseases play a significant role.[2]

In the 1980s, an infectious urban disease known as Acquired Immune Deficiency Syndrome (aids) appeared. This disease is transmitted in the following ways: vertically, during birth or breastfeeding; by sharing contaminated syringes and needles; through blood transfusions; and through sexual relations with an infected person. The disease, which occurs when the HIV virus attacks the defense cells over a period of years, seemed to be irrelevant in the elderly population as, initially, very few elderly individuals were infected.[3,4]

In Brazil, only four cases of aids were recorded among elderly individuals in the first five years of the epidemic.[3,4] Initially, the mistaken idea that the infection was restricted to certain "risk groups" was widespread. These groups included men who had sexual relations with other men, hemophiliacs, users of injectable drugs and sex workers.[3] The elderly population were not considered to be a part of these risk groups. These ideas express the strong prejudice that was evident at the time when the aids epidemic began and which continues to exist in sections of society today.[5] However, scientific studies and health services have identified new profiles of HIV-positive individuals, while strongly criticizing the idea of "risk groups" and focusing on combatting "risky behavior", such as sharing syringes and having unprotected sex. More recently, after greater knowledge of the epidemic and its biological, epidemiological and psychosocial aspects became available, the concept of vulnerability was created, which considers individual behavior, as well as social, historical and cultural characteristics that lead a population to become more vulnerable through the non-adoption of preventive methods.[6] Significantly, not all segments of the population that are classified as vulnerable will adopt risky behavior or develop HIV/aids. Thus, it is interesting to consider how characteristics of vulnerability should be correlated with promotion and prevention policies in the health sector and how they can be adapted for each segment of the population. Elderly individuals are included among those considered vulnerable to HIV.[7-9]

Currently, there is a tendency to feminize and interiorize the HIV epidemic in Brazil, which also affects heterosexuals and the over 40s in an epidemiologically significant manner.[3] The increase in HIV infections among individuals aged 60 years or more has led to reflections on the correlation between the disease and the aging process, including certain stereotypes faced by the elderly population, particularly in relation to the denial of their sexuality. Therefore, it is important to reflect on and discuss sexuality in old age, considering the current context of an increase in HIV/aids cases.

It is also worth noting that the psychosocial impact of being diagnosed with HIV/aids on elderly individuals may be due to stigmatization, as well as the effects the diagnosis has on their identity, participation in groups and social relationships. In terms of social construction, the stigma is born out of relationships between individuals and symbolically defines the territories of "normality". These territories of "normality" represent a set of standards or stereotypes that, when broken, can lead to social rejection, accusations, isolation, a lack of acceptance and the adoption of punitive and corrective measures. Thus, the stigma can be seen as a characteristic or attribute that is both a great discredit to the individual and is reductionist, since it considers one attribute as a priority over other characteristics that make up the individual. When the stigma is internalized by the subject, it begins to control self-references, feelings and even attitudes, leading to feelings of guilt, shame, anger, confusion and an identity crisis. [10,11]

The discussions, studies and policies that have been developed on the theme of the aging population have shown that economic and sanitary changes are not enough to promote the health of elderly individuals. These changes must be accompanied by advancements in the social environment, which consider a wide range of aspects related to aging, including sexuality, which remains relevant to this segment of the population[12] and is currently permeated by the HIV/aids epidemic. The present study sought to expand on the analyses and discussions that considered the prejudice and stereotypes associated with sexual relationships, defining and regulating the experience of sexuality and sexual behavior, so that such parts of life are no longer viewed as a right of the elderly individual.[13-15]

Therefore, considering the questions highlighted in the literature, the importance of multidisciplinary research and discussions is clear, in order to understand the inseparability of certain elements that are fundamental to the promotion of health in the elderly population, including: sexuality; prejudice and stigmas; the challenges of adopting preventive methods during sexual activity; the complexity involved in aging with HIV/aids; and the importance of these issues to the formation of health practices.

