ORIGINAL ARTICLE *DOI: 10.4025/cienccuidsaude.v15i2.26287*

WOMEN'S KNOWLEDGE ABOUT STI/AIDS: WORKING WITH HEALTH EDUCATION

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ABSTRACT
The objective of this study was to evaluate the knowledge of women about prevention, transmission and perception of vulnerability for Sexually Transmitted Infection (STI) and Acquired Immune Deficiency Syndrome (AIDS) before and after the implementation of health education. This is a "before and after", descriptive study, with quantitative approach, involving 30 users of an Integrated Family Health Unit in João Pessoa, PB, with 18 years old and who have started sexual life. Data collection was conducted in February 2014 by the approach of women in the waiting room, who responded to the interview before and after the intervention. The results were analyzed and compared using the chi-square test. Health education has contributed significantly to increased knowledge of the participants and their perception of vulnerability about STI/AIDS. However, this knowledge does not always produce change in attitude and behavior, making I necessary that nurses recognize the importance of educational practices in their daily lives, not only to reduce the incidence of STI/AIDS, but also for the emancipation of the individual, encouraging the development of the sense of responsibility for their own health.

Keywords: Knowledge. Women. Sexually Transmitted Diseases. Health Education. Nursing

INTRODUCTION

Sexually Transmitted Infections (STIs), HIV (Human Immunodeficiency Virus) and, hence, AIDS (Acquired Immunodeficiency Syndrome) are an important public health problem in Brazil and worldwide. With regard to HIV, the epidemic scenario has changed over the years, reflecting changes in the profile of the victimized people[1].

In 2014, the World Health Organization (WHO) launched the consolidated guidelines on the prevention, diagnosis and treatment of HIV, and attention to key populations. These guidelines are designed to contain the increase in the incidence of STIs and HIV, as they constitute a serious global epidemic[1].

Regarding AIDS, whose transmission occurs also, and not only, by sexual contact, from 1980 to June 2013, 686,478 cases of the disease were reported in Brazil, being 445,197 (64.9%) men and 241,223 (35.1%) women. Related to women, 86.8% of the cases resulted from heterosexual intercourses[2].

The contamination is multifactorial and the lack of knowledge of some types of STI can cover the embarrassment of talking about the problem, poor approach by health professionals and/or the power relationship between women and men[3], and the lack or inefficiency of educational activities that is the focus of this article.

In this approach, improving the quality of care of the Unified Health System (SUS) and promoting a counseling environment may become possible when the professional facilitates the reflection on the risk of unprotected sexual intercourses, besides contributing to the adoption of safe practices, promoting the experience of sexuality in a healthy way[4].

Despite the predominance of cases in the male population, the rate of growth of the infection in heterosexual women shows that, in recent decades, there has been a change in the

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profile of the disease in Brazil, and the contamination is probably caused by factors related to the socio-cultural context[5,6]. This national epidemiological picture explains the "feminization" of the HIV/AIDS epidemic, when it ceased to be linked only to immorality and started to enter in marital relations[7].

Until now, the knowledge associated with the regular use of condoms is the only effective alternative for prevention, through sex, of both HIV as STI[8]. However, it involves numerous socio-cultural aspects, the safe sex trading is restricted, because although women understand their vulnerability, many of them know that their power to reduce or eliminate the risk is limited by the partner, and, still, others treat trust and loyalty as elements related to protection[6,7].

This time, it is known that knowledge alone does not guarantee the adoption of preventive behaviors; however, the proper knowledge about the ways of prevention and transmission of STI/AIDS, and the understanding of susceptibility and risk, through the development of educational activities, can promote preventive measures, such as the condom use.

Given the above, it is increasing the need for health education with the evaluation of post-intervention effects, in order to increase knowledge about protection against STI/AIDS in the female population and allow the consequent reduced risk of contamination in women. Therefore, the objective was to assess the knowledge of women about prevention, transmission and perception of vulnerability to STI/HIV.

METHODOLOGY

It is a "before and after" research, descriptive, with quantitative approach. The convenience sample, from the approach on demand in the service, consisted of 30 users of an integrated USF, in the city of João Pessoa-PB, Brazil, over 18 years and who had initiated sexual life.

Data collection was conducted in February 2014, through individual approach to women in the waiting room, who responded to the proposed questionnaire before and after attending educational activity, through dialogued exposition of the main sexually transmitted infections with definitions, transmission and prevention, including HIV. Multimedia technology was used to facilitate the women's understanding about the issues.

