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Family planning nurses facing STI/HIV vulnerability: a descriptive study

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ABSTRACT

Aim: to disclose the perception of nurses working in family planning regarding the vulnerability to sexually transmitted infections (STI) of women who participated in this activity. **Method:** this is a descriptive and qualitative study that was carried out in a university hospital in Rio de Janeiro, involving nine nurses. Thematic content analysis was used. **Results:** nurses perceive women as vulnerable as a result of gender inequalities, manifested by their sole responsibility for protection against STIs and contraceptive measures, lack of partner follow-up, and blame of women for unwanted pregnancies. Male domination was attributed to the fact that man wanted to determine the type of protection and/or contraception that would be used in sexual intercourse. In addition, they expressed the difficulty of these women to negotiate safe sex, especially in stable relationships. **Conclusion:** ISTs are still considered "diseases of the other", influenced by gender inequalities. Traditional family planning actions are not sufficient for the use of preventive measures.

Descriptors: Gender and Health; Health Vulnerability; Sexually Transmitted Diseases; Family planning.

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INTRODUCTION

Sexually transmitted infections (STIs) are among the most common public health problems in the world, and they increase the chances of being infected by the human immunodeficiency virus (HIV)[1]. Data from the World Health Organization[2] estimate that more than one million people worldwide get an STI every day. It is estimated that 357 million people become infected each year with one of the curable STIs (gonorrhea, chlamydia, syphilis and trichomoniasis). These infections are recurrently diagnosed, have multiple etiologies and clinical presentations. They can have a great impact on the quality of life, and on the personal, family and social relations of patients[1].

Among STIs, HIV is relevant because of the repercussions it has on those infected. Despite reaching a considerable share of the global population, new cases of infection have been declining in much of the world, down 6% since 2010. By 2016, the total number of people living with HIV was 36.7 million, and 1.8 million new cases of people infected with HIV were registered worldwide[3].

Increased access to antiretroviral therapy has contributed to a 48% decline in the number of deaths due to acquired immunodeficiency syndrome (AIDS) since 2005. By 2016, 1 million people died of AIDS complications worldwide[3].

In Brazil, the HIV epidemic is considered stable. From 1980 to June 2015, 798,366 AIDS cases were registered in the country. The annual average number of cases of the disease in the last five years was 40,600[1].

The latest available data[4] on HIV infection show that, globally, 50% of all infected people are women. Data show that there are about 380,000 new HIV infections each year in women aged 10-24 in the world. It is noteworthy that, in general, new infections are declining in women, but this occurs disproportionately in young women.

A considerable number of cases of HIV infection are detected in women during the gestational period. In Brazil, from 2000 to June 2016, 92,210 HIV-infected pregnant women were reported, most of them living in the Southeast region (40.5%), and the lowest part of the Central West Region (5.7%)[3].

STIs in pregnant women can cause maternal suffering, in addition to abortion, preterm birth, fetal death, congenital diseases, and even death of the newborn[5].

Vertical transmission of HIV, passing the virus from the mother to the child, can occur during pregnancy, childbirth or breastfeeding. When no prophylactic measures are performed, the infection rate ranges from 25% to 30%. If all recommended measures are carried out, the percentage of transmission is reduced to less than 2% of all cases[5].

In 2016, overall, 76% of pregnant women with HIV had access to antiretroviral therapy to prevent vertical transmission. In this period, a 47% decrease in the number of new cases of infection in children since 2010 was observed[3].

In addition to the magnitude of the data, one must reflect on social and cultural issues concerning women who contribute to the infection. Thus, in view of this panorama and the need to raise awareness in terms of the importance of the use of protective behaviors by women, family planning activities can be effective tools for reducing female vulnerability. This service should not only offer contraceptive methods or techniques for design. It also implies the inclusion of sexual health care actions in various periods of the life cycle of women. In this sense, basic care should guarantee actions based on the reception and development of educational practices that include prevention of STI/HIV[6].

In this context, the objective of this study was to reveal the perception of nurses working in family planning regarding the vulnerability to sexually transmitted infections of the women who participated in this activity.

METHOD

This is a descriptive study, using a qualitative approach, carried out in a prenatal service, of a university hospital located in the city of Rio de Janeiro. In this sector, family planning activities, in which pregnant women are invited to participate in four weekly meetings led by nurses, are carried out. The topics covered follow the guidelines of the Ministry of Health and the STI/HIV issue is discussed on the last day of meeting.

The participants in the study were nine nurses who developed family planning workshops at the prenatal outpatient clinic. Nurses who were on vacation or leave and those who worked in the prenatal clinic exercising another type of activity were excluded from the study.

The study complied with all the requirements of Resolution 466/12 of the National Health Council, which deals with research involving human beings. Authorization was requested to carry out the research to the person in charge of the prenatal service outpatient clinic through the Declaration of Science. The project was submitted for approval and was approved by the Research Ethics Committee of the State University of Rio de Janeiro (Opinion no. 1053450).

