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RECOGNITION OF THE PEOPLE LIVING WITH HIV/AIDS' VULNERABILITIES: NARRATIVE REVIEW OF THE LITERATURE[1]

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ABSTRACT

This study aims to describe the situations of vulnerability that people living with HIV/AIDS are exposed, through a narrative review of the literature. This study considered publications between the years 2010 and 2016. The bibliographic survey was carried out using controlled descriptors and keywords in the databases LILACS (Latin American and Caribbean Literature in Health Sciences), PubMed (National Library of Medicine) and Embase (Excerpta Medica Database). 89 studies were retrieved, which underwent three stages of selection, of which nine articles were included; (access to education, employment and salary) and programmatic (access and quality of health services). It is concluded that it is fundamental to recognize the different vulnerabilities with their dynamics and interfaces in the different social, political, economic and sanitary contexts with a view to coping with the HIV epidemic and the production of responses considering the singularities and specificities of individuals and/or social groups.

Keywords: HIV. Acquired immunodeficiency syndrome. Health Vulnerability. Health profile.

INTRODUCTION

According to the World Health Organization (WHO), Human Immunodeficiency Virus (HIV) infection is a major public health problem, even after about 40 years of the first news in the US, Haiti and Central Africa on the symptomatic phase of infection known as AIDS[1-2]. It is estimated that 1.8 million new HIV infections occurper year, with 36.9 million people living with HIV, 21.7 million in treatment and 940,000 infection-related deaths worldwide in the world[3].

During the epidemic, several terms were used to describe the profile of those people living with the virus. The adoption of the term "5 H Disease" - Homosexuals, Hemophiliacs, Haitians, Heroin addicts (injecting heroin users) and Hookers (sex workers)[4]. However, these terms were considered prejudiced, and the terms "risk groups" and "risk behaviors" were also adopted. Overcoming these descriptions, the most accepted term is "vulnerability", which is composed of three axes: individual, social and programmatic[5].

Individual vulnerability assumes that all individuals are susceptible to infection and concerns the individual's repertoire of information, and the way of life may be an aspect that protects or exposes the person to the virus. Social vulnerability addresses the contextual aspects in which individuals are inserted, such as the availability of material, cultural, political and moral resources; religious beliefs; schooling; access to the media; among others. Finally, program vulnerability refers to the commitments and actions that social institutions, such as health, education, well-being, culture, among others, to provide individuals with elements that transform their relationships, values and interests to overcoming these situations of vulnerability[5].

Considering the epidemiological situation of HIV/AIDS as a public health problem and that the infection is immersed in a context of vulnerabilities, the present work aims to describe to which situations of vulnerability the people living with HIV/AIDS are submitted. In this way, it seeks to advance knowledge with a synthesis of such vulnerabilities and to foster reflections about HIV infection in order to subsidize the planning of prevention, promotion and follow-up actions and enabling more effective responses to the problem.

[1]Extracted from the course conclusion work "HIV/AIDS: profile and vulnerabilities of infected cases from 2010 to 2016", presented to the Undergraduate Program - Nursing Bachelor degree of the Ribeirão Preto College of Nursing - USP, in 2017.

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METHODS

It is a narrative review that seeks to describe the state-of-the-art on a given subject in a short time. However, this method does not usually present a scientific rigor that allows reproducibility, being considered too empirical. In this sense, due to ethical and methodological issues, it was decided to use a methodological context of the integrative review[6], using some of its steps in order to give greater credibility to this type of review.

Thus, the review was guided by the question: according to scientific evidence found in the literature,what situations of vulnerability the people who live with HIV/AIDS are exposed?

The databases used were LILACS (Latin American and Caribbean Literature in Health Sciences), PubMed (National Library of Medicine) and Embase (Excerpta Medica Database) with the following inclusion criteria: studies in article format, whose population people living with HIV/AIDS over the age of 18 and articles published in Portuguese, English or Spanish from 2010 to 2016. The period was defined as the 10-year anniversary of the launch of the Millennium Development Goals (MDGs) by the United Nations, which had until 2015 to halt and begin to reverse the spread of the virus. For this to be achieved, countries would need to provide adequate responses to prevention and care for people in situations of vulnerability. The year following the end of the MDG deadline was defined as the last year of coverage of the articles to be included in this review. We excluded articles that are not available online in full.