The questionnaire involved social-demographic questions, sexual/reproductive history, lifestyle, prevention and transmission of STI/HIV, and perception of vulnerability to these disorders. It is important to notice that, in the instrument, some questions use the word "AIDS" instead of "HIV", precisely to facilitate the women's understanding, given that the first term is more widespread in common sense. During the pilot tests conducted with 10 women, who were not part of the final sample, it was explicit the need to modify this terminology to better adjust the questions to the participants' context.

After delivering the responded instrument, only an individualized educational activity was performed, with an average duration of 15 minutes, especially focusing on the investigated object. Immediately after the action, a new instrument was given, with the same questions. Then the questionnaires before and after the educational intervention were analyzed and compared.

The data were stored, compiled and analyzed with the help of SPSS (*Statistical Package for Social Sciences*), version 20.0. A descriptive analysis and correlations between the variables were performed, and presented as frequencies and percentages. For associations, the Chi-square test was used, comparing the pre and post-educational intervention. A confidence interval of 95% was assigned, with a significance level of 5%.

The research is in accordance with all the criteria established in Resolution 466/2012[9], which deals with human research. The research was submitted to the Research Ethics Committee of the Health Sciences Center (CEP/CCS/UFPB), and approved with CAAE number 25593013.7.0000.5188.

RESULTS AND DISCUSSION

The study participants were found in the age group between 18 and 49 years (mean = 29.93 years, SD = 9,366), 24 (80.0%) were classified as pardo/mulatto/brown, 16 (53.3%) have primary education (43.3% incomplete and 10% complete),

11 (36.7%) live in stable union, 26 (86.7%) claimed to be Catholic, 14 (46.7%) reported survive with a monthly income between one and two minimum wages.

The social-demographic characteristics are important variables to be considered, as they can influence on life habits of a population. These data show that most respondents belong to a less favored economic class, that is, low socioeconomic class, considering the subnormal agglomerates where they live.

Regarding education, as the women users of the study's USF reside in subnormal agglomerate, the 2010 census explained that only 1.6% of the population living in this locality has completed higher education, whereas this percentage in other urban areas reached 14.7%(10). Social-economic inequalities and the deficit in access to education and health services in our country are configured as structural vulnerability related to STI/AIDS[11].

The age at first intercourse ranged from 13 to 28 years, and 19 (63.4%) women were at the age group from 13 to 17 years. It is observed that most of them had sexual intercourse before mature age, showing the precocity of the first sexual intercourse. Starting sexual life earlier has become a reality among young people; perhaps the sexual appeal conveyed through the various media, in intense and commonplace ways, contributed to this practice.

According to a study published in 2009 about this issue, conducted with 3,822 women over 17 years in 13 Brazilian cities, participants living with HIV/AIDS had first sexual intercourse earlier compared to those who did not live with the disease, showing that early first sexual intercourse can increase the risk of infection[12].

Table 1. Distribution of the variables related to sexual habits of the participants. João Pessoa, PB, 2014

Variables (n=30)		N	%
Use of preservative in the first sexual intercourse?	Yes	10	33.3
	No	20	66.7
Pregnancy	Yes	26	86.7
	No	04	13.3
Unplanned pregnancy	Yes	18	60.0
	No	08	26.7
	Not applicable	04	13.3
Sexual partner	Constant partner	22	73.3
	Casual partner	02	6.7
	No partner	06	20.0
Use of contraception method?	Yes	15	50.0
	No	15	50.0

It is found that, among the interviewees, 20 (66.7%) said they had used condom at their first sexual intercourse, 26 (86.7%) have ever been pregnant and 18 (60%) had at least one unplanned pregnancy. Exacerbating this problem, 15 (50%) participants reported not using any contraception method in their sexual relations.

In addition, 22 (73.3%) women had steady relationship at that time. During the interviews, some reports of women who claimed to have stable relationships and/or lasting with their partners were heard, and, therefore they did not use condoms in their sexual relations. However, despite not protecting themselves, many of them also claimed not trusting their partner and recognized their susceptibility to STIs, but could not negotiate the use of contraception method with them.

The great male influence over the historical process related to condom use has forced women to occupy a position of submission in the marital relationship[6]. Due to the restriction of the use of male condoms, depending on the partner to use them, the right of women to free choice and autonomy is affected by their partner's refusal of using it[8].

Given this limitation, the right to free choice and autonomy of women becomes diminished or non-existent, so that women take risks in sexual intercourses when accepting this refusal. The problem points out that the cultural issue is very strong in Brazil, whose female connivance to the risk is an obstacle to change sexual behavior of collectivities.