Semi-structured interviews were conducted during the months of May and June 2015, and all participants read and signed the Informed Consent Term (TCLE). The interviews were carried out in a reserved place and recorded in an electronic device of Media Player 4 until the saturation of the data. After the collection, the statements were transcribed in full and were analyzed according to the assumptions of content analysis according to Bardin. The coherent applicability of the method must be based on the organization of the different phases of the content analysis, which consists of three poles: pre-analysis, material exploration and treatment of results - inference and interpretation[7].

RESULTS

The data were analyzed and grouped into a category called "Realizing women who attend family planning as vulnerable due to gender inequalities", which will be presented and discussed below.

Realizing that women who attend family planning are vulnerable due to gender inequalities

From the actions developed in the workshops, nurses perceive women who attend family planning as vulnerable to STI/HIV. They consider this to be due to gender inequality, characterized by women's exclusive responsibility for protection against STIs and unplanned pregnancies, and lack of follow-up of partners during consultations and health education activities.

Male domination was evident in the interviewees' statements, in the sense that men want to determine what the protection and/or contraception of sexual relations will be. They believe that they feel like the "alpha male", who protect the love relationship and that women are more fragile and vulnerable. These facts contribute to the imposition of women and make them feel powerful and sovereign in decision making.

> (...) in the sense that man generally tries to impose, in some way, what this contraception or protection will

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> be like (...).Most of them say that it is a woman's responsibility because she did not protect herself and because she wasn't careful enough. So, in that sense, I think the responsibility ends up being a burden on the woman's shoulder. Many men do not take this responsibility. (E2)

> (...) men always have that vision of being stronger, women are always the most fragile, so men end up thinking they have power over women, and their will is sovereign. (E3)

> Yeah, I believe that man is the "alpha male." He wants to protect the relationship, so I think that's what they think. (E4)

The interviewees also expressed the perception of the lack of follow-up of the women's partners in these meetings and prenatal consultations. In their view, they think that this does not require their participation.

> (...) we call on women's partners to join the groups, but many won't (...) pregnant women attend meetings more than their partners. (E2)

> First, there is the fact that they come without the companion. Family planning is for the couple and most women go there alone. (E3)

> We realize it all the time (...) few men accompany; only women go there. (E1)

The interviewees also point out that the partners of women participating in family planning activities do not want to use condoms and women accept it even after the educational actions. According to nurses, the women say that their companions do not accept it because they do not like it; they say men use expressions such as "it's like sucking candies with the paper". Thus, machismo emerges once again in the nurses' discourse, and expresses the difficulty of negotiating safe sex on the part of women.

> (...) the partner says that it's bad, that he uses several phrases, like: "it's like sucking candies with the paper", then they show, on that side, that they don't want to use it because of their partner. (E2)

> Sometimes women want to protect themselves, they want to have a safer relationship, but men don't accept it, right? They want to be sovereign in their opinions. (E3)

> (...) men end up laying down some rules for the women, and the women end up agreeing for being in a relationship. They (the women) end up being submissive to them, right, to their impositions. (E9)

Nurses perceive difficulties regarding the use of the male condom in the love relationships experienced by women who attend family planning. They report that many of these women make excuses not to use it, saying that they are not sexually engaged because of advanced pregnancy, they find it difficult to handle and place it, feel embarrassed, uncomfortable, and also they also say they have allergies.

> (...) they make up an excuse, you know? They say, "Oh, this is because I'm not doing it," "Because this pregnancy is

> advanced", "Oh, because it's hard to put it", "oh, because I was ashamed", (...) the vast majority do not use it, even when we give it to people, providing it as part of the planning process. (E6)

> They said it was not cool because it was uncomfortable to use the condom. Some people said that they had allergies, that they thought they had allergies, because they itched after use, which was not cool, you know? They even used some dirty words (laughs). (E9)

From the nurses' point of view, most women, who attend family planning and are in a stable relationship, do not use condoms. The interviewees pointed to the fixed/stable partnership as the main factor of this vulnerability.

> I think that when the relationship is stable, as in the case of a very long marriage, for example, hardly one of them believes he can get any illness... (E2)

> (...) "But will I use a condom with my husband? I have been married for so long.", whatever. (E8)

> That's what we saw most of the time, you know? In most reports, the condom was not used because it was a stable relationship. (E9)

The professionals verbalize that these women, who live stable relationships, do not consider themselves as belonging to risk groups. Nurses point out that, for these women, the disease is the others'. Therefore, women believe that they do not need to protect themselves because they consider themselves outside the risk of being contaminated.

> (...) This is because you don't know who your partner is relating to, that is, if he has other extramarital relationships; because a stable relationship does not guarantee that your partner is faithful to you. (E4)

> But I think in the minds of women, in general, there is still a lot of it; that in the stable relationship you are not in the group considered at risk, you know, as if you were out of risk of contracting the disease. (E7)

Respondents also revealed that women's reliance on their partners for being married or living together for a long time makes them vulnerable to STI/HIV and are often surprised by the long-term infection with the same partner.