To make possible a greater specificity in the search for the studies, it was necessary to use specific descriptors in each database (Chart 1). Words that were not found in the controlled vocabulary of the bases were used as a keyword (Chart 1). It is important to note that, to refine the search, these descriptors and keywords were combined using the Boolean operators AND and OR.

Chart 1–Descriptors and keywords used according to the study databases, 2017

Databases	Descriptors	Keywords
LILACS	Searched onDeCS 1- HIV, VHI 2- Vulnerabilidade em saúde, Health vunerability e Vulnerabilidade em salud 3- Síndrome da imunodeficiência adquirida, Acquiredimmunodeficiencysyndrome e Síndrome de inmunodeficiencia adquirida 4- Infecções por HIV, HIV infections e Infecciones por HIV 5- Perfil de Saúde, Health Profile e Perfil de Salud 6- Características da População, PopulationCharacteristics e Características de laPoblación.	
PubMed	Searched on*Medical SubjectHeadings* (MeSH) 1- HIV infection, 2-HIV infections, 3- Acquired immunodeficiency syndrome, 4- Population Characteristics, 5- Vulnerable Populations.	6- Health profile, 7- Health vulnerability.
Embase	Searched onEmtree 1- Human immunodeficiency virus, 2- Human immunodeficiency virus infection, 3- HIV infections transmission, 4- vulnerable population, 5- Acquired immune deficiency syndrome, 6- Population and population related phenomena.	7- Health vulnerability.

A total of 89 scientific productions were recovered, which underwent a selection process by two independent researchers. Initially, titles and summaries of the materials were read, selecting those with potential to answer the research question, as well as meeting the inclusion and exclusion criteria of this study. Then, the researchers agreed on the articles selected and, in case of disagreement, a third researcher was consulted for the tiebreaker. At the end, nine articles were included in the review (Figure 1).

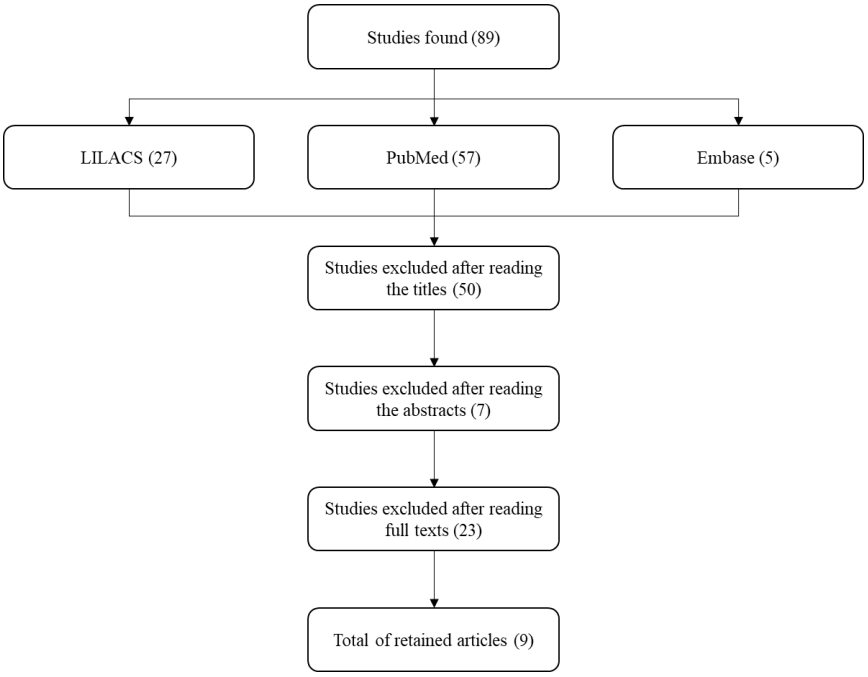

Figure 1. Flowchart: Selection steps for articles

After the selection, the data extraction was started, guided by a cataloguing prepared by the authors, who considered the following variables: title, year of publication, study site, objective, methods, results, conclusions and recommendations. This stage allowed the delineation of the theoretical axis that subsidized the organization, description and analysis of the scientific production included in the review and which was constituted in the elements of the dimensions of vulnerability, which can be individual, social and programmatic (Chart 2).