Among women using any contraception method, six (42.85%) used pill, four (28.57%), the injectable contraceptive, three (21.42%) used a condom, and one (7%) did not mention the method. What is observed is that only 50% of the participants reported using contraception methods, using effective methods in preventing pregnancy, but not exempting them from acquiring any STI, maintaining the vulnerability to illness.

It is important to notice that using contraception methods that do not depend on the partner points out the relationship between the problems involving the STI and gender relations in which women use methods that, given the possibilities, are within their autonomy, consolidating the dependency of women to the partner's concerning using condoms.

That said, a descriptive study, conducted with pregnant women living with HIV receiving care at a university hospital in Brazil, found that the Family Planning proposed in the country is not followed to the letter, because the women became pregnant in apparent vulnerability, not consciously sticking to the program. In other words, the surveyed group did not use condoms to prevent pregnancy, either to reduce cycles of contamination by the disease[13].

Although there are peculiarities in each research, both the research with pregnant women as this study show a similarity: women are/were exposed to the risk of contamination and/or perpetuate the AIDS epidemic from non-conscious use of condoms.

When asked about the sources of information about STI/AIDS, only 11 (36.7%) said they had heard through health professionals. It is worth mentioning that, during the study, it was noticed that many women had questions about the subject. Nevertheless, many do not account for the professionals, it is unknown whether for shame or lack of a bond of trust.

Thus, nurses should use the workplace as a place to develop strategies to promote dialogue and interaction with users, taking into account beliefs, values and customs that surround the population's context of life[11].

Regarding the transmission of STIs by using intimate objects of other people, such as underwear, towels and soap, as well as through contact with contaminated blood, knowledge increased after the intervention ($p<0.05$). Although there was no significant difference, the number of women who claimed not knowing the transmission was reduced to zero, suggesting that the intervention was positive (Table 2).

Table 2. Women's knowledge about STI and perception of vulnerability before and after the educational activity. João Pessoa, PB, 2014.

Variables (n=30)	B(N)	B(%)	A(N)	A(%)	*p*
STI Modes of transmission					
Via sex without condoms	28	93.3	29	96.7	0.933
By using intimate objects*	15	50.0	25	83.3	**0.021**
Contact with contaminated blood	22	73.3	25	83.3	**0.011**
From mother to child**	18	60.0	25	83.3	0.304
I don't know	02	06.7	0.0	0.0	---
STI Mode of prevention					
Using condoms in all sexual intercourses	28	93.3	30	100	---
Using contraceptives	03	10.0	02	6.7	0.193
Being vaccinated	10	33.3	18	60.0	0.117
Sex with a single partner	16	53.3	11	36.7	**0.002**
Not using intimate objects * of other people	19	63.3	25	83.3	**0.003**
Not sharing needles and syringes	20	66.7	23	76.7	**0.002**
Perception of vulnerability to STI					
Yes	12	40.0	21	70.0	0.106
No	12	40.0	05	16.7	0.106
Don't know	06	20.0	04	13.3	0.106
Vulnerability degree					
Extremely vulnerable	03	10.0	01	3.3	**0.020**
Very vulnerable	02	6.7	04	13.3	**0.020**
Moderately vulnerable	04	13.3	07	23.3	**0.020**
Little vulnerable	05	16.7	12	40.0	**0.020**
Not vulnerable	02	6.7	01	3.3	**0.020**
Don't know	14	46.7	05	16.7	**0.020**

With regard to forms of prevention, there was a significant association ($p<0.05$) between the variables: sex with only one partner, not using intimate objects of others and sharing syringes and needles. As for vaccines for prevention, although there was no significant difference, there was an increase in the index of women who recognized the vaccines to prevent HPV and Hepatitis B (Table 2).

Also with respect to STIs, when asked: "Can you inform at least one characteristic of some STIs listed below?", 10 (33.3%) participants were able to relate any symptoms to their respective disease. After the intervention, 26 (86.7%) women did this correlation, demonstrating the effectiveness of the educational strategy.

According to a study with homeless adolescents, inadequate knowledge about STI/AIDS led to increased vulnerability to health problems. Adequate knowledge on a particular disease is essential for the adoption of preventive measures, since knowing how to relate the existing types of STI and its features is an effective way of building knowledge[11].

For the item "Do you consider yourself vulnerable to contracting a STI?", the number of women who reported vulnerability after the activity nearly doubled. This finding is important because perception can influence behavioral change and, thus, reduce the exposure to the risk of contamination.

According to Table 3, after the intervention, it became clear that Aids is a disease that affects the immune system. Regarding the modes of transmission, there was an increase in knowledge about the mother-to-child transmission during pregnancy, childbirth and/or breastfeeding, sex with multiple partners, using pliers and sharp objects ($p<0.05$), showing that these information could have not been well disclosed.

