ORIGINAL ARTICLE *DOI: 10.4025/cienccuidsaude.v17i2.41493*

THE SEXUAL HEALTH OF MENTALLY CHALLENGED WOMEN: BREAKING TABOOS

João Nunes Maidana Júnior*
Diogo da Rosa Viana**
Débora Schlotefeldt Siniak***
Jussara Mendes Lipinski****

ABSTRACT

The main purpose of this study was that of getting to know the perception of mentally challenged women with regard to their sexual health. This is a descriptive and qualitative field study, carried out at a CAPS II (Centre for Psychosocial Care II) on the western frontier of the Brazilian state of Rio Grande do Sul. Eight women diagnosed as having some mental disorder, aged over 18 and with an active sex life, were interviewed. The data was collected in April 2017, by means of an interview with a semistructured outline. The women showed some awareness of what sexual health actually is. Out of all contraceptive methods, the injectable contraceptive was reported to be the most used. The women were able to identify that they were in a situation of vulnerability, and knew the risks to which they were exposed when indulging in unprotected sex. The women who participated in this study also showed awareness of the risks of HIV/AIDS but showed poor knowledge of the other illnesses. It was also identified that the non-use of barrier contraceptives was closely linked to loyalty to their partners, and also to the partner's refusal to use them.

Keywords: Mental health. Sexual health. Mental disorders.

INTRODUCTION

The process of Psychiatric Reform appeared as a change in paradigm, within the sphere of care for people with some kind of psychic suffering. The different transformations that took place in the field of mental health resulted in the deconstruction of the mental home structure and a resulting reorientation of the care model[1].

Out of all the services provided by the Network for Psychosocial Care, we highlight the establishment of the Psychosocial Attention Centres – CAPS, which now play a leading role for the implementation of the Psychiatric Reform. The CAPS are places that provide medical and psychosocial care for people with some kind of psychic suffering, while seeking social and family integration, and working towards the construction of the autonomy of the users[2] . Even though the current purpose of the CAPS is based on an entire approach, the aspects concerning sexual health are often neglected within the daily activities of mental health care.

In this regard, we understand that the concept of sexual health is closely linked to the perspective of the expanded clinic, where the subject is understood well beyond the realm of the disease, occupying different spaces in society. This means that mental health care, as well as co-responsibility, seeks empowerment, autonomy and self-esteem of these women.

In this way, sexual health is men's and women's skill to enjoy and express their sexuality, without any risk of getting Sexually Transmitted Infections (STIs), or of unwanted pregnancies, or suffering any kind of coercion, violence or discrimination. This allows the person to have a well-informed, pleasant and safe sex life, based on self-esteem, which means the need for a positive approach to human sexuality and mutual respect in sexual relations[3].

Here we also point out that the concept of sexuality is closely linked to the definition of sexual health, but is also composed of different forms of knowledge, as sexuality is often viewed as a cultural expression, constructed throughout life, and is marked by history and culture, expressing itself in a unique way in each individual person[4]. In contrast, sexual health addresses issues that are wider in scope, because, apart from the subjective issues concerning each person individually, there is also the prioritisation of the building of awareness in such people, with regard to experience of sexuality in a satisfying and safe manner, without any surprises in the form of illnesses.

In this regard, the relevance of the investigation is that it enables one to meditate about sexuality and its concepts in the qualification of the nurse, allowing the

*RN. Graduated from the Federal University of Pampa. Uruguaiana, RS, Brazil. E-mail: juniordana@hotmail.com
**RN. Gratuated from the Federal University of Pampa. Uruguaiana, RS, Brazil. E-mail: diogoviana95@yahoo.com.br
***RN. MSc, Professor at Federal University of Pampa. Uruguaiana, RS, Brazil. E-mail: debynha33@hotmail.com
**** RN. PhD, Professor at the Federal University of Pampa. Uruguaiana, RS, Brazil. E-mail: jussaralipinski@gmail.com

identification of the importance of this issue in the practice of promotion and education in the health area, and about the reproductive rights of men and women[5].

In the light of the points here mentioned, this study seeks to get to understand the perception of women with mental disorders, about their sex lives.