Chart 2. Vulnerability dimension elements for article categorization and analysis

Individual	Social	Programmatic (emphasis on the health sector)
Knowledge	Social norms	
Attitudes	Gender relations	Organization of the health sector
Behavior	Race/Ethnicity	Access to services
Family relationships	Religious norms and beliefs	Quality of services
Affective-sexual relations	Stigma and discrimination	Technical-scientific preparation of professionals and teams
Material situation	Job	Commitment and responsibility of professionals
Physical situation	Salary	Respect, protection and promotion of human rights
Networks and social supports	Access to education	

Source: adapted from AYRES et. al., 2006[5].

Based on the table above, it was possible to categorize the articles included in the review, grouping and counting the surveys according to the dimensions of the vulnerability, and the same article could be contained in more than one element that composes the theoretical axis.

RESULTS AND DISCUSSION

About the nine articles included in this study (Table 3), three (33.3%) were published in 2014[7-9], two (22.2%) in 2013[10-11] and two (22.2% %) in 2012[12-13]. Regarding the publications, four (44.4%) were linked to magazines with national circulation[8-9,13-14] and five (55,6%), of international circulation[7,10-12,15]. In regard to the selected studies, five (55.6%) were performed in Brazil[7-9,13,15], four (44.4%) of them in the state of São Paulo[7-9,13]. A study was conducted in Mozambique[14], one in England[10], one in Canada[11] and one in Chile[12].

Chart 3. Description of the primary studies included in the review, second title, author, year of publication, journal and database. Ribeirão Preto, SP, Brazil, 2017.

Title	Authors	Years	Journal		Database
			Name	Impact factor	
Vulnerabilidade de mulheres vivendo com HIV/Aids[9]	Duarte MTC, Parada CMGL, Souza LR	2014	Revista Latino Americana de Enfermagem	0,3388	LILACS
Estigma e discriminação: experiências de mulheres HIV positivo nos bairros populares de Maputo, Moçambique[14]	Andrade RG,IriartJAB	2015	Caderno de Saúde Pública	0,4901	LILACS
Gender Differences in Risk Factors for Delayed Diagnosis of HIV/AIDS in a Midsized City of Brazil[15]	Ferreira RFG,Neto SCP,Santana NC,Guimarães DA,OliveiraCDL	2016	Journal of the InternationalAssociation of Providers of AIDS Care	0,9800	PubMed
Meeting complex needs: young people with HIV in London[10]	Hughes A,Hope RL,Nwokolo N,Ward B, Jones R,Von Schweitzer M,BoagF	2013	HIV Medicine	3,2570	PubMed
Causes of Death among People Living with AIDS in the Pre- and Post-HAART Eras in the City of São Paulo, Brazil[7]	Domingues CSB,WaldmanEA	2014	PLOS ONE	3,5400	PubMed
Socio-demographic Profile of Older Adults with HIV/AIDS: Gender and Sexual OrientationDifferences[11]	Brennan DJ,Emlet CA,Brennenstuhl S,Rueda S,OhtnCohort Study Research Team	2013	Canadian Journal on Aging	0,7340	PubMed
Una década de terapia anti-retroviral: Perfil de pacientes con 10 años de triterapia de alta efectividad[12]	Wilson G,Wolff M.	2012	Revista chilena de infectología	0,4900	PubMed
O perfil da mulher portadora de HIV/AIDS e sua adesão à terapêutica antirretroviral[13]	Felix G,CeolimMF	2012	Revista Escola de Enfermagem USP	0,5730	PubMed
O diagnóstico tardio e as vulnerabilidades dos idosos vivendo com HIV/AIDS[8]	Alencar RA,CiosakSI	2014	Revista da Escola de Enfermagem da USP	0,5730	LILACS

