

## EDUCATIONAL PRACTICES FOR HIV/AIDS PREVENTION AMONG USERS OF THE BASIC HEALTHCARE SYSTEM IN RIO DE JANEIRO/BRAZIL

AS PRÁTICAS EDUCATIVAS NA PREVENÇÃO DO HIV/AIDS DAS USUÁRIAS DA REDE BÁSICA DE SAÚDE DO RIO DE JANEIRO/BRASIL

PRÁCTICAS EDUCATIVAS EN LA PREVENCIÓN DEL VIH/SIDA DE USUARIAS DE LA RED BÁSICA DE SALUD DE RIO DE JANEIRO/BRASIL

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### ABSTRACT

The present study aims at identifying educational practices for the prevention of HIV/AIDS in women's health units as well as describing and analysing the social representations of the educational practices in basic healthcare services. It is a qualitative research based on social representations and health education theories. A total of 46 women from eight healthcare units of a municipality in Rio de Janeiro participated in the study. Data were collected by semi-structured interviews and analysed by the ALCESTE software. Results revealed that little information came from individual consultations; that the educational practices were developed in the family planning program basically by social workers that "talk" about AIDS; that the educational practices are represented by "to give" and "to pass" information. In conclusion, the theoretical framework highlighted the significance of the analysis of issues related to educational practices specific for HIV/AIDS.

**Keywords:** Educative Practices; Acquired Immunodeficiency Syndrome; Primary Health Care; Woman's Health.

### RESUMO

O estudo tem como objetivos: identificar a dinâmica das práticas educativas para a prevenção do HIV/Aids nos serviços de atendimento à mulher; descrever e analisar as representações sociais das práticas educativas constituídas pelas mulheres assistidas nos serviços da rede básica de saúde. É uma pesquisa qualitativa, pautada nos referenciais da teoria das representações sociais e da educação em saúde. Participaram 46 mulheres de oito centros municipais de saúde de um município do Rio de Janeiro. Os dados foram coletados por entrevista semiestruturada e tratados pelo programa ALCESTE. Os resultados revelaram: poucas informações nas consultas individuais; que nas reuniões do planejamento familiar são desenvolvidas práticas educativas, principalmente pelas assistentes sociais, que "falam" sobre a AIDS; que as práticas educativas são representadas como "dar" e "passar" informações. Concluiu-se que o referencial teórico mostrou especial pertinência à análise das questões relacionadas às práticas educativas inerentes ao HIV/AIDS.

**Palavras-chave:** Práticas Educativas; Síndrome de Imunodeficiência Adquirida; Atenção Primária à Saúde; Saúde da Mulher.

### RESUMEN

El presente estudio tiene como objetivo identificar la dinámica de las prácticas educativas para la prevención del VIH/Sida en los servicios de atención de la mujer. Busca, también, describir y analizar las representaciones sociales de las mujeres atendidas en los servicios de la red básica de salud. Se trata de una investigación cualitativa, pautada en los referentes de la Teoría de las Representaciones Sociales y de la Educación en Salud. Participaron 46 mujeres de ocho Centros Municipales de Salud (CMS) de un municipio de Rio de Janeiro. Los datos fueron recogidos en entrevistas semi-estructuradas y tratados por el programa ALCESTE. Los resultados revelaron que en las consultas individuales hay poca información, que en las reuniones de planificación familiar se llevan a cabo prácticas educativas, principalmente a través de las trabajadoras sociales que "hablan" del Sida y que las prácticas educativas son representadas como "dar" y "transmitir" información. Se concluye que el referente teórico y metodológico mostró especial pertinencia para analizar asuntos sobre las prácticas educativas inherentes al VIH/Sida.

**Palabras clave:** Práticas Educativas; Síndrome de Inmunodeficiencia Adquirida; Atención Primaria de la Salud; Salud de la Mujer.

## INTRODUCTION

The National STD/AIDS Program highlights prevention as the basic strategy to control sexually transmitted diseases (STDs) and the human immunodeficiency virus (HIV). It emphasizes that prevention activities should promote health education through constant supply of information to the population as well as other educational strategies dealing with risk perception, changes in sexual behaviour and proper use of condoms. The Program states that educational interventions should focus on self-esteem and awareness of HIV and other STIs risk factors. It also considers the population's cultural and regional characteristics and the specific situations of their daily life.