METHODS

This is a descriptive and qualitative field study, carried out at a CAPS II (Centre for Psychosocial Care II) on the western frontier of the Brazilian state of Rio Grande do Sul. This location was selected as a field for research, as it provides care offered by a multiprofessional team with individual appointments and educational lectures for exclusive care for people who diagnosed as living with some kind of "mental disorder".

The participants in the study were taken by the professionals responsible for the service, and were invited to collaborate with the study. After, there was the first contact between these women and the researchers, who provided clarification about the purposes of the research survey. The study included eight women who had received medical diagnosis of some kind of mental disorder, aged over 18 and with an active sex life. There was also the exclusion of women who had difficulty in understanding the purposes of the study, or who had verbal expression difficulties that would prevent any communication in order to answer the questions as raised. To make sure of anonymity, the women who responded were identified with the letter W (for woman) followed by a number from 1 to 8, according to the order in which the interviews were carried out.

The data was collected in April 2017, at the CAPS II, which at that time provided an appropriate location for conducting the interviews, allowing privacy of the statements made. The survey used a semistructured interview outline with 20 questions covering general aspects of sexual health, such as: contraception; STIs; and ways of gaining access to information about sexual health. Each interview lasted for some 20 minutes.

The analysis of the data was based on Bardin's Content Analysis, and occurred in three phases. The first phase, pre-analysis, was where the material was organised in order to make it operational, by systematising the initial ideas. In the second phase, there was the exploitation of the material, with the establishment of categories and the identification of registration and context units. The third phase was that of the treatment of results; and was where the condensation and highlighting of information were carried out, for a reflective and critical analysis[6].

The data were analysed with the perspective of bringing up, for discussion, the commitment of health care professionals, regarding sexual health of men and women, calling attention to women with mental disorders, faced with the need to discuss sexual and reproductive rights as part of the qualifications of the nurse.

While carrying out this study, all ethical aspects as set out by National Health Council (CNS) Ruling 466 of 2012 were followed. This ruling regulates research studies involving human subjects. The study got the approval of the Research Ethics Committee of the Federal University of the Pampa, with Opinion Statement No. 1,806,453/2016[7]. All participants in the study signed the Free Informed Consent Form (ICF).

RESULTS AND DISCUSSION

The eight women who participated in this study were aged between 22 and 57, and had an active sex life, in most cases with a fixed partner. Turning now to educational level, we see that most of the interview subjects had studied for up to five years. Women with many kinds of mental disorders were interviewed, these including: depression, intellectual disadvantage, schizophrenia, bipolar disorder, and different levels of intellect, thus allowing a heterogeneity of analysis of the themes here explored.

Based on the thematic analysis of the statements, the following categories emerged: 1) Discussion of sexual health, with women speaking out; 2) Repressed demand: exercising of sexual activity, the possibility of pregnancy, and preventive measures; and 3) Complexity of mental health care: about sexually transmitted infections and how the professionals approached the patients.

Discussing sexuality, with women speaking out

In this study, all the participants were in affective relationships. Some of the women had long-standing relationships, typically between 3 and 10 years long, while three women were in recent relationships.

The participants also mentioned involvement with CAPS users, a fact which nurtures the importance of discussing the issue of sexual health, it also being important to build awareness in the professional people who act in the area, sexual, so that they may be able to understand the sexuality of these women as being

something natural, and not just connected to the disorder or the intensification of psychiatric symptoms.

> I don't have a regular partner, I am on my own. Sometimes I go out with a guy here from CAPS, but it's nothing serious. (W3)

> I have a boyfriend and have been with him for 4 years. I met him here at CAPS. (W7)

> I have been married for 37 years. My husband comes to CAPS with me. (W8)

It is quite common for there to be relationships between users of mental health care services, and there is latent denial of the sexuality of these people, shown by the professional staff. Most of the staff considers such expressions as having arisen from "madness itself" meaning that, as such, they should be repressed, and about which the preferred attitude is that of silence and detachment[8]. In some cases, on addressing issues related to mental health, there is neglect of the possibility of there being any kind of loving or sexual involvement with and between these subjects, therefore denying their sexuality.

