



# Women's perception of their vulnerability to Sexually Transmitted Infections<sup>a</sup>

*Percepção de mulheres quanto à sua vulnerabilidade às Infecções Sexualmente Transmissíveis*

*Percepción de las mujeres de su vulnerabilidad a las Infecciones Sexualmente Transmisibles*

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## ABSTRACT

**Objective:** To analyze the perception of women regarding their vulnerability to sexually transmitted infections. **Method:** This is an exploratory and descriptive study with a qualitative approach, developed between August 2018 and October 2019, in a Primary Healthcare Unit. Eight women, aged between 21 and 44 years participated in the study with previous history of sexually transmitted infections. The data collected with semi-structured interviews were submitted to thematic analysis proposed by Bardin. **Results:** There is low perception and disregard by women about their condition of vulnerability to these infections. They believe that the possibility of acquiring them is related to behaviors considered deviant, being likely in the life of those who do not experience a stable relationship. **Conclusion and Implications for the practice:** The main challenge is to overcome situations experienced by women that enhance their vulnerabilities generated by mistakes and misconceptions. It is necessary to plan preventive actions that are not limited to the transmission of information, but the exchange of knowledge, beliefs and values linked to the way in which women experience their sexuality.

**Keywords:** Vulnerability in Health; Sexually Transmitted Infections; Woman; Gender and Health; Collective Health.

## RESUMO

**Objetivo:** Analisar a percepção de mulheres quanto à sua vulnerabilidade às infecções sexualmente transmissíveis. **Método:** Trata-se de um estudo exploratório e descritivo com abordagem qualitativa, desenvolvido entre os meses de agosto de 2018 a outubro de 2019, em uma Unidade Básica de Saúde. Participaram do estudo oito mulheres, na faixa etária de 21 a 44 anos com histórico prévio de infecções sexualmente transmissíveis. Os dados coletados com entrevistas semiestruturadas foram submetidos à análise temática proposta por Bardin. **Resultados:** Há baixa percepção e desconsideração das mulheres sobre sua condição de vulnerabilidade a essas infecções. Elas acreditam que a possibilidade de adquiri-las está relacionada a comportamentos considerados desviantes, sendo provável na vida de quem não vivencia um relacionamento estável. **Conclusão e Implicações para a prática:** O principal desafio é superar situações vivenciadas pelas mulheres que potencializam as suas vulnerabilidades geradas por equívocos e erros de concepções. Precisa-se planejar ações de prevenção que não se limitam ao repasse de informações, mas a troca de saberes, crenças e valores vinculados à forma pelo qual a mulher vive sua sexualidade.

**Palavras-chave:** Vulnerabilidade em Saúde; Infecções Sexualmente Transmissíveis; Mulher; Gênero e Saúde; Saúde Coletiva.

## RESUMEN

**Objetivo:** Analizar la percepción de las mujeres de su vulnerabilidad a las infecciones de transmisión sexual. **Método:** Trata-se de um estudo exploratório e descritivo com abordagem qualitativa, desenvolvido entre os meses de agosto de 2018 a outubro de 2019, em uma Unidade Básica de Saúde. Participaram do estudo oito mulheres, na faixa etária de 21 a 44 anos e histórico prévio de infecções sexualmente transmissíveis. Os dados coletados com entrevistas semiestruturadas foram submetidos à análise temática proposta por Bardin. **Método:** Se trata de un estudio exploratorio y descriptivo con enfoque cualitativo, desarrollado entre los meses de agosto de 2018 y octubre de 2019, en una Unidad Básica de Salud. Ocho mujeres en el grupo de edad de 21 a 44 años participaron en el estudio con historia previa de infecciones de transmisión sexual. Los datos recopilados con entrevistas semiestruturadas se sometieron a un análisis temático propuesto por Bardin. **Resultados:** Hay una baja percepción y desprecio por parte de las mujeres de su vulnerabilidad a estas infecciones. Creen que la posibilidad de adquirirlas está relacionada con comportamientos considerados desviados, siendo probable en la vida de aquellos que no experimentan una relación estable. **Conclusión e implicaciones para la práctica:** El principal desafío es superar las situaciones experimentadas por las mujeres que aumentan sus vulnerabilidades generadas por errores y conceptos erróneos. Es necesario planificar acciones preventivas que no se limiten a la transmisión de información, sino al intercambio de conocimientos, creencias y valores vinculados a la forma en que las mujeres experimentan su sexualidad.