Concerning health promotion and quality of life in the elderly population, it is worth noting the relevance of production and the dissemination of information that allow elderly individuals living with HIV/aids to share their experiences and the difficulties they face. The experiences reported and the reflections on the impact of stigmas related to the disease could help in the creation of more adequate methods of dealing with these issues.

Therefore, the aim of the present study was to present the results of a qualitative investigation that sought to identify the psychosocial impacts of the diagnosis of HIV/aids on elderly individuals who use the public health system, based on the perceptions of the subjects who were interviewed. The following psychosocial aspects were considered in the investigation: experiences of sexuality and sexual behavior; relationships with family members, friends and colleagues; social relationships, based on participation in groups, institutions and daily activities; and possible prejudice suffered by the interviewees.

METHODS

Given the complexity, specifications and multidisciplinary approach of the health sector,[16] and particularly the situation of the participants, the present study was characterized as an exploratory, qualitative study, which sought to expand knowledge of a new phenomenon, for which research projects are non-existent or in the very early stages.[17]

Semi-structured individual interviews were conducted with HIV-positive elderly patients who lived in the Center-West macro-region of the Brazilian state of Minas Gerais and were attended by the public health service, with or without anti-retroviral therapy. There were no restrictions on their autonomy and the participants spontaneously agreed to take part in the investigation.

The interviews were conducted in a secondary level health clinic linked to the Secretary of Health in the most important of the 55 municipalities in the Center-West macro-region of Minas Gerais. The health service in question deals with the diagnosis, treatment and screening of sexually transmitted infections (STIs), including aids, viral hepatitis and syphilis. It monitors approximately 726 patients with HIV (291 women and 435 men). At the time of the study, the number of patients aged 60 years or more was estimated at 40.[19]

The patients were only approached within the health center, respecting the routines of the unit, as well as the timetables and schedules of patient appointments. During the data collection period, it was possible to approach 22 patients who were attending scheduled appointments and invite them to participate in the research. However, only 14 of these elderly individuals agreed to participate and sign a free and informed consent form. The interviews took place between December 8, 2011 and June 26, 2012. The fear of their diagnosis becoming known to people outside the health center was the main reason given by the majority of the individuals who refused to participate, despite the fact that the confidentiality of the project was explained to them. Others did not provide a reason for their refusal, although it is probable that they were concerned about discussing intimate aspects of their lives. Once the interview process began, none of the participants opted to give up before completing the research. In order to minimize the difficulty of addressing the topic in question, the research group was organized so that the female elderly participants were interviewed by a female researcher and the male elderly participants were interviewed by a male researcher.

This project was approved by the Research Ethics Committee of the *Universidade Federal de São João Del Rei* (Center-West Campus) under registration number CEP-UFSJCCO 006/2011. All ethical issues were respected and the interviewees were identified using pseudonyms. The 14 interviews were recorded and then transcribed in full, prior to analyzing the content.[20] During this analysis, the content was grouped based on the themes that emerged in the statements of the interviewees, using the following four categories: 1) sex and sexuality; 2) reactions to the diagnosis; 3) changes in their lives after the diagnosis; and 4) prejudice suffered as a result of diagnosis with HIV/aids.

The main theoretical reference that upholds the reflections and analysis of the present study was the work of Goffman,[10] who discussed social stereotypes, stigmatization and their repercussions on the identity of individuals who exhibit characteristics that could potentially place them in stigmatized categories. HIV infection is one of these potentially stigmatizing characteristics, for the following reasons: it affects the individual's identity; it is linked with moral precepts, particularly in relation to sexuality; it may lead to the development of physical signs on the body; and it has a common connotation of "divine punishment", which affects people who deviate from current sexual standards.

