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# Narratives about risk and guilt among patients of a specialized HIV infection service: implications for care in sexual health

Narrativas sobre risco e culpa entre usuários e usuárias de um serviço especializado em infecções por HIV: implicações para o cuidado em saúde sexual

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## **Abstract**

The objective of this study is to understand how perceptions about HIV and AIDS are articulated in narratives of male and female patients of the Public Health System, with qualitative elements that demonstrate the importance of sexual health counseling. Nine male and female patients of a specialized health service (CTA) were interviewed in Porto Alegre when they visited the CTA for the HIV, Syphilis and Hepatitis B and C Rapid Test. The narratives generated two understanding axes: Risk/Promiscuity and Guilt/Accountability. These axes synthesized some of the innumerable possibilities of meaning in relation to the need to perform the HIV test. The elements promiscuity, risk, guilt and accountability were composed of different social markers, involving social experiences that were articulated with the epidemiological biomedical discourse. In this context, counseling represents a powerful space to deconstruct essentialist meanings and stereotyped notions of risk. This study shows that the narratives reaffirm the understanding of sexuality as an individualized dimension, which indicates the need for health work proposals on singularity. Qualitative analyses focused on the patients' experience are strategic measures in a project to promote sexual health as a collective process.

**Keywords:** Counseling; HIV; Sexuality; SUS; HIV Rapid Test.

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## Resumo

O objetivo deste estudo é compreender como se articulam percepções sobre HIV e aids em narrativas de usuários e usuárias do Sistema de Saúde, trazendo elementos qualitativos que demonstram a importância do aconselhamento em saúde sexual. Foram entrevistados nove usuárias e usuários de um serviço de saúde especializado (CTA) em Porto Alegre, no momento da procura pelo Teste Rápido para HIV, sífilis e hepatites B e C. As narrativas geraram dois eixos de compreensão: Risco/Promiscuidade e Culpa/Responsabilização. Estes eixos sintetizaram algumas das inúmeras possibilidades de significação frente à necessidade de realização do teste de HIV. Os elementos promiscuidade, risco, culpa e responsabilização se compunham a partir de diferentes marcadores sociais, envolvendo experiências sociais que se articulavam com o discurso biomédico epidemiológico. Neste contexto, o aconselhamento se apresenta como um espaço potente para desconstruir significações essencialistas e noções estereotipadas de risco. Este estudo mostra que as narrativas reiteram entendimentos de sexualidade como dimensão individualizada, indicando a necessidade de propostas de trabalho em saúde pela via da singularidade. Considera-se que análises qualitativas centradas na experiência de usuários(as) são estratégicas num projeto de promoção de saúde sexual como processo coletivo. **Palavras-chave:** Aconselhamento; HIV; Sexualidade; SUS; Teste Rápido.

## Introduction

The facilitated access of patients of health systems to its services is related to better levels of health and quality of life. Although there are investigations that corroborate this, current analyses show that in Brazil, diverse populations have serious access difficulties, including economic, class, race/ethnicity and sex/gender discrimination (Boccolini et al., 2016). In the field of Gender Analysis and Sexuality Studies in Health Psychology specifically, thematic issues such as vulnerabilities to HIV/AIDS, care strategies and preventive measures have collaborated to problematize the diversity of the population attended by the public health services and, at the same time, the difficulty of access involved in this process (Costa; Nardi, 2015). Aspects related to the stigmatization and exclusion of the so-called “sexual minorities,” for example, have been the subject of research and recent study, pointing to the precarious situation of access to the health system by the population of Lesbian, Gay, Bisexual, Transvestite, Transsexuals and Queers (Alencar Albuquerque et al., 2016).

Otherwise, the tensions provoked by the current discussions in the field of identities/differences is evident when observing the relationship, and some lack of articulation, between epidemiological data (using generalist terminologies, which seek to contribute to a larger population), and qualitative studies (that focus on the potentialities of thinking about the current microcontexts) in the field of sexual health. Recent research, for example, aim to emphasize strategic categories such as MSM (men who have sex with men), raising tensions concerning the weaknesses of removing aspects of identification and particular sexual practices from the discussion on health (Hamann; Ew; Pizzinato, 2017; Young; Meyer, 2005). Although epidemiological information is important to explore aspects related to population health – such as contexts of vulnerability –, the need to study discursive dimensions related to sex/gender, morality and discrimination are indicated as strategic measures by many of the scholars of the area, which may complicate analyses and broaden horizons (Alencar Albuquerque et al., 2016).