**Palabras clave:** Vulnerabilidad en la salud; Infecciones de transmisión sexual; Mujer; Género y salud; Salud pública.

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## INTRODUCTION

Sexually Transmitted Infections (STIs) are among the most common public health problems worldwide, despite all the scientific, technological, preventive and curative advances. It includes a number of clinical syndromes, which can be spread mainly through sexual contact. They are able to make the human body more vulnerable to other diseases and present more serious complications in women, such as infertility, spontaneous abortion, congenital malformations and even death, if not treated.<sup>1,2</sup>

According to the World Health Organization (WHO), more than one million people acquire an STI daily and every year 500 million people acquire one of the curable STIs (gonorrhea, chlamydia, syphilis and trichomoniasis), with syphilis in pregnancy causing approximately 300,000 fetal and neonatal deaths/year and putting 215.000 newborns at risk of premature death, low birth weight or congenital syphilis; 530 million people are infected with the genital herpes virus and over 290 million women are infected with the Human Papilloma Virus (HPV). HPV infection causes 530,000 cases of cervical cancer and 275,000 deaths per year.<sup>3,4</sup>

It is clear that the epidemiological profile of STIs has been changing during the last decades all over the world, with a significant increase in the number of cases among women. Historical contexts reveal that Brazilian women face obstacles due to prejudice, processes linked to gender dynamics and sexual and reproductive relations. The multiplicity of sexual partners, asymmetry in relations between women and men, religious dogmas and moral implications expose the female public to STIs and, concomitantly, accentuate women's vulnerability.<sup>5</sup>

Women are especially vulnerable to STIs due to biological characteristics, gender and social issues, which impose on them conditions of submission and inferiority to men, even depriving them of the power to make decisions about protected sexual activity; early sexual activity, low schooling, low income and economic dependence on women, especially in developing countries. In addition, there is a lack of perception by the female population of contracting an STI, as they link this risk to other women and not to themselves. It is also noteworthy that most women associate condom use as a way to avoid unplanned pregnancy and not as a prevention for these illnesses.<sup>6</sup>

Vulnerability can be defined as a situation resulting from a set of individual, programmatic, social and cultural factors that are interdependent and mutually influenced, related to the degree and mode of exposure to a given situation, and which lead to increased susceptibility to illness. Thus, its definition can be applied to a person or to a social group according to their capacity to prevent, resist and circumvent potential impacts.<sup>7,8</sup>

The vulnerability is a process that comes from

[...] non-recognition or disrespect, with harmful consequences for those who suffer from it, while at the same time exposing weaknesses (affective, normative and ethical) that demand responses that can extend from the level of interpersonal relationships to the macropolitical field of the conformation of social norms and institutional structures.<sup>8:22</sup>

The concept of vulnerability in health has been elucidated, starting from concerns arising from the perception that the sense of risk is still linked to pre-existing concepts and considering that essential elements of vulnerability must be sustained by the subject and the social. Thus, the author brings as definition: "[...] a human condition, built in the interaction between the subject and the social, characterized by a power relationship that moves towards a condition of precariousness when the empowerment is not experienced by the subject or collective".<sup>9:126</sup> In this perspective, it is understood that vulnerability carries fruitful inaccuracies in the process of conceptual construction in which it finds itself, there are advances in the discussion of dynamic and multidetermined reality. It is because of this understanding that the present research adopts this concept of vulnerability, as a theoretical reference.