RESULTS AND DISCUSSION

In total, 14 elderly individuals were interviewed (seven men and seven women), with an age range from 60 to 77 years. In general, the participants had not completed primary education. One was illiterate and only two had completed secondary education. Six of the interviewees were living under the poverty line and three were under the extreme poverty line. [21]

All of the interviewees claimed to be heterosexual. Six of the 14 were married or part of a civil union, while five were widowed and three were single. The time since the diagnosis of HIV/aids ranged from five months (minimum) to 11 years (maximum). Of the 14 participants, 11 reported less than eight years of diagnosis and treatment. These characteristics are convergent with the national and international trends of internalization, pauperization and heterosexualization of the HIV/aids epidemic.[3]

Most of the participants claimed to have contracted the virus through sexual activity and made adequate scientific reference to contagion. With the exception of one of the women, all of the female participants were in a civil union with a single partner who was the cause of their contamination with the HIV virus. Four of the men stated that they had contracted the virus during extra-marital relations. Two others did not know how they had contracted the virus.

Based on the reports from the interviewees, it is necessary to stress the complexity of the elements circumscribed to the feminization of the epidemic, particularly when considering the extreme gender inequality in a country such as Brazil, where many women are trapped in oppressive conjugal or civil union relationships.[22-25]

From the set of cultural issues that permeate the phenomenon of feminization of the epidemic, the most significant were the construction of female identity, the fulfillment of sexual roles and the power relationships that exist between men and women. Brazilian studies have shown that the familiar standard of fidelity for the husband or partner creates a feeling of protection from the HIV virus among women, something that was very evident among the poorest women. Discussions about preventing STIs and aids are considered unnecessary or inconvenient among long-term relationships, since they create tension related to the concrete possibility of infidelity. In addition, when the idea of prevention (use of contraceptives) is introduced by the woman, the suspicion of infidelity and promiscuity tends to fall upon them.[22,23,25,26] These reflections are fundamentally important in helping health professionals to understand the complexity of their professional practices, specifically in relation to the health of elderly individuals, sexual and reproductive rights and health promotion in general.

The categories that emerged in the analysis of the interviews are presented below.

Sex and sexuality

This category discusses the feelings created by the interviewees throughout their lives about sex and sexuality, as well as aspects referring to the education they received on these issues and how this education contributed to the process.

The statements provided by the men and women were made with great difficulty and in situations of extreme embarrassment. Most notably, they mentioned the equivalence of the concepts of sex and sexuality, the sexual act itself, the satisfaction of sexual desire, physical contact and sexual acts. During the statements, very few referred to elements such as affection, confidence, companionship and respect in connection with sexuality. Below is the statement from the only participant who addressed sexuality in great detail:

> *I believe that sexuality is part of a person's life. For me, sexuality is one thing and sex is another. I think we show our sexuality from the time we are born, in the clothes that we wear, the way we carry ourselves, how we interact with people and how we participate in groups. So for me, sexuality is different from sex. Sex is something else. Sexuality is part of the person, especially in women I think, more so than in men. It is present in all phases of life. The sexuality of a teenager is different to that of a pensioner, but that doesn't mean that an elderly person doesn't have sexuality. Sexuality is there from the time you get up and look at yourself in the mirror. I think my sexuality is belongs to me, not to anybody else, and it's there to make me feel good. (Maria 1)*

The statements made by the interviewees also contain ambiguities related to sex and sexuality. At times, they raised questions about sexuality and sexual practices that were grounded in conservatism, while at other times they discussed health promotion and disease prevention, in connection with a more reflective concept of sex and sexuality.

There were also many demonstrations of a lack of knowledge concerning sex and sexuality, the use of contraceptives, STIs and HIV/aids, which at times reflected the precarious nature of the information received throughout the lives of the men and women interviewed. There were also frequent references to imprecise information or issues associated with prejudice and stereotypes, thereby demonstrating the difficulties associated with addressing this subject. During the interviews, there was a notable use of terms such as "useless" when referring to male contraceptives, and "that thing" when referring to sex and sexual activity. In general, it seems that the issue of sexuality is addressed in a restricted, prohibited manner by women throughout their lives, and is seen as a subject that women should not discuss. At the same time, despite attempts on behalf of the researchers to minimize embarrassment, one cannot disregard the possibility that the participants may have felt shy during the interviews, as they were questioned about intimate details.