Although Brazil has developed research since the emergence of AIDS, in an attempt to subsidize the demands of sexual relations and practices, these studies have followed the abovementioned conflicts with a smaller entry in the subjective field and with emphasis on epidemiological data. Since the beginning of the epidemic, the care strategies outlined in different guidelines, which have changed from a curative health perspective to a healthcare perspective, have been modified. Ways of understanding care are particularly important in this process, especially involving a non-hegemonic or generalist project in caring for the patients or the workers. This implies that the health professionals' sensitivity has to meet the needs of the population, especially when mapping their idiosyncrasies becomes a possibility of work. It implies, at the same time, the surveys, indicating the particularities and needs of the patients and the relationship that is built with the services and professionals.

Historically, analyses of population needs and particularities operated in association between identity aspects and sexually transmitted diseases (with populations such as prostitutes, homosexuals, transsexuals and transvestites, injecting drug users), and stressed the prospect of social rights and visibility with the possibility of new stigmatization. The notion of "risk groups," for example, while attempting to delimit the dynamics of infections in certain populations, led to hygienic and moralizing purposes. Since these actions were consistent with essentialist perspectives that only blamed individuals for their "contagion," thus, the forms of identification based on the disease were updated. The stigmatizing limitation of the concept of "risk group" as an operative vector of the evidence on the spread of HIV was explained by the heterosexualization, feminization, aging, low schooling, internalization and pauperization of the epidemic (Brasil, 2015a).

The concept of vulnerability provided a vision of health/disease processes beyond the perspective of "risk groups," also promoting the interpretation of these phenomena as conjunctions of individual, social and institutional aspects (Ayres et al., 2003; Camargo Junior, 2000). The notion of vulnerability,

which composes some of the facets related to the process known as the "Brazilian response to AIDS," considered a perspective aligned with the notion of human rights which is implied in a process of identification of the phenomenon in the spheres recognized as social, programmatic and individual (Paiva, 2013).

Among the profits of the Brazilian response to STDs and AIDS is the emphasis on notions of territory, diversity, healthcare and prevention, as well as aspects linked to a health/disease perspective that simultaneously conceives the biological and social character (Rocha; David, 2015). These perspectives seek to reflect on sexualities and their interplay with social scenarios and focus their looks on everyday practices as a way of denaturalizing certain behaviors related to specific groups, as well as strengthening "diversity" as a concept that should be part of the agenda of discussions in public health. This field of dialogue in Brazil is changing, especially over the last three decades. One of the aspects that comes to be emphasized in this trajectory is the care centered on the patient(s) of the Unified Health System.

The importance of two approaches of militancy regarding the transformation of the notion of risk group towards a more dynamic understanding of the vulnerabilities of the field of health must be highlighted. The first, from a feminist perspective, addresses the implications of biomedical control, especially in the field of sexual and reproductive rights (Diniz; Guilhem, 2008). In this discussion dimension, the extension of the concept of "women's health" to the specific scope of "reproductive rights" in the 1980s and 1990s in Brazil (Lemos, 2014), for example, indicates steps to incorporate critical discussions regarding naturalizations of the body, as well as establishing dialogues with spheres of non-heteronormative sexuality. In this period, the incorporation of the notions of "reproductive rights" and "sexual rights," as facets inseparable from the notion of "human rights," has allowed the construction of areas of political discussion that are not restricted to traditional readings of health and legality. The other militancy dimension that promotes changes in relation to the

generalist status of the health subject is that of trans movements. Guaranha (2014) observes that the reflection conducted by these movements criticizes the reiteration of a cissexist system, in which the experience of cisgender people - who live with a gender identity in accordance with the sex/genital designation - is considered legitimate and universal.