> (...) What happens is that many women with 20 years of marriage, for instance, get surprised by HIV. (E2)

> (...) we never know (...) although the relationship is stable, it does not mean that the husband has not had other women. (E3)

> (...) I think that, because of this trusting thing, of thinking that it will not happen with them, I think that's what made them vulnerable, you know? They think like "oh, I have only one partner." I think that that's why they did not take care of themselves; I think it was related to that. (E5)

The nurses assume that the presented situations, added to the fact that the women experience a stable relationship, influence the non-use of preventive measures for STI/HIV.

DISCUSSION

The idea of holding women accountable only for STI protection and contraception historically refers us to culturally diffused gender roles. Even if the role assigned to women as responsible for contraception prevails, this does not mean that they have autonomy in decisions. They are directed towards the partners' wishes, especially regarding the use of condoms[8].

Culturally, gender inequalities are imposed and permeate the context of female vulnerability. Hegemonic patterns of male and female gender behavior remain, with male power predominating over women[9-10]. Women are devalued after the onset of sexual life and when they have several partners, men, in turn, are honored for these same reasons. In addition, those who violate these standards suffer from group repression due to moral control[10]. The idea that men are the providers and represent the sexual power validates this way, the macho values and the negotiation of the condom[10]. Added to this, the view of women as passive and dependent beings contributes to their vulnerability to the STI/HIV epidemic, since it is excluded from the power of decision and freedom over sexual life[11]. This situation was also discussed in a survey conducted in South Africa on the quality of the relationship, power and implications for vulnerability to HIV/AIDS[9].

In addition, the lack of follow-up of men to pregnant women at family planning meetings, prenatal consultations, and contraception was highlighted by nurses. A survey of women revealed that they feel helpless by partners because they cannot count on the partners' presence. They reported that women's partners prioritize work on family planning and the follow-up of prenatal partners. They also said that they do not notice their commitment to participate in the planning and construction of the family[8]. This inequality between the sexes is historical, a fact that shows the power of men over women in different generations, as well as their hegemony regarding the protection of women's health. In this way, the insertion of partners in family planning activities is of paramount importance. Strategies should be developed for sharing responsibilities and choices through dialogue[8].

In this context, the vulnerability of women is influenced by cultural aspects and social and economic exclusion processes to which they are exposed, factors that can be established as obstacles to their perception of risk to HIV infection[12]. Female behavior, coupled with the conditions of the natural and social environment in which they live, contributes to individual vulnerability, which is related to individuals' awareness of these behaviors and to the understanding and possible modification of behaviors after awareness[12].

The difficulty regarding the use of preventive measures by the women who carry out the planning workshops was reported by the nurses in a way linked to the gender inequality. Negotiations on safe sex are unfeasible when men have greater power over decisions in the love relationship[13-14]. Given that male condom adherence is greater among couples, it is necessary for women to be counseled and empowered to negotiate the use of condoms with their partners regardless of their socioeconomic or cultural conditions[12,14,15].

Research conducted in the United States of America states that the difficulty in negotiating safe sex is aggravated in relationships in which

decisions are not shared and women may experience various forms of sexual coercion, including persuading women not to use condoms by means of emotional manipulation, sabotage, and, even, physical aggressions. As a result, they are unable to negotiate safer sex and reduce their risk[13].

Women who are in a stable relationship attribute greater vulnerability to other women in the same marital situation because they do not use preventive measures. However, they perceive themselves as less vulnerable, since they are excluded from the group at risk of contracting STI/HIV. Such a situation can be understood as reflecting the gendered cultural inequalities in the society in which we live[16].

Women believe that dating or marriage is safe protective measures against the AIDS virus, a fact that has exposed their vulnerability to HIV. Thinking about the characteristics of the stable relationship, trust and the monogamy pact are often used to reduce risks[13,15-17].

Such an occurrence illustrates the idea of AIDS as an illness of the other, which infects only people with suspicious behavior or unstable marital status[16]. This data also brings the idea of stigma and prejudice related to the disease and its carriers[18].

Sexual health policies should be carried out by emphasizing the dissemination of information, accountability and empowerment of women. Such actions must be carried out by means of reception, sensitive listening and assistance, thus promoting conditions for the decisions to be made by them[19].

Thus, nurses play a fundamental role in the gender discussions that are present in family planning activities and in other instances of support to women. Thus, women can become active in decisions in terms of their own bodies and sexuality, impacting on reducing gender inequalities and, consequently, reducing vulnerability to STI/HIV.

CONCLUSION

In view of the results presented by the study, it became clear that nurses perceive women who participate in family planning activities as being vulnerable to STI/HIV. It is concluded that these infections are still considered diseases of the other, suffering strongly interference from gender inequalities. It is worth noting that, despite the educational actions, taken at family planning meetings by nurses, these are not enough for women to use preventive measures for STI/HIV.

In this way, it is important to highlight the importance of promoting family planning activities that go beyond birth control, with a focus on double protection. The reflection of women, especially those living in a stable relationship in terms of gender issues should be raised, sensitizing the negotiation of safe sex.

This study was carried out based on the perception of nurses working with family planning workshops in a certain region in Brazil and in a specific context. Thus, it is important to develop new studies on the topic addressed, expanding its scope from the inclusion of other health professionals who attend women, in different contexts, especially those of primary care, in order to deepen the theme and possibly reveal new perspectives on the subject.

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