Conversely, throughout their lives, very few of the participants sought information about sex and sexuality from sources other than family members or an educational facility. The contraceptive was a recent preventive option in the lives of the elderly individuals interviewed. Most of them only found out about contraceptives after diagnosis or through recent HIV/aids prevention campaigns that were broadcast on national television during carnival.

In general, the participants said that they had received a repressive sex education in their childhood and teenage years, with little or no access to correct information based on scientific knowledge. Notably, the women reported a more prohibitive and restrictive sex education, whereas the men spoke of a more permissive sex education. However, it is important to stress that both the repressive and permissive perspectives of sex education contributed little or nothing to the promotion of behavior that protects individuals from STIs or aids. These issues are still seen as taboos, which are difficult to discuss.[26-31]

Studies have shown that in the history of Brazilian society, concepts and practices related to sex and sexuality are rooted in a traditionally patriarchal, sexist culture linked to Christian religious dogma. Therefore, women feel that they are stuck in a restrictive and punishing society, while men live in a world without clearly-defined rules or reflections, in terms of the ethics of those involved. [26,27]

Sexuality represents one of the central aspects of life and involves a wide range of issues related to sex and reproduction (sexual activity, sexual orientation and sexual roles) as well as issues related to pleasure, desire and love.[26] However, dealing with these issues is not easy for people, particularly men. Furthermore, since sex and sexuality are historically linked to reproduction and repression, which are still relevant in society today, there is a set of restrictions in place when addressing this issue in health education programs. These restrictions also apply to health professionals when raising the question of sex and sexuality with elderly individuals.[4,26,27,32]

Nowadays, Brazil is engulfed in an ambiguous context in which the sexist and patriarchal values held by more conservative sections of society live side by side with more reflective references.[26,27] The statements of the elderly participants in the present study exemplify the coexistence of these perspectives and demonstrate the need for a health approach that considers how each individual creates meanings and concrete modes of existence, with a view to serving their specific needs in healthcare services, as well as addressing the sexuality of the elderly population in order to plan health education and HIV/aids prevention programs for this segment of the population.

Reactions to the diagnosis

This category discusses the many different reactions revealed by the interviewees, as well as those of their family and friends, on hearing of their diagnosis. The reactions were placed in three groups, based on affinities: 1) fear; panic; sadness; revolt; surprise; perplexity; shock; guilt; denial; feelings of inferiority about themselves; worrying about how long they would live; a desire to die; 2) accepting the treatment and self-care; and 3) indifference or resignation to the diagnosis. Most of the participants (10) reacted in a manner that is described in the first group of reactions. One person reacted by accepting the treatment and self-care and three of the interviewees were resigned to their fate or indifferent when hearing of their diagnosis.

The following statements exemplify the main reactions of the interviewees:

> *Everything crosses your mind. Death is the first thing you think of. Not even fear. It felt like I had taken an anesthetic... Sometimes we put a wall in front of our feelings, don't we? That's what I felt like at the time. I didn't cry.... (Maria)*

> *I hadn't a clue about it [what HIV was and how it is transmitted]. I had no idea... But I panicked, I almost... I ended up on the ground. Wow. I thought I was going to die. I said to myself, I should die now. What's the point? Now that I have this disease, I won't want to go out, meet people or have sex. (Márcia)*

> *You really feel like you have a weight on your shoulders. There is no cure........so what are you living for? Many bad things cross your mind, like jumping in front of a car for example......not caring about life anymore. It would be over quicker. Things wouldn't get any better here. I didn't have any money [...] You feel a weight alright. That's when ... a wall in my mind fell down and I felt like an animal, because my life now has nothing good or pleasant about it. (Jair)*

Fear was the main feeling reported by the interviewees. They mentioned a fear of death and a fear of disability, but their greatest fear was that their diagnosis, which they considered shameful, would be revealed to family members, friends and others in their social circle, causing feelings of embarrassment, rejection, discrimination and isolation. The interviewees reported doubts about the performance of daily activities and the possibility of maintaining contact with family members and affectionate relationships after the diagnosis. As a result of the fear of isolation, a high number of the interviewees said that they did not tell most of their friends and family about the diagnosis. In general, they only told one close relative.