Although not always continuous, the relationship established between different social movements and health administrators in Brazil, generated co-constructed policies and programmatic actions with great adherence. If, on the one hand, the proposals for coping with the epidemic developed in Brazil are now part of another scenario, such as investments in technological devices - such as oral fluid for the *Viva Melhor Sabendo* project ("Live Better Knowing") (Brasil, 2015b) -, or the possibility of communicating with new social groups, the national panorama is still too discriminatory. This discrepancy is noticeable in studies currently developed in the country with a focus on traditionally strategic populations such as sex workers (Salmeron; Pessoa, 2012) and homeless people (Carneiro Junior; De Jesus; Crevelim, 2010). In this sense, the articulation between health policies in Brazil and care practices deserves to be questioned. One of the forms of problematization can operate by focusing on the encounter between the technologies (hard and light) and how they reverberate in the spaces of dialogue between patients and health professionals.

The authors know that it is necessary to develop forms of counseling more effectively focused on the needs of each person (Carvalho et al., 2016, Terto Junior, 2015). However, in the wake of this discussion, it is considered necessary to also offer subsidies so that the professionals can take control over the different social dynamics involved, analyze and re-signify the various spheres of sexual practices and discourses involved. Following this perspective, this article seeks to understand how social perceptions about HIV and AIDS are articulated in narratives of patients of the Health System, bringing

qualitative elements that demonstrate the importance of sexual health counseling.

## Methodology

Our study is the result of a survey conducted at the Center for Testing and Counseling (CTA) of the Ambulatory of Sanitary Dermatology (ADS), Porto Alegre/Rio Grande do Sul, Brazil. The CTA/ADS was the first CTA in Brazil, created by the Ministry of Health in 1988. It is located in the ADS, which has been operating since 1920, historically destined to the treatment of dermatological problems, leprosy and sexually transmitted diseases, in which the first AIDS cases in the country were dealt with. In this sense, the CTA, as well as the ADS, function as important references in the capital and in the State for the diagnosis and treatment of STD/HIV/AIDS, as it has a long tradition of access to the most vulnerable segments of the population.

People who visited the CTA in the period from March to July 2015 were invited to perform the Rapid Test. Nine people who used the service during this period (2 cisgender women, 6 cisgender men and 1 female transgender woman, all patients) participated in the study. Interviewees were between 24 and 55 years old, mostly with Higher Education, all whites and singles (aspects not listed as criteria, but that characterized the people interviewed). The interviews lasted approximately 40 minutes, they were recorded, transcribed and digitized, bringing together a single corpus of analysis. The interviews with the people participating in this study comprised the "pilot study" for the consolidation of the research *Testes rápidos para HIV, sífilis e hepatites virais: análise do impacto dessa tecnologia de cuidado no acesso a populações em situação de maior vulnerabilidade em um Centro de Testagem e Aconselhamento (CTA) de Porto Alegre/RS* ("HIV, syphilis and viral hepatitis rapid tests: analysis of the impact of this care technology available to populations in situations of greater vulnerability in a Center for Testing and Counseling (CTA) of Porto Alegre/RS")<sup>1</sup>, which

1 Research approved by Research Ethics Committee of PUCRS, financed by the Brazilian Ministry of Health (Public notice for the selection of research subprojects in STD, HIV/AIDS and Viral Hepatitis - 2013/1).

evaluated the impact of the implementation of the Rapid Test in Porto Alegre.

The data generated were analyzed from the assumptions of the Thematic Analysis. The researchers followed the steps established by Braun and Clarke (2006): familiarization with the data (through the process of data transcription, reading and re-reading), generation of initial codes (production of systematic codes throughout the interview, grouping relevant data), search for themes (grouping of codes into themes), revision of themes, definition and naming of final themes and production of the report. The results finally supported two thematic axes: Promiscuity/Risk and Guilt/Accountability, which demonstrate some of the innumerable possibilities of meaning of this period in the CTA, as well as articulations of the counseling with social discourses that involve this field of research - an emerging dimension lacking qualitative studies.