According to the Brazilian Department of Health,<sup>1</sup> low-income women are the main users of public healthcare services. Therefore, basic care units are the appropriate spaces to address HIV infection and AIDS and to develop educational and preventive actions.

Women of low socioeconomic status are the most vulnerable to HIV infection and are the ones who most depend on the Unified Health System (SUS) basic healthcare. Health programs targeting this population are, in theory, guided by comprehensive care principles which include educational activities so women can acquire knowledge and have a better control over their own health. Counselling e.g. could incorporate educational actions in the context of STDs and AIDS and is an essential tool for the prevention of these diseases.<sup>2</sup>

In this context the following questions were posed: "Which HIV/AIDS educational practices are identified by the female users of the basic healthcare system?" and "In which spaces of the basic healthcare system are the educational activities recognised by the female users?"

Based on the above questions, the objectives of the study were defined: to identify the dynamics of educational practices for the prevention of HIV/AIDS in women's health units; to describe and analyse the social representations of educational practices created by the female users of basic healthcare services.

After assessing the context of health education in Brazil since its origins, educational practices were characterized by two approaches: traditional and critical.

The traditional approach regards education as the transmission of information and codes of conduct seeking to change values, beliefs, habits and unhealthy behaviours. According to this approach, health is defined as the absence of disease and the individuals are responsible for their health problems.<sup>3,4</sup>

The critical approach is based on the principle that the health/disease process is closely related to socioeconomic and political determinants, i.e. it is invested with historicity. This method considers educational practice as the process of providing the proper instruments so individuals and social groups can identify and analyse health problems and propose solutions.<sup>3,4</sup>

In the context of HIV/AIDS, health education experts claim that this model intends "to preserve the autonomy of individuals and prompt the professional to understand and deal with the users' cultural background and to share their knowledge."<sup>5</sup>

From such perspective, the present study will delineate the educational practices with support of the social representations theory, a major perspective within social psychology.

According to Serge Moscovici, "we understand social representations as a set of concepts, propositions and explanations originating in daily life in the course of interpersonal communications".<sup>6</sup> Succinctly, but without compromising the essence of other concepts developed by researchers of Moscovici's ideas, social representation is also defined as "a form of socially elaborated and shared knowledge, that presents a practical guidance for building a common reality to a social group".<sup>7</sup> There is, therefore, a close relationship between social representations and the life of individuals. The historical, social and ideological aspects, the individual characteristics and the elements that influence a group's behaviour and thinking are directly related to the creation, circulation and stability of social representations.<sup>8</sup>

Although this research did not aim at evaluating programs and health services, its results may provide subsidies to this goal. On the other hand, the study could also be relevant on its theoretical aspect, given that the intersection between the social representations theory and the investigation of health programs or interventions is little explored in various areas, particularly in nursing.

## METODOLOGY

This is a qualitative study conducted with 46 women being cared for by clinical-gynaecological, family planning and antenatal-postpartum services at eight local healthcare centres of a municipality in the state of Rio de Janeiro.

Inclusion criteria were age and frequency of consultations. Women aged 20 years or over were included; that is young women but not adolescents, according to parameters of the Adolescent Health Programme. Regarding the second criterion, participants should have been assisted in one of the mentioned health services at least twice.

The participants were gathered while in the waiting room. Once identified, the prospective participants were explained about the research and questioned about their interest in being interviewed. After acceptance, place and time were agreed upon to data collection.

The Ethics in Research Committee of the Pedro Ernesto University Hospital of the State University of Rio de Janeiro approved the study under Protocol No CAAE: 0047.0.228.000-05. Furthermore, the research subjects signed the free and informed consent, according to CONEP Resolution N° 196/96.

Data were collected through semi-structured interviews from July to August 2006. They consisted of ten closed-ended questions with personal and social variables and seven guiding questions whose contents were extended according to the participants' narratives.

Data analysis used the ALCESTE software (lexical analysis of the context of a set of text segments), which carried out the lexical analysis from quantitative techniques in five steps, culminating in the creation of six classes or themes, whose discursive productions were analysed according to the theoretical framework.

## RESULTS

The characteristics of the study participants could be summarized as follows: 56.5% were aged 20-29 years; 52.2% did not perform remunerative activities; 50% were Catholic; the majority lived with a partner; 91.4% reported having one sexual partner; most women lived in the north and centre of the city and had been attending the health centre for the last five years.