On being asked about the definition of "sexual health", many participants have associated this concept with that of living without sexually transmitted diseases, having sexual relations, and also the issues of companionship with the partner, showing a wider understanding of this concept.

> It is not just a matter of pleasure. Everything has to be fine, even health. (W1)

> Sexual health is taking care of your partner, using a condom, and going to the doctor. (W2)

> As I see it, sexual health is not catching any kind of VD. (W3)

> Sexual health is being partners, one taking care of the other, without hiding anything. (W4)

> Sexual health is having a lot of sex. (W5)

> I think sexual health is being clean, without any illnesses – and also knowing who you are having sex with. (W6)

> Sexual health is knowing about the illnesses, such as HIV. (M7)

With regard to reproductive health, no statements were made about this concept, showing that the people interviewed were not aware of this terminology. However, we must stress that, even though there may have been difficulty for the users to understand this concept, it is essential that health professionals be ready to address this issue at health services.

From this standpoint, we believe that having a talk about sexuality, with people who are mentally challenged, is a permanent challenge, due to the complexity involved in understanding just how much such disorders may affect the cognitive capacity of each person, as also the person's ability to establish relationships[9].

Even though the women have shown a wide analysis of what sexual health actually is, through their lives they have to tackle many different situations, such as a reduction of their sex drive (libido), either through the natural process of aging, or through the use of medication or contraceptives. This is confirmed by the following statements:

> I am unable to see sex as something important. (W3)

> There are so many things better than sex. (W5)

> After the age of 40, sex is no longer that important. (W8)

Therefore, the woman's health may, indeed, be jeopardised not only through physical and psychic changes, but also due to other factors that play a part in reducing the woman's self-esteem. Changes to the body, naturally expected in the aging process, also have an impact on the female self-image and therefore intensity psychic suffering and reduction of sex drive[10].

This makes it essential that health professionals acknowledge the situation experienced by each woman, so that they may help with the search for options, so these women may be able to rediscover themselves as people in their own right, and as protagonists in their lives.

Repressed demand: exercising of sex life, possibility of pregnancy and preventive measures

In this study, it was observed that most women had already been through the experience of pregnancy. One of them reported that she did not wish to get pregnant again, which shows good mastery of her reproductive planning, which reinforces the importance of the health care professionals showing respect for the patients' autonomy.

> I have six children, and now I do not want to get pregnant again. (W2)

> I have two children, a boy and a girl, they are really cute. (W3)

> I have a seven-year-old son. (W7)

> I have three children. I used to like getting pregnant, but not any more. (W8)

Pregnancy among women with mental disorders

must be analysed from at least two different standpoints. The first refers to the fact that, in general, this public also wishes to experience a pregnancy, like anyone else. The second involves the need for them to be included in family planning programmes so that they may, according to their possibilities and that of their families, plan their reproductive lives.

Pregnancy is a moment of transition for any woman, and any pregnancy involves some risk, whether normal risk or high risk, this latter classification also including pregnancies of women who have mental disorders that need monitoring[11].

The gestational risks in women with mental disorders may be made more serious as a result of the women's conditions of social and emotional risks; therefore it is important to implement specialised services that are appropriate for this population11. In order to help the women to live after this period, the professional people must prepare themselves to deal with the needs of different women, with different degrees of mental challenge.

In addition, pregnancy appears as a unique window of opportunities for the tracking of disorders in mental health. After all, this is a phase of life when the woman is present at the health service, which makes it possible to identify these problems and start treatment[12]. Here we highlight that this is also a golden opportunity for health care professionals to address all the special care related to sexual health, and also to carry out actions that seek to work on life expectations and dreams, including family planning, and contraception as available at the service, always respecting the desires and the individuality of each woman.

With regard to contraception, one interviewee used the Pill, and one said that she had had a tubal ligation, as can be clearly seen in the following statements:

> I have had my tubes tied, so I would not have any more children. (W3)

> I use Microvlar (a brand of Pill). (M5)

> I use an injectable contraceptive, as there is no way I can forget. (M7)

These findings are a warning to professional people, so that they may think about the participation of the woman in the choice of contraceptive method to be used, to envisage full and humanised care, respecting the autonomy of people. The use of contraceptive methods, even though it is common within the normal lives of women, still brings doubts among many women, with or without mental disorders.