## Results and discussion

The thematic axes presented were organized from the narratives of the different patients of the health service. The theoretical dimensions that organize them (promiscuity/risk and guilt/accountability) are discussed in the light of the scientific literature that stresses the ways of apprehending phenomena related to health promotion. This discussion also seeks to understand some of the possible places occupied by those involved in this context, which are intrinsically related to future strategies in the sexual health counseling process.

### Promiscuity/Risk

The notion of promiscuity and exposure to risk situations permeated the narratives of participants. However, their position in relation to the affirmatives in this field was incorporated in different ways in the statements. Some examples of these differences in positions are Patient 1<sup>2</sup> and Patient 2<sup>3</sup> which will be presented below. The two participants did not use condoms with their

respective partners, indicating this aspect as a reason for the demand of the health service.

For the Patient 1, the sexual practice that is considered inadequate, related to who is at greater risk, is the one performed by those who have sex "with several people." According to the Patient, the problem would be the "promiscuity" that encompasses their ways of acting and thinking. This Patient makes a very clear distinction between her situation in relation to the illness and the social position held by others: "There are people who have no knowledge [about it] at all [...]. It is the environment in which they live, they are accustomed to this kind of thing" (Patient 1). The participant states this shortly after commenting that she had been infected by her husband, categorized as promiscuous and with reprehensible habits. Although social position may change, the idea of accountability and "personalization" was present for other participants who, like her, totally blamed promiscuous partners - or themselves, when understood as such.

For Patient 2, the idea of promiscuity and risk (terms used by the patient himself) is intrinsically linked to being gay:

Now I decided to do it because I did it without a condom with my ex, and we end up having oral sex without a condom, you know? People often do not take care of themselves, and usually end up going out at parties where they have a dark room... *You know what it is like, gay people...* We end up *going with the flow* and... We just do not take care of ourselves (Patient 2, our highlights).

This notion of a type of attitude or way of being gay, while intrinsically linked to promiscuity, is a recurring interpretation. One can understand that the repetitions that constitute this normative field manifest themselves historically as related to movements of pathologization or stereotyping of sexualities considered dissidents (Pelúcio; Miskolci, 2009). In this process, statements that manifest the supposed promiscuity intrinsic to

2 Female cisgender, white, heterosexual, married, 55, complete Higher Education.

3 Male cisgender, white, homosexual, single, 29, complete Higher Education.



gay people contemplate a social logic that reiterates the functioning of moral vigilance, as well as a supposed “substance” of these people. In Patient 2’s report, the process of identification with “being gay” arises in the narrative as a justification, an argument before the “accusation” that not manifested by the interviewer, but socially present, that gays are prone to attitudes considered morally promiscuous and inappropriate. At the same time, the identification with this discourse is present, and it develops as a possibility of action within what it seems to conceive in the narratives as a type of gay experience that is evoked every day.

Patient 3<sup>4</sup> reiterates the idea that homosexuals are more HIV-prone than heterosexuals. Although we can understand this fact as a remnant of the discourse disseminated at the beginning of the epidemic in the 1980s, the organization and the used narrative attributes stand out:

I think that the homosexuals’ demand is much higher than that of heterosexuals in the testing service. First, due to *the indices that show* that homosexuals have far more HIV than heterosexuals. I think that’s why homosexuals look for the service more than heterosexuals. The people who work with it are already more prepared to deal with a homosexual, really. (Patient 3, our highlight)

The use of supposed information in interviews regarding infection and homosexuality, as in the speech of Patient 3, leads one to think about the interfaces between social discourses and the scientific field in a logic of control and vigilance. Conceived as a form of power/knowledge and inscribed in this logic, the notion of biopolitics (Foucault, 1999) looks at the organization of certain social discourses on the itineraries and vital processes that are constantly being updated in health services. This field, which can be composed of what is acknowledged as biopolitics (to some extent, state, disciplinary and controlling bodies), points to non-unilateral statements, but (co)acting

and self-updating statements in discursive networks. In this sense, to circumscribe the narrative using a scientificist presupposition, in expressions like “indexes that show” (Patient 3), it is demonstrated how the statements of the field of biopolitics are organized dynamically and not vertically, as it is reproduced by the one who is the target of this type of social production.