Given the set of reactions reported by the first group, as well as the strategies and care used by most of the participants to keep their diagnosis a secret, the impact of a diagnosis with HIV/aids can be understood as a process of radical biographical discontinuity.[10] This radical rupture of identity is evident in the questionnaires that were completed by the interviewees, based on the possibilities and impossibilities in their lives after the diagnosis and how they organized their lives after this event. These issues are evident from the moment they received the news and are invariably accompanied by reports of psychological suffering.

The interviewees spoke of the shame of being HIV-positive, feeling that they would be judged by others exclusively in terms of the shameful moral stereotypes linked to this STI. Thus, it is easy to understand why shame can stigmatize an individual as a central possibility in relation to their identity.[5,10]

According to ten of the 14 interviewees, the most common reaction of family members was supportive. However, they believed that conversations with people not involved in the treatment of their condition, including family members, should be avoided for fear that it would cause disagreeable feelings such as sadness, fear, guilt and anger. However, this strategy, which leads to an apparently calm environment, may have negative repercussions on the psychological welfare of individuals with stigmatizing diseases, given that they prevent the changing of prejudiced ideas related to HIV/aids.[33]

In addition, this pact of silence may hide the real difficulties faced by HIV-positive individuals, as well as their friends and families, in dealing with their situation. This issue is exemplified in the following statement by José:

> *My family found out about it. All of them know and they have accepted it. They support me and they never say anything about it. None of my sisters know. Some of my nephews and nieces know, maybe all of them, they've never said anything about it to me or told anybody else. I have a sister who is always asking me 'are you taking your medication correctly?' [laughs] That's all she asks. The others don't like to get involved in the lives of other people. None of my friends know about it. (José)*

Changes after the diagnosis

This category deals with the changes reported by the interviewees after they were diagnosed with HIV/aids and the effects the diagnosis had on several dimensions of their lives, including sexual activity, contact with others, participation in social groups and daily activities.

The statements made by the interviewees were divided into two groups: those who said that their lives had changed and those who claimed that nothing had changed. The first group contained four patients (two men and two women) who promptly declared that their lives had been affected by financial, professional and social changes after their diagnosis. These changes included the following: a feeling of isolation; "professional weakening"; a "loss of desire"; a loss of interest in pleasurable activities and even a loss of self-care. They spoke of how they stopped participating in sport and leisure activities, religious groups and daily activities, such as going to the beauty salon. These interruptions to their activities were caused by the shame caused by the diagnosis, the fear that their condition would be discovered by others and the fear of contaminating somebody else. The following statement exemplifies these issues:

> *I don't go out anymore. I can't... there's a lot of things I used to do that I can't do anymore. For example, my beard... I can shave it, but very badly. I don't have the courage or strength to do anything else. If I needed to move these little things I have here, I can't do it. I don't have the strength anymore, you know? (...) And like I explained before, my financial life has collapsed, it's over. ...Sometimes I get some money from the INSS, but it's very little. I don't have a social life anymore. I don't go out, I don't do anything. It's over. (José Pedro)*

Conversely, two women in this group reported improvements in their lives after a period of time had passed from the time of the diagnosis, which represented a turning point in their lives and a stimulus to solve problems more quickly, such as separation from their husband, returning to college, increasing self-care and performing more leisure activities.