It is also known that, for women who already have children, the more common recommendation is the use of permanent contraception, such as tubal ligation or tying uterine tubes[13]. However, it is also necessary that the women and/or the couples are informed of the purpose of the procedure, the risks involved, and its long-lasting effect, so that they may also think about it and choose the option that is best adapted to what they really want.

Through the statements made when asked about the methods of contraception that they knew, "the condom and the Pill" were those mentioned most often, as well as the Intrauterine Device (IUD).

> I only know about the Pill. (W2)

> The contraceptive pill is the only one I can remember right now. (W3)

> I know about the Pill and the IUD. (W7)

> Condoms and injectable contraception. (W8)

This result could be associated to the fact that these methods are the most popular and are more often available at health services. However, management personnel must work to make different contraceptive options available. It is also important that the health care professionals are aware of these possibilities, offer them to the women, and then help them choose the method that suits them best.

We can also see that, in the case of women whose partners use condoms, when asked about the frequency of use, all the women interviewed mentioned the occurrence of at least one episode of unprotected sex. In addition, two women reported that they never use a condom, as they only have one fixed partner, while others mentioned that the men with whom they have had sex did not approve of the use of condoms.

> There was one occasion when I had sex without using a condom. (M4)

> I never use, and have never used, a condom, as I trust my partner. (M5)

> I am not using a condom. They do not like to use it. (M6)

> No, I have had tubal ligation and have only one husband. (M8)

The findings of this study back up the findings of another study that reports that women show patterns of behaviour suggesting that they are somewhat dependent on their partners, and passive when it comes to caring for their own health. For example, they do not use condoms when having sex, in the name of trust

and the stability of the marital relationship[14].

A study performed on young people has shown that the fact that they have stable and long-lasting relationships was one of their main reasons for not using a condom. We also saw that negotiation of choice of contraceptive methods within the partnership is more difficult. Therefore, the use of condoms in stable relationships is understood as something irrelevant. However, this issue needs to be addressed by health professional, to stamp out stigmata and beliefs that make people prone to disease and unwanted pregnancies[15].

The results thus observed can be linked to cultural issues that mean that some women take on limited roles when deciding which contraceptive to use, particularly with regard to condoms. It is therefore important that health professionals discuss the importance of using a male or female condom, with a view to prevention of unwanted pregnancies, stressing that prevention is a responsibility of both sexes.

There is also the need for the construction of discourse arrangements that promote the equality of health care between men and women, based on health practices and on looking at women and their experience of sexuality, in a safe and pleasant manner[16].

Complexity of mental health care: on sexually transmitted diseases (STIs) and the approach used by professional people

Asked about STIs, all the women interviewed said that they were aware of AIDS, while only two mentioned syphilis as a sex-linked disease. This fact could be due to the historical issues behind these diseases, which are the most commonly addressed by professional people when they give lectures, generating greater knowledge and greater fear among women. It becomes clear that there are different ways to address prevention of STIs, which should not be based on fear, but rather on information and on the empowerment of women with regard to the choice of use of male or female condoms, which reduce prejudice and discrimination, while strengthening protection among both men and women[16].

On asking the interviewees what they knew about HIV, they all said that this pathology has no cure, but there is treatment available. One of the interviewees said that her awareness of the disease to family experience with diseases, and another said that there could be a cure through divine intervention.

> There is no cure, but for Jesus there is. And there is treatment. (W1)

> I am very much afraid of these diseases. My brother died of AIDS. (W3)

> They give lectures about this issue at CAPS. I know that AIDS does not have a cure. (W6)

> My husband's sister has AIDS. She got it from her boyfriend. (W7)

The women accepted that they were in a situation of vulnerability and knew the risks to which they were exposed during unprotected sexual relations, these being risks that they tried to reduce as much as possible, through frequent submission to quick testing.

> These diseases are very dangerous, and are bad for your health. I am always taking care of myself. (W2)

> Yes, I have already taken a test. Whenever there are these examinations, I always get tested. (W4)

> I am very much afraid of these illnesses. (W8)

These findings go against those of another research study carried out with young people, where these were not able to perceive that they were in a situation of risk for picking up HIV/AIDS15. With regard to the women interviewed, it became clear that they were afraid of disease, even though on some occasions they had had unprotected sex at least once.