For Patient 4<sup>5</sup>, there is currently a sexual liberation and possibilities of diverse practices closely connected to the technological possibilities of interpersonal communication. However, it is important to look at the notion of communication in this context, which is intrinsically connected to the possibilities established by anonymity. Despite the widening of the social possibilities of homoerotization, homosexual sex is still closely linked to notions such as discretion and marital betrayal.

These Internet and phone dating tools, even of *so-called heterosexual couples*. Until you said “man who has sex with man”... The number of heterosexuals who have sex with men is much greater than you can imagine. It’s all calmer, easier and it can be done *in a discreet way*. (Patient 4, our highlights)

Several times throughout the interviews, references to “false” or “true” heterosexuals are present. These positions can be interpreted as persecutory movements in relation to homosexuality or to the sexual practices among men, part of the heteronormative social discourse. Considering sexual orientations as processes established through self-naming (as identification dynamics), it is interesting to observe that the notion of sexuality or ‘veiled’ orientation is present in several reports. This is about what kind of sexuality practice that can be legitimized and understood within a social spectrum that is discursively heteronormative and discriminatory. Moreover, such movements reiterate a logic in which sexual practices are supposed to account for the complexity of the social

4 Male cisgender, white, homosexual, 24, some Higher Education.

5 Male cisgender, white, homosexual, single, 39, complete Higher Education.

and subjective positions of all men and women, in a kind of generalizing holism.

The focus of this type of discourse (persecutory regarding orientation) seems to be focused on men, especially in relation to the diverse forms of exercise of masculinity(s), although several markers such as race, gender and sexuality focus on the need for more dynamic interpretations of “being a man” in contemporary times (Vigoya, 2011). In this perspective, persecutory ways of “unveiling” true sexuality would work both in a logic of “normal sexuality” and in a form of examination in a perspective of essentialist identity, marked by the fear of identification with the feminine and possible related practices to the historically subaltern position of women. Patient 4 also states, regarding the information between gays and masculinity aspects:

We talk more about it between us. Well, I think between families this is all veiled, but if you check, the internet is full of married men seeking sex. It is much more frequent, but it is not talked about, people do not know it. I think women are others who live in the ministry, in the ministry of the home [laughs]. I think they never know what's going on, they always believe that the man is faithful, that thing that I think is very masculine, right? I say, *these issues of promiscuity, betrayal... they're not a gay thing, they're a male thing.* (Patient 4, our highlight)

On several occasions, in the research context, the masculinity/betrayal/virility situation was related to promiscuity. These aspects are consistent with other interpretations of the exercise of sexuality in the context of masculinity. Welzer-Lang (2001: 462), for example, defends the term “the house of men” to understand some of these social constructs. The term coined by the author seeks to encompass the set of places and spaces destined to the structuring of the masculine – like groups of interaction in the school, bars, clubs or cafes – in which the homoeroticism can be experimented with, allowing for the incorporation of knowledge structured in codes and rites, in which

learning is conducted through suffering and dissimulation. As evidenced in the report, the conception of man and woman, as well as the exercise of masculine and feminine attributes, takes place in a relational way. So, in Patient 4's narrative, references to a generic form of woman serve as a way of circumscribing an attribute taken as essentially male, masculinity.

These knowledges/actions are embedded in a daily surveillance logic that takes different forms – for example, in what concerns the anxiety generated in the possible identification of men with the feminine (Torrão Filho, 2005) through certain practices and exercises of sexuality. Traditional understandings of sexual practices, which involve penetration and operate on the active/passive hierarchical distinction (Carrara; Simões, 2007), are updated in narratives daily and give one a good overview of these issues. One speech that illustrates this traditional and normative discourse is that of Patient 2. At one point in his narrative, while describing one of his partners, he states: “When he smokes, he ceases to be a man and wants buttsex.” For this Patient, “being a man” is related to penetrating/being penetrated positions in the sexual act, which brings us to certain discursive updates of themes that continue to have social reverberation.