With regard to forms of prevention, vaccination and having relationships with a single partner showed reduction after the intervention. These data strengthen the educational role of the health professional, steadying him as the agent responsible for sharing knowledge necessary to adopt good health habits (Table 3).

As for the cure, the number of women who understood that there is still no cures for AIDS increased. Despite being a widely publicized issue in the media for decades, there are still people who do not assimilate basic information about a disease so common in the country.

Concerning vulnerability, after the intervention, it was noticed that many have come to better understand the concept of vulnerability, but some also said they do not consider themselves vulnerable. A significant increase in the category "a little vulnerable", indicating that some have come to realize their vulnerability, even still considering it small, verifying that the educational action sparked reflection on sexual behavior.

Considering the situation of the AIDS epidemic in women, there are some aspects that make them vulnerable to contamination, such as social status, access to education and information, health and guarantee of respect for human rights[14]. However, even if the subject recognizes the forms of infection and the mode of prevention of STI/HIV, not all of them apply this knowledge for protection and, thereby, increase their vulnerability[11].

During the interviews, many women, despite recognizing that condom use is one of the main measures for the prevention of STI/HIV, were in doubt to answer this question. Thus, although they realize they have a risk behavior, they do not admit they can get infected by STIs/HIV.

It was also noticed that those who answered "yes" about the vulnerability to STIs do not always answered "yes" in the question about AIDS. This leads to think over the reasons that may make them feel vulnerable to STIs, but not to HIV, since they have the same main mode of transmission. Perhaps the term "AIDS" generates an unconscious fear, causing the woman to deny her vulnerability. Although a stigmatized illness, treatment is available, enabling quality living for many years.

The vulnerability is strongly related to the influential role of man in the choice and effective use of contraception methods[15]. Educational activities must be based on techniques that contribute to the subject to be able to carry out meaningful learning[16].

Health education activities should not be isolated, but part of everyday life for all involved[16]. Education is a fundamental variable to explain the transformation of phenomena related to reproductive health. It is an important step for the

conservation and recovery of the health of individuals and communities[17].

Table 3. Association of the variables regarding the women's knowledge about Aids before and after the educational activity. João Pessoa, PB, Brazil, 2014. (n=30)

Variables		B(N)	B(%)	A(N)	A(%)	*p*
What is Aids?						
A disease that affects the immune system		08	26.7	15	50.0	**0.018**
A sexually transmitted disease, with a difficult treatment		20	66.7	23	76.7	0.429
An incurable disease transmitted via sex and blood		16	53.3	23	76.7	0.143
A disease of those unaware of prevention		07	23.3	05	16.7	0.068
A homosexual disease		01	3.3	04	13.3	0.133
I don't know		02	6.7	01	3.3	0.933
How can Aids be transmitted?						
Sexual intercourse without condoms		29	96.7	29	96.7	0.967
Contact with contaminated blood		24	80.0	25	83.3	0.254
Shared needles and syringes		25	83.3	28	93.3	0.310
Having sexual intercourses with various partners		23	76.7	22	73.3	**0.007**
Blood transfusion		17	56.7	22	73.3	**0.005**
Sharing bath soaps, towels.		02	6.7	07	23.7	0.469
From mother to child *		19	63.3	22	73.3	**0.015**
Nail pliers and needlestick objects		19	63.3	16	53.3	**0.000**
Tableware, dishes and cups/glasses of infected people		02	6.7	01	3.3	0.967
How to prevent Aids?						
Using condoms in all sexual intercourses		29	96.7	27	90.0	0.900
Using contraceptives		04	13.3	02	6.7	0.253
Being vaccinated		10	33.3	01	3.3	**0.033**
Having sexual intercourses with a single partner		15	50.0	09	30.0	**0.000**
Not using syringes, needles, sharp objects of other people		20	66.7	22	73.3	0.230
Avoiding close contact with infected people		01	3.3	04	13.3	0.867
Is there a treatment for Aids?	Yes	27	90.0	28	93.3	0.888
	No	01	3.3	02	6.7	
Does Aids have a cure?	Yes	03	10.0	02	6.7	**0.014**
	No	21	70.0	28	93.3	**0.014**
	Don't know	06	20.0	0	0.0	**0.014**
Do you think you're vulnerable to Aids?	Yes	10	33.3	17	56.7	**0.001**
	No	12	40.0	09	30.0	**0.001**
	Don't know	08	26.7	04	13.3	**0.001**
How much you think you're vulnerable?	Extremely	02	6.7	02	6.7	0.034
	Very much	02	6.7	03	10.0	0.034
	Moderately	04	13.3	04	13.3	0.034
	A little	04	13.3	09	30.0	0.034
	Not at all	05	16.7	02	6.7	0.034
	Don't know	13	43.3	10	33.3	0.034

Subtitle: (B): before the educational activity; (A): after the educational activity; (*): through pregnancy, child-birth and/or breastfeeding.