The weakness of knowledge and awareness of syphilis and Human Papillovirus (HPV) was also observed in this study, as none of the participants was able to describe the characteristics of the disease, or even the ways in which one could pick up these diseases.

> I have already heard of these diseases, but I don't know anything about them. (W1)

> They have talked about them once, at CAPS, but I do not know much about them. (W2)

In this regard, we reinforce the need for the professional people to expand the publicity of information about other STIs, rather than focusing exclusively on HIV and AIDS, taking up wide-scope educational actions, which are effective in the improvement of early detection, and help to eliminate the specific mortality caused by syphilis . Sex life is inherent to human beings and, so that it may be lived to the full, must be associated with pleasure and with health. Educational practices must permeate the guidance, prevention of diseases, and the monitoring and treatment thereof. For this reason, health care must be focused on the woman, as also on her family and on the society in which she is inserted[18].

We observed that the interviewees had a gynaecological appointment on an annual basis; one had been seen to by a nurse, and the others by doctors. Even though they regularly sought medical care, we could see that some of the interviewees were ashamed to address their sexuality and the transmission of diseases, with the health professionals.

> Yes, here the "aunts" book appointments with the doctor. (W3)
>
> I go to the gynaecologist every six months. My mother died of breast cancer. (W5)
>
> Every years I am examined by the nurse. (W6)
>
> Ask the "aunts" at CAPS. I feel more at ease than I would with any doctor. (W1)
>
> I speak to my sister-in-law. I get very embarrassed. (W3)
>
> I always talk about my sex life with the nurse or with the doctor. (W4)
>
> I always sort out my doubts with my nurses. (W6)
>
> I don't ask anyone, I am ashamed to talk about my sex life. (W8)

Within the health system, there is a lot of discrimination, taboo and lack of preparation to deal with sexuality of people with mental disorders, with the professional people not accepting these women, thereby making entire health care impossible[19]. Only with dialogue would it be possible to demystify stigmata and prejudice, in order to lead to a more responsible and more holistic type of health care[20].

The statements made by the interviewees suggested that health professionals, nurses and doctors, play a key role in the promotion of the health of women who have mental disorders. However, for the health care to be effective, there is a need to update oneself about transformations in sexual and reproductive health, diseases, prevention and treatment, and also to review practices that do not include the specificities and autonomy of each interviewee, thereby breaking the taboos that insist on denying the sexuality of these women.

FINAL CONSIDERATIONS

The participants in the study understood the concept of sexual health and associated it with pleasant sexual practice and with living without ailments. It was also observed that the interviewees showed awareness and knowledge of the risks associated with HIV/AIDS and shortcomings in their understanding of other STIs. It was also observed that the non-use of barrier contraception was closely linked to the issue of loyalty to the partner, and to the fact that, in many cases, the partner did not accept the idea of using condoms. Turning to contraceptive practices, we see that it is necessary to rethink activities and services regarding reproductive planning, in order to get women informed and welcomed, with respect for their autonomy, so that they may choose whatever suits them best.

We also consider that the results of this study show a gap in mental health care, with regard to the promotion of health and prevention of diseases among the population investigated in this study. Finally, we believe that, despite its limitations, this study has indeed contributed for establishing the problems linked to an important issue that is still considered taboo, especially in the fields of social services and health care. We therefore stress the importance of new studies involving the sexual health and reproduction in people with mental disorders, so that the mental health care services reflect, and include in their daily activities, space for discussion and hearing, about the general issue of sexuality, thereby contributing to a level of care that considers the patient in his or her complexity.