Regarding the parameters of the ALCESTE analysis, the *corpus* consisted of 2,166 elementary context units (ECU), i.e. fragments of speeches. Through its operational stages, ALCESTE made the descending hierarchical classification, dividing the ECUs into six classes, namely: classes 6 and 3; classes 5 and 2; classes 4 and 1. The Hierarchical Ascendant Classification (HAC), which displays the words present in the classes and their degree of association to the class, was then performed. All of these procedures resulted in the visualization of the ECUs that constitute each class allowing the researchers to define the characteristics and meaning of the contents implied therein; it enabled naming each class, according to their correlation, as follows:

- class 6: educational actions: sources and strategies;
- class 3: HIV testing and counselling;
- class 5: information on HIV/AIDS transmission and prevention;
- class 2: representations of AIDS;
- class 4: condoms: ideas and use;
- class 1: daily social conversations about AIDS.

Contents relevant to the study object were found in all classes; 6, 3 and 5 are most significant and will be described in more detail.

Class 6 grouped 17 subthemes whose contents dealt with: care delivered in the centres; professionals participating in the activities; different sources of information about HIV/AIDS; strategies that are used or could be used in the development of educational activities. These sub-themes are briefly illustrated by the interviewees in the following ECUs:

*In this health unit, no[...] in the V. G. health unit they did a lecture, I attended it. They talked about AIDS, they taught how to prevent it, how to avoid pregnancies (Class: 6 x<sup>2</sup>: 17).*

*There are social workers in the health units; here too, they talk to us, they explained it when I went to apply for family planning. The social worker talked about how to use condoms, that it is important to use it because of AIDS, how to prevent it (Class: 6 x<sup>2</sup>: 2).*

*No, during visits no one talked about AIDS. During visits you have the IUD checked, if it is in the right position, (they ask) if there is anything wrong and that's it (Class: 6 x<sup>2</sup>: 3).*

*I think there should be more meetings on the subject; it would help people, mainly people that live in the shanty towns or in poor places, to be aware of what they do (Class: 6 x<sup>2</sup>: 9).*

*I think the gynaecologist has direct access to the patient. The general practitioner doesn't know the patient deeply. The gynaecologist knows about STDs and can better inform women (Class: 6 x<sup>2</sup>: 4).*

In class 3, eight subthemes are identified. Their contents regard pregnancy, antenatal care, examinations (including HIV testing), as well as procedures and conducts related to the examinations and their results. The following ECUs are examples of this class contents:

*It is frightening. When she says that the HIV result has arrived, it is nerve racking, till she tells you it is negative (Class: 3 x<sup>2</sup>: 14).*

*(The doctor) only asked me to do it and didn't say anything else; (He) only asked me to bring the results as soon as they were ready. I was told about AIDS in the O.C. Institute in a project in Laranjeiras, in the television, in the health unit (Class: 3 x<sup>2</sup>: 9).*

*During pregnancy it is in the antenatal, now it is mandatory to have the HIV test when you are pregnant, even because if the baby has the virus it is possible to get treatment, so, it is normal to do a pregnancy test, and an HIV test during pregnancy (Class: 3 x<sup>2</sup>: 36).*

The contents of class 5 are identified in 17 subthemes and refer to HIV modes of transmission and prevention recognized by the study subjects as well as the feeling of exposure to the virus, especially in healthcare services, as can be seen in the following narratives.

*Yes, you don't know, because there is no sign in the forehead of those infected. In the dentist, if the needle for the anaesthesia is not clean, you can get the HIV. I think so, I don't know. I don't know if the person is going to be honest and throw the thing away (Class: 5 x<sup>2</sup>: 25).*

*Through sexual relations and blood as well. These are the two ways I know. Through blood, if a person is bleeding and touch another's wound, I think it is transmitted (Class: 5 x<sup>2</sup>: 45).*

The contents of Class 2 relate to the meanings, concepts and images of the respondents' representations about AIDS. It also reveals aspects related to HIV prevention focussing on information and education. Class 4 has seven sub-themes; its contents refer to the use of condoms (either male or female), to their irregular use and to AIDS prevention. The contents of Class 1 refer to the interviewee's family and friends and how HIV/AIDS issues are addressed. It emphasizes the difficulty of talking about issues related to sex and sexuality.

The results revealed also that 52.1% of the respondents said that, despite attending the local health centres, they had had no access to information or advice. Most centres are located in the northern (33.3) and southern (29.2%) areas of the city. Of the 36.4% who reported having received information or advice in these scenarios, 31.8% were visited in the centre of the municipality. It is important to notice that participants mentioned both access and lack of access to information/advice in the same study setting, even in the same type of service.