In the perspective of individual vulnerability to HIV/AIDS, in regard to exposure to the virus and the illness, there was an approach with greater expression of the following elements: physical situation; knowledge, behaviors and attitudes; and affective-sexual relations. In relation to the social dimension of vulnerability, the following elements were identified: access to education, employment and wages. As for the programmatic vulnerability, there was a greater expression of the elements: access and quality of health services, with the identification of strengths and weaknesses (Chart 4).

Chart 4. Distribution of articles according to elements of each dimension of the vulnerability, 2017

Individual	Social	Programmatic
Values[9]	Social standards[10]	Multi-sectoral articulation of actions[7]
Beliefs[9,13]	Cultural references[10]	Inter-sectoral activities[9]
Knowledge[8-11,13]	Gender relations[9,14-15]	Organization of the health sector[8,10]
Attitudes/behavior[8-11,13,15]	Race/ethnicity[10]	Access to services[7-10,12-13]
Family relations[8,13-14]	Religious norms and beliefs[13]	Quality of services[8,10,13-14]
Affective-sexual relations[9,10-13,15]	Stigma and discrimination[11,14]	Integrality of attention[8]
Professional relations[9]	Employment[8-11,13-14]	Techno-scientific preparation of professionals and teams[8]
Material situation[7-8,13]	Wages[13,15]	
Psycho-emotional situation[11,13]	Social support[11]	Commitment and responsibility of professionals[8]
Physical situation[7,10-15]	Access to education[8-9,11,13-15]	
Networks and social supports[8-9,13]	Access to justice[14]	Respect, protection and promotion of human rights[8]

Individual Vulnerability

In the category "physical situation", six articles shows a higher occurrence of HIV/AIDS among males[7-8,10-12,15]. Being a man had an association with the delay in diagnosis[11] and being a woman pointed to increased deaths[7].

The most affected age group and skin color by the disease were not clear, as one study emphasized the young populations[7], and the others, the older populations[8,11]. There were studies conducted in places with the majority of the black population[14] or white[9-13]. The choice of distinct populations for these studies is based on the multi-faceted character of the AIDS epidemic, with different impacts on social groups, challenging public health policies in the design of more general actions focused on specific populations.

As for affective-sexual relationships, two studies reported that the majority was sexually active[16-17], four were predominantly heterosexual women[9,13-15] and three were men who had sex with other men[10-11,15]. Two articles mentioned that most HIV transmissions occurred due to sexual exposure[9-10], since they did not use a condom before the diagnosis[9,13], and some women contracted the virus through fixed partners[9].

In family relationships, networks and social support and material situation, the majority was married/stable union with children[8,13] and "single" women reported abandonment or death of the husband[14]. It was identified the rupture of the familiar and religious networks due to the diagnosis; however, this resulted in the training and empowerment of small groups of people living with HIV, where they are well accepted and secure[14]. The supportis related to help in times of financial difficulty by parents and family, as well as concern for children's orphanhood, which has been a motivating factor for returning to treatment after abandonment[13].

Regarding knowledge, behaviors and attitudes, there is presence of subjects who denied the use of drugs[9,11,13,15]; however, among those who reported the use of licit and illicit drugs[8,10], there was an emphasis on injecting drugs, abusive use of alcohol and tobacco, exacerbated mainly among gay men[11].

Alcohol consumption is a predictor of non-adherence to antiretroviral therapy (ART), besides being a risk factor for low viral load suppression and worse clinical outcome for those living with HIV/AIDS[16]. In addition, individuals with a history of illicit drug use were 2.6 times more likely to no adherence to ART[17].