Otherwise, many patients use scientific terminologies, directed to the hegemony of biomedical knowledge on sexuality, in the constitution of their narratives about the demands and the health service. Some statements make the researchers/interviewees relationship more explicit, that is, of an investigation contextually performed in a Health Center and that, therefore, calls the interlocutors to a situated exercise of communication. However, the researchers are particularly interested in the narrative strategies created due to the approximation to the biomedical discourse. Patient 5<sup>6</sup>, for example, observes some of the social interpretations linked to infectious diseases through the use of these expressions in the scientific field. In this movement, he reiterates the notions of promiscuity and risk as characteristics of men – especially those who have sex with other men.

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6 Male cisgender, homosexual, married, 30, complete Higher Education.



Even if I'm cured of a *little detail*, like, I have relationships with *men*, you know? And then I know that it is a *risk group*, promiscuity is very high, they hook up with a lot of married dudes that hook up with others and then you cannot trust anyone, nobody nowadays trusts anyone. You cannot trust anyone. (Patient 5, our highlights)

Even though the “little detail” may represent some Sexually Transmitted Infection (STI) and the evident distrust of potential partners may set up a protective attitude, what stands out most in this speech is the identity assumption of the term “risk group.” Scientific literature from the field of HIV and STI policies aimed at the notion of “risk groups” has increased actions aimed at hygiene and moralizing (Parker; Camargo Junior, 2000). Through this speech, we understand that this process is not unilateral, but updated in the form of statements. In this context, the emphasis given by Patient 5 regarding the sense of distrust towards sexual partners is evident. However, for the participants, this distrust appeared mainly related to the figure of the men. In Patient 5's talk, the focus is on married men who are available to be in a variety of settings, with the discretion provided by “anonymous” media such as the internet and mobile applications. This historical disposition of men (both in the social incentive for the exercise of sex by boys and men, and in a process of male domination in which virility is related to betrayal and the number of sexual partnerships) indicates what kind of discourse is present in these reports. However, as far as women are concerned, the movement has not been the same:

One person asked me and I recommended it because the other person also has a *very disturbed sex life*. It's a colleague of mine who goes out and has sex with a guy, every three days she goes out and has sex with a different guy. But she does not tell me if it's with or without a condom, *but if it's her, it seems to be pretty promiscuous*. (Patient, 6<sup>7</sup>, our highlights)

In the context of the research, if the distrust on men had a tone of accusation regarding the possibility of illness, for women the narratives were focused on exposing sexuality and sexual practices. If in the context of men the accusatory movement is related to the anonymity and the availability of discreet and dangerous sexual itineraries, in the context of women this movement turns to what she “seems to do.” For Patient 6, for example, this way of acting is an indication of sexual practices.

The aspects that permeate the statements of the people interviewed lead us to think of the promiscuity/risk axis as a strategic dimension of negotiations on personal risk management. Narratives to a large extent had an accusatory character in which the possibility of personalizing the HIV problem is intrinsically articulated with forms of moralization of the exercise of sexuality or ignorance. Whether it is through the association of a gay experience with an idea of a promiscuous life – which despite being a historical factor, it is still strongly present in services – of a certain “way of being” as an indication of this promiscuity between different sexual orientations, or of the image of the “illegitimate” man who, even married, circulates among men with whom he has sex, there is a field of certain legitimacies that are organized under the effects of moral panic (Miskolci, 2007).

## Guilt/Accountability

The statements of the Patients, commonly associated with the issue of “contamination,” are placed between positions that are closer to or more distant from notions of guilt/accountability. For Patient 7<sup>8</sup>, for example, the responsibility for “contamination” is closely linked to the male figure:

Nobody's going to care if it was my ex-husband, if it was my boyfriend. It is *because of the stigma that HIV-positive people carry*. That's what I think of a seropositive. *I use quotation marks for myself and two or three other people*. Because they are inconsequential people, who lurk at night, use

7 Female transgender, white, bisexual, separated, 37, complete High School.

8 Female cisgender, white, heterosexual, separated, 32.

drugs, sleep... Have sex with anyone. That's what my husband did. I knew what was happening, because *men are bringing it to women*, more and more. (Patient 7, our highlights).