FINAL CONSIDERASTIONS

The educational intervention carried out in the waiting room through this study was able to generate significant increase in knowledge of the unit's users about STI/AIDS. This highlights the importance of such practices to be routinely performed by professionals as a form of health promotion strategy and disease prevention, although in the long term.

A socializing and participatory environment, based on the needs of specific groups, involving health professionals, strengthen the role of this as an educator and responsible for health promotion interventions agent. Health education is still a challenge because, for it to be effective, must be able to transform attitudes and behaviors.

Not always knowledge is a guarantee of more responsible sexual behavior. One must think of actions aimed at greater adherence to safe sex practices. Changing attitudes is generated from the internalization of awakened sense of responsibility and assumed by the individual, not by imposition or obligation. So while the educational activities carried out has resulted in satisfactory answers, we still need to go further, raise major flights in order to promote health.

From the results of this research it is suggested that health education practices, as part of the systematization of nursing care, are constantly reevaluated so that the health professional identify intervention needs, contributing not only to reduce the incidence of STI/AIDS, as well as for the emancipation of the individual, favoring the development of accountability for their own health.

CONHECIMENTO DE MULHERES SOBRE IST/AIDS: INTERVINDO COM EDUCAÇÃO EM SAÚDE

RESUMO

O objetivo deste estudo foi avaliar o conhecimento de mulheres sobre prevenção, transmissão e percepção de vulnerabilidade em relação às Infecções Sexualmente Transmissíveis (IST) e Síndrome da Imunodeficiência Adquirida (AIDS). Trata-se de um estudo "antes e depois", descritivo, de abordagem quantitativa, envolvendo 30 usuárias de uma Unidade de Saúde da Família Integrada de João Pessoa-PB, maiores de 18 anos, com vida sexual iniciada. A coleta dos dados foi realizada em fevereiro de 2014 por meio da abordagem de mulheres na sala de espera, que responderam à entrevista antes e após a intervenção. Os resultados foram analisados e comparados utilizando o teste Qui-Quadrado. A educação em saúde contribuiu significativamente para o aumento do conhecimento das participantes e da sua percepção de vulnerabilidade a respeito de IST/AIDS. Porém, nem sempre este conhecimento produz mudança de atitude e comportamento, fazendo-se necessário que o enfermeiro reconheça a importância das práticas educativas em seu cotidiano, não só para a redução da incidência de IST/AIDS, como também para a emancipação do indivíduo, favorecendo o desenvolvimento do sentido de responsabilidade por sua própria saúde.

Palavras-chave: Conhecimento. Mulheres. Doenças Sexualmente Transmissíveis. Educação em saúde. Enfermagem.

CONOCIMIENTO DE MUJERES SOBRE ITS/SIDA: INTERVINIENDO CON EDUCACIÓN EN SALUD

RESUMEN

El objetivo de este estudio fue evaluar el conocimiento de mujeres sobre prevención, transmisión y percepción de vulnerabilidad con relación a las Infecciones de Transmisión Sexual (ITS) y el Síndrome de la Inmunodeficiencia Adquirida (SIDA). Se trata de un estudio "antes y después", descriptivo, de enfoque cuantitativo, involucrando a 30 usuarias de una Unidad de Salud de la Familia Integrada de João Pessoa-Paraíba-Brasil, mayores de 18 años, con vida sexual iniciada. La recolección de los datos fue realizada en febrero de 2014 por medio del abordaje de mujeres en la sala de espera, que respondieron a la entrevista antes y después de la intervención. Los resultados fueron analizados y comparados, utilizando la prueba de chi-cuadrado. La educación en salud contribuyó significativamente para el aumento del conocimiento de las participantes y de su percepción de vulnerabilidad con respecto a ITS/SIDA. Sin embargo, ni siempre este conocimiento produce cambio de actitud y comportamiento, haciéndose necesario que el enfermero reconozca la importancia de las prácticas educativas en su cotidiano, no solo para la reducción de la incidencia de ITS/SIDA, sino también para la emancipación del individuo, favoreciendo el desarrollo del sentido de responsabilidad por su propia salud.

Palabras clave: Conocimiento. Mujeres. Enfermedades Sexualmente Transmisibles. Educación en salud. Enfermería.

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Submitted: 30/03/2015
Accepted: 16/05/2016