One study indicates that psycho-educational actions are capable of mitigating processes of stigma and discrimination in HIV/AIDS in Brazil[18]. Stigma and discrimination represent important barriers to the prevention, diagnosis, treatment and care of people living with HIV. In this sense, the development and/or incorporation of stigma reduction interventions are necessary in the process of producing a social and sanitary response to the epidemic.

The availability of information on risk behaviors in relation to drug use was strength for the diagnosis, reflecting the importance of establishing a relationship of trust[15].

Increasingly, the health professional is required to seek and to construct spaces for dialogue in order to increase the relationship between professionals and subjects. In this context, it is important to welcome women in a unique way, considering their individual characteristics, understanding how they experience sexuality, love life and reproductive projects, to provide information that supports the process of decision-making[19].

Another study focuses on the behavior and attitudes of women living with HIV, so that 65% showed a self-sufficient stance in denying the need for help with taking anti-retroviral medications[13]. Therefore, since 55% of these women have withdrawn from treatment at some point, other measures and behaviors are necessary to adopt practices and changes in behavior to improve health conditions. In this sense, the health team assumes an important role as supporters and motivators in the therapeutic process, since adherence is not a linear process, providing autonomy of care[20].

A study that investigated the intensity of depression symptoms in people with HIV/AIDS compared quality of life with different degrees of intensity of depression symptoms according to gender; it identified that 27.6% of individuals had symptoms of depression. This comparison revealed that women had more severe depression symptoms than men. Thus, the approach to the depression symptoms constitutes an important measure for the development of therapeutic interventions and psychosocial support[21], so that health professionals should be attentive to such health condition, since depression and expectation of impending death represent causes of ART abandonment[13].

Social Vulnerability

In the elements "access to education", "employment" and "wages", there was a predominance of low level of schooling[8-9, 13-15]; in relation to sex, women with higher levels of education had a timely diagnosis[15]; in regard to sexual orientation, heterosexual individuals have less access to education[10].

The interface of the schooling level with the HIV/AIDS epidemic refers to the individuals' knowledge about the prevention and treatment measures

of the disease. Incorrect forms of transmission and prevention of the disease were observed among older and individuals with low level of schooling[22] and association with ART adherence in individuals with higher educational level[17].

In Brazil, as the macro-economic conditions have improved, there is an increase in the level of employment and a decrease in mortality[23]. In addition, higher education levels were related to improvements in health. Thus, thinking about coping with HIV implies the strengthening of social policies based on education, professional qualification and measures to stimulate the generation of employment and income.

Regarding the elements related to social norms and gender relations, studies were identified that mentioned women as vulnerable due to sexual exposure by the partner, who had multiple partners[9-14]. The double responsibility of the women was verified, because they acquired the HIV infection and the transmission of any sexually transmitted infection[14].

Regarding social norms and religious beliefs, the predominance of the Catholic religion was identified[13], considering that the belief/religiosity element can be an important source of social support during treatment for HIV/AIDS. It also reveals the importance of religiosity in confronting illness in a positive way[24], and its approach by health professionals is important due to influences in the therapeutic process. In this aspect, religion can be experienced as a way of receiving anxieties and strengthening in times of coping with HIV, contributing to the acceptance of the diagnosis, reducing guilt and being motivating for the individual to experience and to accept his new condition[15].

Regarding stigma and discrimination, after HIV diagnosis, women were abandoned by their husbands[14]. Regarding the diagnostic revelation, heterosexual women and men were more concerned about this because of the possibility of being stigmatized, besides having negative self-image when compared to gay men living with HIV. These ones reported less stigma both from their own and from others[11], raising the hypothesis that these individuals and the people in contact with them have greater acceptability of the disease due to the history of HIV/AIDS in this population.

Discriminatory attitudes were identified as a result of the characteristics of a person living with HIV/AIDS. Among them there are very thin and weak individuals, expressing stigmatizing corporal marks, which result in barriers to hiring and maintaining employment bonds[14].

Among the strategies identified for the reduction of HIV discrimination, the use of ART that minimizes body signs stands out; insertion into religious groups; training and strengthening groups of people living with HIV, so that in such spaces people feel more accepted and safe.