The separation between “us” and “them” is a common process in which positive attributes can be linked to the group of “belonging” of the speaker and the negative attributes linked to those that are part of the “others” (Tajfel, 1981). Patient 7 emphatically states that the culprits for the “contamination” of married women are husbands. In addition to the aforementioned notion of promiscuity as something indicated in the male universe, reiterated in the statement of Patient 7, the researchers observed that the position of women regarding the use of condoms is not linear. The meanings attributed to the use of condoms can be traversed by the forms of male domination in the conjugal context (Heilborn, 2004). Moreover, the patient's movement is to reiterate throughout the personal narrative a very well defined distance between her situation and that of others. This movement of detachment and differentiation, however, is marked by moral attributes that differentiate her in relation to others, outside of their “quotation marks” of security. Those outside the “quotation marks” are inconsequential, drugged, promiscuous.

Some social discourses connect the notion of care, shelter and protection, masking male-dominated sexist relationships that transform linear interpretations of conjugality and HIV protection nebulous (Guilhem, Azevedo, 2008). If the interviewees' statements denote the loss of trust in their spouses, they somehow resume a protection discourse related to conjugality, romantic love, fidelity, respect and complicity historically constructed in the West. However, they contextualize this discourse through the loss of a supposed space of protection.

In the argument constructed by Patient 7, it is interesting to observe that, in addition to the attempt of men's estrangement from conjugal complicity, she tries to remove from herself the stigma of HIV in her the history of her infection

“no one's going care if it was my ex-husband, if it was my boyfriend. It is because of the stigma that HIV-positive people carry” (Patient, 7). The Patient 7 during part of her interview reiterates the traditional notion of coexistence of two different possibilities of exercising sexuality that vary according to gender, in which women would fit the exercise with a reproduction function, connected to conjugal monogamy, while for the man, it would be connected to pleasure, whether within a monogamous or extramarital relationship (Lóbo; Silva; Santos, 2012). These aspects talk about forms considered legitimate for infection, such as children and women, especially those with fixed partners, and others who do not threaten moralizing ideas of sexuality and illegitimacy, promoted by people who question the dominant imaginary (Guilhem; Azevedo, 2008).

For Patient 8<sup>9</sup>, the position in relation to the contamination is of greater proximity and of great suffering.

today, I would not be able to have sex with someone without a condom. Knowing that I may be passing this on... Harming someone. So this is my... Maybe (cry). Maybe it's *my punishment* now, right? Of all the times that I was stubborn and did not want to use a condom because it was uncomfortable, because there are people who do not like to use it. Maybe this is *my punishment*, *my conscience*, because I never wanted to harm anyone, I never wished for *evil in people's lives*. (Patient 8, our highlights)

The recurrent use of expressions such as “punishment,” “conscience,” “evil,” throughout the interview with this Patient, denotes a position that cannot be understood simply as justification or excuse, but as a response to a context of moral judgment about the infection that refers to the discourse of Christian guilt. The religious dimension, beyond studies that work with possibilities of coping in contexts of health promotion, is indicated as practices, knowledge and experiences that permeate and constitute subjectivities. The discursive

9 Male cisgender, white, homosexual, 24, single, complete High School.

aspects of a religious nature are a nodal point about social memory regarding AIDS, as indicated by the various expressions of the sacred in the discursive, a field that strongly impacts health promotion (Lobato Vianna, 2014).

The Patient 8's position denotes a dimension of the reprehensible, understood here as something worthy of repression. In other contexts, the notion of social defense (Moutinho, 2014) seems to emerge in a hygienist discourse. For Patient 9<sup>10</sup> for example:

*I think it should be mandatory, like the vaccine. It's against people's freedom, but if you have it why will not you get care? Why will not you avoid passing to someone else? I think it should be mandatory, you have to vote, it's more about fear than notion.* (Patient 9, our highlights)

This perspective - which stresses autonomy promotions in the context of health/STIs - it retakes a notion of body control, linking public health narratives with discourses that lie between social protection and coercion (Souza and Czeresnia, 2007). In addition, while Patient 9's statement places an idea of social defense as the focus, and in opposition to the possibility of autonomy, it silences the public's non-recognition of different ways of experiencing sexuality (Moutinho, 2014).