## DATA ANALYSIS

### THE DYNAMICS OF EDUCATIONAL PRACTICES ADDRESSED TO WOMEN IN BASIC HEALTHCARE UNITS

The discursive productions of the respondents indicate that there is no consistency in the delivery of information and advice within the same service and between areas or healthcare programs addressed to women. Such fact, added to the insufficient supply of information related to HIV/AIDS, as observed by most participants, could explain why health services and health professionals do not appear as the main sources of information.

Most interviewees affirmed that individual consultations (mainly gynaecological and, to a lesser extent, antenatal) were not used for educational purposes, in relation to HIV/AIDS or other sexually transmitted diseases. There are few references to an educational conduct on the part of health professionals during individual consultations. In such cases, the narratives reveal a super-

ficial, one-off and sometimes normative approach that does not provide the opportunity for questionings or considerations about recognizing risk situations and adopting preventive measures.

Several aspects contribute to this context; some of them regard the services organization, like great demand of patients and short visits, mentioned by most interviewees. Basic care structural problems – such as insufficient human and financial resources<sup>4</sup> – are obstacles to healthcare implementation as recommended by the Women's Comprehensive Healthcare Program (PAISM), which includes health promotion and protection as well as health education.

On the other hand, the study suggests that the implementation (or not) of such activities are related to the attitude of each health professional. The reports are not short of examples of healthcare professionals, especially physicians, which prioritize clinical interventions and routine technical procedures rather than educational interventions. Such practice is still common in individual consultations, and it does not contribute to quality or humanization of care.<sup>9</sup> A previous study of health professionals working in basic health care in a municipality of the state of Minas Gerais<sup>10</sup> demonstrated such conduct. The study recognized the difficulties to change people's behaviour through educational practices, but it did not emphasize strategies to overcome such difficulty. Therefore, the health professionals' lack of qualification to promote educational activities should be taken into consideration.<sup>11</sup>

Although being able of identifying situations not conducive to educational practices in individual visits, the study participants pointed out, unanimously, that medical consultations are suitable for HIV/AIDS educational activities. Privacy and individualized attention provide the perfect occasion to address issues that, in collective educational events (meetings and lectures), could cause inhibition or embarrassment.

The study shows that interactive and dialogic educational events between professionals and the female clientele are restricted to antenatal and family planning programs. This context highlights the current gap between the actual practice and the recommendations of the Women's Health Policy and the STD/AIDS Program, suggesting that educational aspects are not incorporated into the general context of women's healthcare. This restricts or even prevents the access of such population to the necessary interventions. It prevents, among others, the deconstruction and modification of aspects of their representations, keeping these women in a state of permanent vulnerability against AIDS.

It is important to note that the study subjects themselves, to the best of their abilities, analysed the processes of healthcare services and proposed strategies that matched those suggested by the National STD/AIDS Program guidelines. This means that, given the opportunity, service users may contribute to the development of the educational practices that best suit their needs.

Antenatal care and family planning were the types of care that most often addressed issues related to HIV/AIDS. However, in the antenatal program, such subject was not brought up as frequently or as systematically as in the family planning program.

Since the second half of the nineties the Brazilian Department of Health, through the National STD/AIDS Program, has been offering HIV testing as well as pre- and post-test counselling to all antenatal care customers.<sup>1</sup> Counselling is a process of active listening, individualized and client-centred, that tries to establish a trusting relationship between the interlocutors. It is grounded on interpersonal professional-client relationship and aims at prompting the individual to reflect on his own risk, to make informed choices and to adopt safer practices.<sup>1,2,12,13</sup> The study demonstrated that while in antenatal care HIV testing is offered systematically counselling is not frequent. The participants reported that counselling was not exhaustive or individual.

To undergo an HIV test, especially the first one, is a challenge to many women. The situation goes beyond the detection of the virus. A probable positive result implies in bringing to light social representations constructed and collectively shared, especially those that reflect negative aspects.