The concept of vulnerability as a parameter for reflection and action implies the recognition of the concomitance of ethical, political and technical factors, bypassing the incidence of risks in the territories and the human capacity to face them.<sup>10</sup> Therefore, it is necessary to think that each element of vulnerability can be adopted as a parameter for the interpretation of various health hazards. Thus, it can expand the performance in health, as well as generate reflections and actions of health policies based on the community needs.

Faced with the problem elucidated, it is considered that women's vulnerabilities to STIs represent an important problem and should be the target of actions in the field of health, since it mainly influences the quality of life of the population. It is also considered that the vulnerability situations can be minimized for the occurrence of STI, if effective and transforming sexual prevention actions are effective that can trigger a process of empowerment, corresponsibility and biopsychosocial well-being in women. In this sense, the research aimed to analyze women's perception of their vulnerability to Sexually Transmitted Infections, based on the following guiding question: what is women's perception of their vulnerability to STIs?

It is believed that this study will have an important impact on women's health, as it is expected to subsidize health managers and teams in the development of preventive and clinical quality strategies that address the needs of this group in a more effective, integral and participatory way, thus providing a systematic and contextualized professional practice, contributing to the mitigation of this problem and optimization of services provided in Primary Health Care. It is vital to search for new knowledge and alternatives to reduce the existing problems in the community where we are inserted.

## METHOD

This is an exploratory, descriptive and qualitative research, which takes as a reference the concept of vulnerability in its individual and social scope, developed between the period of August 2018 and October 2019. The scenario was UBS Otilha Feitosa da Silva/PSF V because it is located in a territory that presents a higher index of IST cases, according to the analysis of the database, of the SINAN/NET<sup>11</sup> system.

This development of this research was carried out in 3 stages: 1<sup>st</sup> Stage: identification of the participating women, through a search in the medical records and in the gynecological exam book in order to identify those who, according to the established criteria, could participate in the study. A total of 26 women were identified; 2<sup>nd</sup> Stage: home visit, moment when the research was presented and the invitation to participate and, as accepted, the interview was scheduled. 3<sup>rd</sup> Stage: a script instrument was applied for the interview with the women, previously selected, with the intention of knowing the contexts of vulnerability.

Eight women from 21 to 44 years of age, selected according to the following inclusion criteria, participated in the research: women living in the territory of UBS Otilha Feitosa da Silva with ages ranging from 15 to 44 (reproductive phase), approached at random, regardless of educational level, race and religion; history of contamination by a STI and self-declared ability to demonstrate conditions to answer and understand the interview script questions. The sample composition was intentional, random and by saturation. It should be noted that of the 26 women selected, eight interviews were carried out, since the sample reached saturation and none of them refused to participate in the study.

Saturation sampling is used to establish or close the final size of a study sample, interrupting the capture of new components, based on the fact that the addition of new observations does not contribute to a significant increase in information and, thus, the inclusion of new participants in the evaluation of the researcher leads to redundancy or repetition of information.<sup>12</sup>

The interviews were applied in a reserved place, suggested by the participants. Soon, these happened at UBS, in a closed room, free from interference, which guaranteed confidentiality and continuity of the process. Therefore, they took place at their suggestion at UBS, in a closed room, free of interferences, which guaranteed confidentiality and interruption of the process. They lasted 60 minutes with questions mediated by the researcher in charge, recorded in a digital device with prior authorization of the participants and later transcribed, which ensured data in its entirety and the essence of the statements.

In view of the coherence between the theoretical and methodological assumptions and the most appropriate way of analyzing the contents arising from the application of the instrument, the thematic categorization proposed by Bardin was adopted as a technique of analysis and treatment of information, a modality of content analysis that operationally consists of three stages: pre-analysis, analysis, treatment of results and interpretation.<sup>13</sup>

Since this is a scientific research involving human beings, the ethical and legal principles postulated in the National Health Council Resolution No. 466/12<sup>14</sup> were ensured, being approved on June 8, 2019, by the Research Ethics Committee of the State University Vale do Acaraú, in Sobral/CE, under the opinion of No. 3,378,814/ CAEE - 13897819.2,0000,5053. As a guarantee of confidentiality and anonymity, it was used to identify research participants to the letter "E" followed by an Arabic number (E1, E2, E3, E4, E5, E6, E7, E8...).