Scientific discourse, like "epidemiological data," is used to legitimize a stereotyped discourse about ways of living sexuality outside the limits of heteronormativity and romantic love. The ways of exercising sexuality beyond these norms were seen as potentially dangerous and risky. Narratives also point to the antagonism between guilt and victim-related "contagion" with the virus, which somehow shows that there is a hierarchy between people and their sexual practices, in which some are more of victims than others. These hierarchies are also reflected in the idea of "contamination" as punishment.

We can also conclude that the mechanisms of behavior control - which are established by logics of repression, non-recognition of differences,

and sometimes under the pretext of social defense - indicate the need to think about sexual health from the notion of diversity and of otherness. This is especially true in the context of sexual health-care services, when the perception that health interlocutions are involved in a social space that favors a premise of heterosexual and masculine sex, both by males and females - as the interviews indicate - as well as by actions of health professionals. Although the field of research and professional experiences in the area indicate advances in the singularization of care strategies, there is an need to reflect on ethical needs as means to improve the analyses in this direction.

## Final Remarks

The alarming epidemiological panorama of HIV infection in the Porto Alegre context indicates that it is necessary to invest in different analyses related to care in health service, especially through qualitative studies, which appear peripherally in Brazil although the scientific literature points to the need for this kind of problematization. Following this perspective, it is considered that investigating the situation of the male and female patients, understanding the cultural dimension in which they are inserted is important, in such a way that conditions for changes can be produced in this conjuncture.

In this study, the diversity of the narratives of the participants revolved around the axes: Promiscuity/Risk and Guilt/Accountability. These axes synthesized some of the possibilities of significance regarding the need to take the HIV test. The discourses of promiscuity, risk, guilt and accountability are articulated from different social markers. It is possible to observe this in the articulation between the relationships of feminization and heterosexualization of HIV and the updates of the romantic love discourse (intrinsically related to sexual care strategies), in the forms of identity collage between non-heteronormative sexual experience and the notion of group of risk, or other aspects that are transversal to narrative contents

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<sup>10</sup> Male cisgender, white, homosexual, 29, married, complete High School.

such as guilt mechanisms and narrative strategies connected to the biomedical discourse.

The permanence and transversality of stigmatizing discourses that comprise a certain memory of “risk group” also invites us to think about the current strategies in sexual healthcare and the work on the health/care interface that has been promoted. Ways of maintaining normative aspects are glimpsed in these narratives, and although they are not limited to stagnation and impossibility of health promotion, they are centered on a heteronormative and masculine subject that is updated with focus on the control of sexual health. The reiteration of these markers – such as specific sexual practices or identifications in terms of orientation, for example – indicates that sexual and reproductive healthcare still lacks a vision that can operate in favor of the deconstruction of sexuality understood as individualized (and therefore, susceptible to a form of vertical control). The researchers understood that the work focused on counseling should operate in a unique way to the particularity of the sexual itineraries, not seen as detached from a social fabric that composes it. Thus, care strategies can be elaborated in the patient receptions to provide encounters between stories that, despite what are read in the listed narratives, are constructed in the same complex social field, providing health production beyond the professional/patient relationship.

This scenario, which makes sexual and reproductive health counseling an important device for research and social care, would also enable to glimpse some nodal points, for example, regarding access to and permanence in public health services. Thinking about a space of deconstruction of stereotypes, problematization of notions of risk and guilt, from a singular view on the patients allows them to also be able to elaborate and construct their sexuality more autonomously, as well as to delineate self-care strategies in their sexual itinerary.

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### Authors' contributions

Rocha and Pizzinato drew up the initial project design. Hamann drafted the first version of the manuscript. All authors participated in the study design and contributed to the data analysis plan, worked in the manuscript and its critical revision, and gave final approval of the version to be published.

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