As for the collective counselling developed in antenatal care, the study observed that these practices did not always favour actions directed to pregnant women. In a study on collective counselling at a basic care unit, the authors also found the absence of such practice<sup>14</sup>. It was also observed that when the participants talked about these activities, they made it clear that they differed, both in purpose and content, from those held in other care facilities. In the study settings, meetings of pregnant women, according to the narratives, inform about antenatal care routine, like the number of visits, tests, and other procedures. A similar result was obtained in a study on the users' perception about counselling.<sup>2</sup> The authors stated that "in these services, the guidelines are usually prescriptive, and disregard personal knowledge and local culture."<sup>2</sup>

When talking about the exams, health professionals mention the HIV testing (at the discretion of users), and eventually emphasize its importance for the prevention of vertical transmission of HIV. Instances in which issues related to HIV and its implications for women and children are addressed in detail – as in other services or types of care, like family planning – are unusual.

Family planning meetings conducted chiefly by social workers are the educational practices most frequently cited. As expressed by the respondents, the professionals "speak about", "explain" or "teach" various issues related to HIV/AIDS, particularly sexual transmission and preventive measures. The strategy favours information dissemination (traditional education approach), rather than a participatory and dialogic approach that could facilitate the exchange of information and experiences as well as the expression of beliefs, values and representations.

Such practice could encourage users to think about risk situations and make decisions about preventive practices.

The effectiveness of a traditional approach is undermined when the objectives are to stimulate reflection, awareness of risk situations and behaviour changes.<sup>3,5,14</sup> Investigators on the subject<sup>5,9,15-17</sup> revealed that knowledge internalization, even at a satisfactory level, does not necessarily produce the expected results, i.e. behavioural changes and consequent adoption of preventive measures against infection.

These aspects, among others, justify educational practices based on dialogical methods or strategies that enable women to learn and capture both the most elementary knowledge as well as the most complex one, favouring and promoting the questioning of such knowledge at the same time. Therefore health teams play an important role given the relevance of dialogue, of the cultural universe and of supporting the users' critical stance and reflection about social reality.<sup>5</sup>

Sporadic or decontextualized talks about reducing the number of sexual partners as a form of prevention, as mentioned in some interviews, confirm to women that they strictly follow the recommendations. Since they are in a monogamous and stable relationship, as observed in the characterization of the study subjects, this contributes to the maintenance of their vulnerable state.

As a result of lack of help or guidance, some women create their own strategies along with their partners, such as providing condoms in case they should have an extramarital relationship. The narratives reveal that these women, at some point, became aware of the risk of HIV infection and the action adopted was the result of a lonely, unshared and uncomfortable process. The study also demonstrates their difficulty in discussing or negotiating affective and sexual conditions with their partners. In a study on female sexuality and its relation to the prevention of HIV/AIDS,<sup>18</sup> researchers established that, given the lack of emotional conditions and/or support (including institutional one), excuses or concealment are necessary resources to address these issues with the partners. Such context confirms the importance of spaces where women can describe their experiences and reflect on the conflicts and difficulties in dealing with their partners on issues that keep them vulnerable.

## USER'S SOCIAL REPRESENTATIONS OF EDUCATIONAL PRACTICES

Several situations present in the study indicate that banking education and its concept of education constitute a model commonly employed in educational activities in the study scenarios. The narratives reveal situations that prove the content transmitted was absorbed. However, the lack of discussion, exchange of experiences and interaction during the educational activity means that the group cannot use knowledge in a real life situa-

tion and, therefore, maintain the beliefs, ideas, images and concepts of their social representations. Healthcare procedures are a typical example. Most participants know that items such as syringes and needles should be disposable and that blood and blood products should be analysed before being transfused. However, participants consider themselves susceptible to HIV infection when undergoing such practices once they are uncertain about how to act. Thus, they are always circumstantial victims of professionals or health services, to which they attribute irresponsible attitudes that promote people's exposure to the virus.

At the end of the fifties, new ideas about health education practices were introduced in the country, bringing different conceptions and gaining prominence within the area of women's health care.

The PAISM contributed to a different proposal on women's health care, focussing on full assistance and educational practices. The concept of participatory education was adopted in individual and collective programs, aiming at ensuring a space for women to express their doubts, fears and concerns as well as to exchange information and experiences. Health professionals were offered training courses and guidance manuals on the subject.<sup>19</sup>

Despite all the investment in education methodologies that have been incorporated into health programs and in professional training for the development of such activity, the present study detected an important gap between care practices and the guidelines of women's health programs, particularly on issues related to HIV/AIDS.

This data is also cited by authors who have studied health education practices targeting the prevention of HIV infection<sup>4,5,20</sup>. Paradoxically, the study assesses that care services and health professionals that should promote the reduction of women's vulnerability to the disease end up contributing to its perpetuation.