A second group of ten patients (five men and five women) declared that their lives had not changed since the diagnosis. However, it was clear during the interviews that most of these individuals simply had difficulty admitting the occurrence of these problems, many of which were linked to experiences of prejudice they had suffered as a result of their diagnosis. There was also evidence of changes related to isolation, financial difficulties, the performance of daily activities and self-care among these individuals.

The characteristics and/or explanations of the interviewees for the set of changes were also classified into two inter-related types: changes that are linked to the physical transformations caused by the disease and its treatment; and changes linked to the social repercussions of the disease. It is important to highlight that HIV infection generally leads to symptoms such as tiredness and fatigue, which hinder their social lives and cause a feeling of continuous weakening, according to a number of the interviewees. Furthermore, sadness, despondency, fear and prejudice (self-inflicted or from others) have also been correlated with the changes cited by the interviewees.[34]

Concerning the changes related to sex and sexuality, there was a clear distinction between men and women. For five of the men, the diagnosis represented a change in their sex lives, with a decrease in the number of partners and the frequency of sex, as well as the use of contraceptives during sexual relations, which led to certain adaptation difficulties. Two other men said that they had abandoned sexual activity altogether. For six of the seven women interviewed, the diagnosis of HIV meant the end of their sex lives, for several reasons: the impact of having a sexually transmitted infection; a lack of interest; difficulty in finding new partners after widowhood; and a loss of sexual pleasure, as seen in the following statement:

> *[On sexual pleasure] No. No I don't feel it... it's not possible. For either of us. You feel different when you discover that you have been contaminated, don't you? You feel the difference. (Regina)*

For those who declared that the diagnosis meant the end of sexual activity, the use of contraceptives was not considered to be an option that would enable the resumption of sexual activity.

Both the male and female participants spoke of the fear of contaminating another person or being rejected by a new partner if they revealed their diagnosis. The difficulties related to the changes in sexual activity and the adoption of contraceptives by HIV-positive individuals reinforce the importance of addressing sexuality with the elderly in health clinics in a clear, dialogue-based manner. This should enable them to understand these data, which are extremely important to an individual's quality of life, particularly those with HIV/aids. Explaining methods of safe sex, thereby providing a greater awareness of how the disease is transmitted, and an emotional approach focusing on the infected and their partners are essential factors in the maintenance of sexual activity in this new situation. [35]

Discrimination linked to HIV/aids diagnoses

Discrimination appears to be closely linked with a diagnosis of HIV/aids, based on the experiences reported by the participants during the interviews and the prejudice that is associated with this disease. Although the issue appeared as a separate category, for analysis and discussion purposes, it is possible to state that discrimination was present in all of the aspects analyzed in this investigation, permeating all of the other categories that were analyzed.

Eight of the interviewees admitted that they have faced prejudice since their diagnosis, whether it was self-inflicted, disease-related, or on behalf of family members, friends or close colleagues. The interviews contained reports of discrimination based on the fear of contagion, the supposed immorality of the STI and the life-threatening nature of the disease. Prejudice on behalf of family members caused great suffering to the participants of the present study. The following statements illustrate these issues:

> *They kept to themselves and I kept to myself [referring to her children]. There is one of them who wanted...... not wanted, wants me to separate my food, cups and plates. He told me to separate them and I said that I had already done that.....they were not kept together with the rest. (Maria do Bairro)*
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> *... One day I went to my sister's house and my brother-in-law said that when his friends were there, I couldn't stay in the living room with them because they might find out and stay away from his house.... (José)*

The other six interviewees stated that they had not suffered direct prejudice, although many of them recognized that it is commonly associated with the disease and attributed this discrimination to the ignorance of people in relation to the disease, how it is contracted and how it can be prevented. However throughout the interviews with these six people, they reported several incidents of discrimination on behalf of family members and others in their social circle, thereby demonstrating their difficulty in identifying these episodes.