A SAÚDE SEXUAL DE MULHERES COM TRANSTORNOS MENTAIS: ROMPENDO TABUS

RESUMO

Este estudo teve o objetivo de conhecera percepção de mulheres com transtornos mentais acerca da sua saúde sexual. Estudo de campo, descritivo, de abordagem qualitativa, realizado em um CAPS II na fronteira oeste do RS. Foram entrevistadas oito mulheres com diagnóstico médico de algum transtorno mental, maiores de 18 anos e com vida sexual ativa. A coleta de dados foi realizada em abril de 2017 através de entrevista com roteiro semiestruturado. As mulheres demonstraram algum conhecimento sobre o que é saúde sexual. Dentre os métodos para prevenção da gestação, o anticoncepcional injetável foi relatado como o mais utilizado. As mulheres identificaram que estavam em situação de vulnerabilidade e conheciam os riscos a que estavam expostas em relações desprotegidas.As mulheres participantes deste estudo demonstraram conhecimentos acerca dos riscos de HIV/Aids e indicaram fragilidades no conhecimento das demais doenças. Identificou-se, também, que a não utilização de preservativos de barreira estava associada à fidelidade ao parceiro e também à não aceitação do parceiro em usar.

Keywords: : Saúde mental. Saúde sexual. Transtornos mentais.

LA SALUD SEXUAL DE MUJERES CON TRASTORNOS MENTALES: ROMPIENDO TABÚES

RESUMEN

Este estudio tuvo el objetivo de conocer la percepción de mujeres con trastornos mentales acerca de su salud sexual. Estudio de campo, descriptivo, de abordaje cualitativo, realizado en un CAPS II (Centro de Atención Psicosocial) en la frontera oeste de Rio Grande do Sul - Brasil. Fueron entrevistadas ocho mujeres con diagnóstico médico de algún trastorno mental, mayores de 18 años y con vida sexual activa. La recolección de datos fue realizada en abril de 2017 a través de entrevista con guión semiestructurado. Las mujeres demostraron algún conocimiento sobre qué es salud sexual. Entre los métodos para prevención de la gestación, el anticonceptivo inyectable fue relatado como el más utilizado. Las mujeres identificaron que estaban en situación de vulnerabilidad y conocían los riesgos a los que estaban expuestas en las relaciones desprotegidas. Las mujeres participantes de este estudio demostraron conocimientos acerca de los riesgos de VIH/SIDA e indicaron fragilidades en el conocimiento de las demás enfermedades. También fue identificado que la no utilización de preservativos de barrera estaba asociada a la fidelidad al cónyuge y también a la no aceptación del compañero en usar.

Palabras clave: Salud mental. Salud sexual. Trastornos mentales.

REFERENCES

1. Ferreira TPS, Sampaio J, Souza J, Nascimento AC, Oliveira DL, Bezerra L. Produção do cuidado em Saúde Mental: desafios para além dos muros institucionais. Interface (Botucatu). 2017;21(61):373-384. doi: http://dx.doi.org/10.1590/1807-57622016.0139.

2. Ministério da Saúde (BR). Secretaria de Atenção à Saúde. Departamento de Ações Programáticas Estratégicas. Saúde mental em dados. Brasília, 2012.

3. Ministério da Saúde (BR). Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Saúde sexual e saúde reprodutiva. Brasília, 2013.

4. Silva MA, Capitao CG. Oficina de sexualidade, uma abordagem ampliada para se trabalhar com alcoolistas: relato de experiência. Rev. SBPH. 2011; 14(1):112-124. Disponível em: http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S1516-08582011000100007.

5. Figueiroa MN, Menezes MLN, Monteiro EMLM, Andrade ARL, Fraga DPF, Oliveira MV. A formação relacionada com a sexualidade humana na perceção de estudantes de enfermagem. Rev. Enf. Ref. 2017;(15): 21-30. doi: http://dx.doi.org/10.12707/RIV17044.

6. Urquiza MA, Marques DB. Análise de conteúdo em termos de Bardin aplicada à comunicação corporativa sob o signo de uma abordagem teórico-empírica. Entretextos. 2016; 16(1):115-144. doi: http://dx.doi.org/10.5433/1519-5392.2016v16n1p115.

7. Conselho Nacional de Saúde (Brasil). Resolução n o 466, de 12 de dezembro de 2012. Brasília, 2012.

8. Barbosa JAG, Souza MCMR, Freitas MIF. A abordagem da sexualidade como aspecto essencial da atenção integral de pessoas com transtornos mentais. Ciênc. saúde coletiva. 2015; 20(7):2165-2172. doi: http://dx.doi.org/10.1590/1413-81232015207.01792014.