Programmatic Vulnerability

As for the access, quality and organization of health services, the timely diagnosis of HIV/AIDS is questioned, since in women it may occur late after the partner's illness[9]; in the elderly people, there was a timely diagnosis at the secondary and tertiary levels of health in the presence of comorbidity[8].

In regard to access to ART, we identified the beginning of therapy in advanced stages of AIDS, through immunological involvement and the presence of opportunistic diseases[12]. This late discovery is detrimental because the moment the individual discovers his/her serological status is related directly to the immune compromise, the prognosis of the infection and the risk of exposing others to the virus[25].

There were weaknesses in the segment of women with HIV, because, even because of the high prevalence of Sexually Transmitted Infections (STIs)[9], almost two-thirds had no records in the charts on cervical cytology[10]. This situation shows the weaknesses in the provision and integration of health services for the integrality and continuity of the care provided to women.

As strength, it is important to perform the diagnosis in the routine of the service pertinent to gestational assistance[9]. Brazil is a signatory of the Pan American Health Organization (PAHO) for the elimination of vertical HIV transmission. In 2011, the Stork Network was established, which also targets infection prevention actions; therefore, the HIV test should be offered at the beginning of pre-natal care and in the second trimester of pregnancy, as part of the routine health services exams[26]. Public policies need effective strategies of support for these women, because to reduce transmission, it is necessary to know the seropositive pregnant women[27].

Regarding access to ART, even the therapeutic process started late, it is considered an element of protection, since there is an improvement in the health condition after starting treatment[13], providing a reduction in mortality due to AIDS-related causes[7].

It should be considered that the Brazilian public policy of universal access to anti-retrovirals has reduced morbidity and mortality, reduced admissions and treatment costs, improving the immunological

conditions and the quality of life of individuals. The importance of ensuring the user's maintenance of the treatment, with improvements in the quality of care, but also with policies that extrapolate other areas[28], is reinforced.

There have been many advances in the management of HIV. However, programmatic weaknesses still challenge the access and quality of services in the care provided, highlighting the rigidity of protocols that break with the confidentiality of the HIV diagnosis that can reflect in the abandonment before the beginning of the treatment. It is noteworthy that the health services in Maputo (Africa) required the presence of a relative for the initiation of ART, resulting in the abandonment of follow-up/treatment due to the cultural conditions of stigma and prejudice suffered by women living with HIV[8].

Advancing from the perspective of the weaknesses in access to treatment maintenance and loss of therapeutic clinical follow-up, especially discontinuation/lack of adhesion or abandonment to ART[10], programmatic challenges emerge in the daily work of health teams. Identifying and evaluating permanently the individuals in situations of individual and social vulnerability aim at proposing actions and interventions that foster the linkage to health services and retention of individuals in the care plan.

Regarding the "quality of services" element, the reduction in the number of AIDS deaths in the city of São Paulo in the post-HAART period (2000-2006) was highlighted, suggesting a positive impact of the policy of universal access to diagnosis and treatment of HIV/AIDS[7].

As for the elements "technical-scientific preparation of professionals and health teams", "commitment and responsibility of professionals and respect", "protection and promotion of human rights", important program weaknesses were identified. They represent challenges to the management of care and health services and the STD/AIDS Program in the effectiveness of HIV control actions.

The diagnosis of HIV in secondary and tertiary services for comorbidities suggests postponing the diagnosis that should have been performed at the primary level. However, it is questioned the preparation, sensitization and instrumentalization of the professionals of the primary level for the diagnosis of HIV[8], since the subject is little approached in primary care[29].

It indicates the positive impact of ART on the reduction of AIDS-related deaths. However, there is an increase in deaths due to external causes, with possible explanations of factors present in large urban areas that include violence, heavy traffic, high population numbers and poor living conditions[7]. Thus, investments beyond ART should be implemented to improve the quality of life and survival of individuals living with HIV/AIDS, since their confrontation requires the articulation of the health sector with education, social service, public safety and urban planning.