In general, the interviews confirmed the suffering caused by a diagnosis with HIV/aids, particularly in terms of discrimination, whether inflicted by the patients themselves or by others. This suffering appears to be intimately linked to the doubts that arise after the diagnosis about socializing and whether they will be accepted or rejected by individuals in their social circle. It is also linked to feelings of inferiority that the patient applies to him/herself.

It is important to consider the repercussions of social stigmas and discrimination in relation to health-disease processes and the peculiarities of the aging process in individuals who have been diagnosed with HIV/aids. In general, there is great social pressure to fulfil social expectations and this pressure is internalized by all individuals. However, people deal with these stereotypes in different ways. Some adhere more strenuously to those that define the territories of normality, abnormality and the patterns of socially acceptable behavior.[10] Since they adhere more strongly to social stereotypes, some of the interviewees faced discrimination in relation to themselves and their seroconverted condition.

Discrimination linked to HIV/aids has been discussed in the scientific literature and has been linked with sociocultural concepts dating back to before the emergence of the disease, which are sustained by certain pillars of society, including stigmas related to sexuality and gender. In addition, the historical production and reproduction of these social stigma reflect the prejudice and discrimination associated with aids today. [36]

Certain aspects that are intrinsic to the disease help us to understand its stigmatizing potential: 1) the fact that it is a life-threatening disease, from a biological or social point of view; 2) the fear of people contracting HIV; 3) the link between the disease and stigmatized behavior (homosexuality, prostitution and the use of injectable drugs); 4) the accountability of the person who lives with HIV/aids for the disease; and 5) religious or moral beliefs that classify aids as a moral flaw that deserves to be punished.[37]

Considering the specificities of qualitative research, the number of subjects addressed does not take into consideration the statistical representativeness of the elderly population in the public health service assessed. Therefore, the results and discussions do not intend to generalize or define general trends of the situation of elderly individuals who live with HIV/aids. Its relevance is linked to the elucidation of the specificity of the situation being investigated, which enables the planning of research that can expand on the results and discussions in future studies, possibly providing comparisons between different situations in a qualitative approach. They can also serve as a basis for studies in which qualitative and quantitative perspectives are complementary. The limitations of the present study are linked to the difficulties of addressing issues related to intimacy, which cause embarrassment and are sometimes strongly associated with suffering.

FINAL CONSIDERATIONS

Based on the results of the present study, it is possible to conclude that the diagnosis of HIV/aids in elderly individuals generates major changes in the following aspects of their lives: the relationship they have with themselves (the event causes them to redefine their identity); the relationships they establish with people they are close to; their self-care; their sexual behavior and daily activities; and their participation in social groups. Most of the suffering reported by the interviewees was linked to the stigmas and stereotypes that have been created by society in relation to the disease and the efforts they have made to keep their diagnosis a secret. Concerning the prejudice linked to the disease, the main aspects of psychological suffering addressed by the participants were related to the following: fear of contact with people due to the possibility of rejection and discrimination; experiences of isolation; doubts about the possibility of performing activities of daily living; and feelings of inferiority.

Both the peculiarities linked to the life history of each individual as well as the specificities of living with HIV/aids in old age should be considered by the population at large and specifically by health professionals and healthcare services that seek to fulfill the needs of this segment of the population. Thus, the importance of considering the effects of prejudice linked to stigmatizing diseases is clear, whether in relation to family support and adherence to treatment or how health professionals deal with the situation.

Finally, it is important to stress once again that the analyses used herein did not seek to establish generalizations for the complexity of the situation analyzed or exhaust discussions on the set of elements that comprise the sexuality of the elderly in the context of the increasing number of HIV infections in this population. The results should be considered within the specific situation and as an invitation to conduct further research in order to extend our knowledge of the psychosocial effects of a diagnosis with a stigmatizing disease. The aim was to alert others to the complexity of these issues and to highlight the relevance of studies that address social stereotypes, stigmas and prejudice and their effects on health promotion and professional activity in the health sector.

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