9. Barbosa JAG, Souza MCMR, Freitas MIF. Violência sexual: narrativas de mulheres com transtornos mentais no Brasil. Rev Panam Salud Publica. 2015; 37(4-5):273-278. Disponível em: https://scielosp.org/pdf/rpsp/v37n4-5/v37n4-5a13.pdf.

10. Cavalcante AC, Silva RM. Experiências psíquicas de mulheres frequentadoras da rede pública de saúde em Teresina (PI, Brasil). Ciênc. saúde coletiva. 2011;16(4):2211-2220. doi: http://dx.doi.org/10.1590/S1413-81232011000400020.

11. Kassada DS, Waidman MAP, Miasso AI, Marcon SS. Prevalence of mental disorders and associated factors in pregnant women. Acta paul. enferm. 2015;28(6):495-502. doi: http://dx.doi.org/10.1590/1982-0194201500084.

12. Henriques T, Moraes CL, Reichenheim ME, Azevedo GL, Coutinho ESF, Figueira ILV. Postpartum posttraumatic stress disorder in a fetal high-risk maternity hospital in the city of Rio de Janeiro, Brazil. Cad. Saúde Pública. 2015;31(12):2523-2534. doi: http://dx.doi.org/10.1590/0102-311X00030215.

13. Di Bella ZIKJ, Bianchi AMHM, Araújo FF, Sartori MGF, Girão MJBC. Contraception and family planning at the extreme of reproductive life – climacteric. Rev. Assoc. Med. Bras. 2016;62(5):454-457. doi: http://dx.doi.org/10.1590/1806-9282.62.05.454.

14. Sehnem GD, Schmalfuss JM, Bonadiman POB, Pereira FW, Lipinski JM, Bogorni L. Gênero e sexualidade: influências na prevenção das dsts/aids e as contribuições para a enfermagem. Rev. Enferm UFSM. 2014;4(4):678-688. doi: http://dx.doi.org/10.5902/2179769212408.

15. Fontes MB, Crivelaro RC, Scartezini AM, Lima DD, Garcia AA, Fujioka RT. Determinant factors of knowledge, attitudes and practices regarding STD/AIDS and viral hepatitis among youths aged 18 to 29 years in Brazil. Ciênc. saúde coletiva. 2017; 22(4):1343-1352. doi: http://dx.doi.org/10.1590/1413-81232017224.12852015.

16. Sampaio J, Santos RC, Callou JLL, Souza BBC. He does not want it with condom and I want to protect myself: exposure of female adolescents to STD/AIDS in the semi-arid region of the Brazilian northeast. Saude soc. 2011 jun; 20(1):171-181. doi: http://dx.doi.org/10.1590/S0104-12902011000100019.

17. Lazarini FM; Barbosa DA. Educational intervention in Primary Care for the prevention of congenital syphilis. Rev. Latino-Am. Enfermagem. 2017; 25(2845). doi: http://dx.doi.org/10.1590/1518-8345.1612.2845.

18. Carvalho CFS, Brito RS, Medeiros SM. Contextual analysis of gynaecological care provided to women with physical disability. Rev. Gaúcha Enferm. 2014;35(4):114-117. doi: http://dx.doi.org/10.1590/1983-1447.2014.04.45335.

19. Detomini VC, Rasera EF, Peres RS. Sexualidade e saúde mental: vivências, serviços e estigmas. Rev. SPAGESP. 2016; 17(2):81-95. Disponível em: http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S1677-29702016000200007.

20. Sehnem GD, Ressel LB, Pedro ENR, Budó MLD, Silva FM. The sexuality in nursing care: removing veils. Cienc Cuid Saude. 2013; 12(1):72-79. doi: http://dx.doi.org/10.4025/cienccuidsaude.v12i1.16639.

Corresponding author: João Nunes Maidana Júnior. Rua Sete de Setembro, 1943 AP 402. Centro, Uruguaiana/RS, Brasil. E-mail: juniordana@hotmail.com

Submitted: 28/01/2018
Accepted: 29/06/2018