CONCLUSION

The review shows that several characteristics of the people living with HIV/AIDS profile persist over the years and even after the establishment of global policies and recommendations to combat HIV, such as the MDGs. It should be highlighted the male gender, men who have sex with men, users of drugs as a factor of non-adherence to treatment and the occurrence of depression during the virus infection. It is noteworthy that women are mostly heterosexual, infected by husbands and abandoned after diagnosis.

Low levels of schooling have resulted in delayed diagnosis and difficulty in adhering to ART, as well as concerns about stigma and discrimination, which still constitute a barrier to the social integration of people living with HIV. Despite this, it was observed the importance of religion in coping with the infection.

As for health services, it has been found that diagnoses do not often happen in a timely manner and ART is initiated late, showing the need for training of health professionals, especially primary care.

It is believed that recognizing the profile of people living with HIV in the different dimensions of vulnerability is important for the response to the HIV epidemic, since it must consider the singularities and specificities of individuals and/or social groups.

RECONHECIMENTO DAS VULNERABILIDADES DAS PESSOAS VIVENDO COM HIV/AIDS: REVISÃO NARRATIVA DA LITERATURA

RESUMO

Objetivou-se descrever quais as situações de vulnerabilidades a que as pessoas vivendo com HIV/AIDS estão submetidas por meio de uma revisão narrativa da literatura. Este estudo considerou publicações entre os anos de 2010 e 2016. O levantamento bibliográfico foi realizado com a utilização de descritores controlados e palavras-chave nas bases de dados LILACS (Literatura Latino-americana e do Caribe em Ciências da Saúde), PubMed (National Library of Medicine)e Embase (Excerpta Medica data BASE).

Foram recuperados 89 estudos que passaram por três etapas de seleção, dos quais foram incluídos nove artigos; estes abordavam aspectos da vulnerabilidade individual (situação física; conhecimentos, comportamentos e atitudes; e relações afetivo-sexuais), sociais (acesso à educação, emprego e salário) e programáticos (acesso e qualidade dos serviços de saúde).Conclui-se que é fundamental reconhecer as diferentes vulnerabilidades com suas dinâmicas e interfaces nos diferentes contextos sociais, políticos, econômicos e sanitários com vistas ao enfrentamento da epidemia do HIV e à produção de respostas considerando as singularidades e especificidades de indivíduos e/ou grupos sociais.

Palavras-chave: HIV. Síndrome da imunodeficiência adquirida. Vulnerabilidade em saúde. Perfil de saúde.

RECONOCIMIENTO DE LAS VULNERABILIDADES DE LAS PERSONAS QUE VIVEN CON VIH/SIDA: REVISIÓN NARRATIVA DE LA LITERATURA

RESUMEN

El objetivo fue describir cuales las situaciones de vulnerabilidades que las personas con VIH/SIDA están sometidas por medio de una revisión narrativa de la literatura. Este estudio consideró publicaciones entre los años de 2010 y 2016. La búsqueda bibliográfica fue realizada con la utilización de descriptores controlados y palabras clave en las bases de datos LILACS (*Literatura Latino-americana e do Caribe em Ciências da Saúde*), PubMed (*National Library of Medicine*) y Embase (*Excerpta Medica Database*). Fueron recuperados 89 estudios que pasaron por tres etapas de selección, de los cuales fueron incluidos nueve artículos; estos trataban aspectos de la vulnerabilidad individual (situación física; conocimientos, comportamientos y actitudes; y relaciones afectivo-sexuales), sociales (acceso a la educación, empleo y sueldo) y programáticos (acceso y calidad de los servicios de salud). Se concluye que es fundamental reconocer las diferentes vulnerabilidades con sus dinámicas e interfaces en los diferentes contextos sociales, políticos, económicos y de salud con miras al enfrentamiento de la epidemia del VIH y a la producción de respuestas considerando las singularidades y especificidades de individuos y/o grupos sociales.

Palabras clave: VIH. Síndrome de inmunodeficiencia adquirida. Vulnerabilidad en salud. Perfil de salud.

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