The ways in which issues related to HIV/AIDS are approached in health services, associated with strategies for information dissemination and educational guidance focused on prevention, have also contributed to women's opinion on educational practices. In other words, the result shows that experiences with such educational practices determine their social representation in the group.

The relationship between representations and practices are still object of discussion in the field of social representations. Some researchers argue that these relationships are not one-dimensional, i.e. they are inextricably linked and interdependent. However, practices determine the representations in situations in which individuals engage themselves in practices that result from physical or material environment or from dependency on a certain relationship or social power.<sup>21</sup> The social representations of the studied educational actions are thought to be constructed on this principle.

Educational strategies in our country's formal education were, for a long time, based on pedagogical theories known

as non-critical theories<sup>5,23</sup> that favour knowledge transmission and behaviour changes. Such theoretical frameworks were incorporated into health education and reproduced in educational practices. This study designates them as "traditional approach model", which has been the only reference for a long time and, even after the introduction of critical and reflective approaches, still shapes educational interventions.

Although official agencies establish or recommend the use of other pedagogical approaches in formal or health education, professionals who develop such practices have a leading role. They employ their own ideologies and representations and assert their authority by imposing their *modus operandi*.

Control actions and, especially, preventive and educational practices are instituted and offered to customers and, in most cases, do not arise from these customers' needs or expectations. It is therefore understandable why the group studied represented the educational processes as "giving", "to pass" and "to transmit" information or guidance, or even as "to talk about AIDS," and mostly "how you get infected and how to prevent it", since they are passive subjects and mere recipients of information. According to the group, information, disseminated primarily via mass media or in health services, is considered "little", "insufficient" and even "poor". It must be made available so people "can prevent themselves" – they consider that acquiring knowledge/information will necessarily mean a behaviour change.

The way education measures are represented (give/receive information) are unanimously characterized by the group as necessary, important, and also as the main instrument for HIV/AIDS control and prevention. They should, therefore, be carried out in several places, especially on television and in health-care services. Despite considering educational interventions necessary and important for all individuals, including themselves, the interviewees affirmed that activities should be directed to men, women, and especially young people who are not informed and do not prevent themselves against infection. As constructed by the group, there is an aspect of the social representation of AIDS that has an influence on the educational practices, i.e. if AIDS is something that "belongs to the other", it is on him that these practices should ostensibly focus.

It is interesting to argue that this social representation establishes the following relationship: practice-representation-practice. It means that the social representation of the educational practices – and how they are created and experienced by the group – reflects the group's opinions on how they should be carried out, in terms of strategies. The narratives reveal that the suggested strategies (educational posters and brochures, meetings and, primarily, lectures) are the most used. The same does not occur with education agents or health professionals participating in educational activities, in the study scenarios. Regarding this aspect and according to the narratives, so-

cial workers are the most engaged professionals in such educational activities. On the other hand, in the group's imaginary, doctors, especially gynaecologists, are the most suitable ones to undertake the task since they "know a woman's body" and "know about STDs". However, it must be considered that this is also a social representation of the medical professional, full of symbolism and meanings, that attributes to this professional the command over scientific health knowledge.

## FINAL CONSIDERATIONS

Although educational activities do not constitute a new research object, the originality of this study lies in analysing such actions in terms of social representations by means of reports obtained exclusively from healthcare service users.

The theoretical framework was particularly relevant to the study and analysis of issues related to HIV/AIDS and educational practices since it incorporates psychosocial phenomena that reflect knowledge construction of common sense guiding actions and communication in daily life. It also highlights its relevance to educational and political actions aimed at creating social transformation.

In this respect, the study results demonstrate that planning and operationalization of AIDS educational interventions cannot ignore the representations of healthcare service users, since such representations involve knowledge that entails concepts, propositions, values, beliefs, stereotypes and other elements shared by the social group. In the context of a health-disease process such as HIV/AIDS, knowledge is independent from the logic of science, even though aspects of scientific studies may be considered. It is, therefore, a kind of knowledge that has its particularities and cannot, or should not, be overlooked or undervalued.

It should be highlighted that using the theoretical perspective on the operationalization of HIV/AIDS education activities means to identify not only social representations of the disease but also representations of other objects or phenomena, as well as the process of its creation and transformation, which interfere in the previously mentioned aspects.

Finally, the theoretical framework that allows researchers to use social representations in health education may lead to the overcoming of scientific perspectives. It could also be an important step towards understanding the complexity of issues related to health, especially AIDS.

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