## RESULTS

In analyzing the interviews, aspects emerged about women's perception of STI vulnerabilities, which lead them to feel protected and limit their consideration of vulnerability to carry out concrete prevention actions, situations that strengthen Vulnerabilities in Health. Common elements emerged that favored the progressive construction of three categories, namely: infection contracted by the sexual act: will it happen to me?; stable relationships: risk groups or protection? and disregard of vulnerabilities to STIs: I know, but I don't care!

### Infection contracted by the sexual act: will it happen to me?

According to the testimonies, some women understand that unprotected sexual practices have an impact on sexual health and can contribute to the occurrence of infections, because they perceive themselves as vulnerable to STIs due to risky sexual behavior from not using a condom. They have even indicated that the only way they are immune to STIs is through sexual abstinence:

*Because I don't like to do condom relations. (...) I know if anything happens is because of myself because I don't like it. (E1).*

*Now I think a woman would be immune to STD, only if she didn't have any kind of relationship or was a virgin, those things. (E2).*

*My vulnerability is precisely because of that, because I know the situation, I know the history of what happened, but I'm still on the same path. (...) because I don't prevent myself in any way there I think I have more possibilities of having these. (E5).*

Some women perceive their vulnerability related to previous experiences with STI, and one of them has noticed that such condition is characteristic of her own body, as she is predisposed to contracting these infections:

*Cause I already got it, so I guess I can get it again, too. (E1).*

*I think, from what I've been through with this disease (...). (E3).*

*I think that my organism is adapted to catch other things. (E5).*

Women's statements elucidate that the majority have a low perception of vulnerability, since for them being vulnerable is characteristic of those who have a sexual lifestyle of promiscuity, derangement and behaviors that are not morally accepted, being these "protected" because they do not fit these criteria that they consider central to being vulnerable to STIs:

*(...) if you're alone with that person, you don't have sex with other people, I guess (...). (E3).*

*(...) because the person who goes out with guys picks up. (...) I go out with other men, then I have the capacity to catch (...). (E4).*

*(...) if the woman has a relationship with one, with another and with another, then yes. (E5).*

*(...) only if this is the case, if the woman has other men, then it is dangerous to catch, but I only have the one I live (...). (E6).*

Women construct the premise that the “other” is responsible for the contamination. For them, insecurity about their partner’s behavior, lack of knowledge or knowledge of their sexual health situation, neglect of their health and lack of hygiene are factors that place them in a vulnerable situation. Thus perceiving in their partner the potential to contract these infections:

*(...) then we went to take a blood test and he had genital herpes (...). Yeah, so, I don’t know. (E2).*

*Because I don’t know what situation he is in, if he has any disease, if he doesn’t have it. (...). (E3)*

*I’m afraid, I don’t know, because the way it is these days no one can even trust. (E5).*

*There are men who are dirty, some are clean, some are dirty, from a rancid person to a rancid one. (E4).*

*(...) It’s no use just me taking care of myself, without him taking care of him (...). (E8).*

### **Stable relationships: are they risk/protection groups?**

The perceptions revealed in the interviewees’ statements reflect that women’s vulnerability to STIs in stable relationships is anchored to risk and protective groups. Those who consider themselves “at risk groups” are precisely those who perceive that having an active sexual life is already reason enough to be vulnerable to STIs, even having a stable relationship:

*I think it has, I don’t know why, but I think it has, because it has a direct relationship there, and somehow it transmits, in an I know, even though it has a stable relationship, I think it has. (E5).*

Another situation revealed among those who perceive the stable relationship as a group at risk for contracting STIs is linked to the behavior of the “other”, in this case the partner, as the main responsible for putting them in a vulnerable situation, mainly due to infidelity:

*In this case it’s dangerous, no one knows with whom he stays, she won’t know, and no one will believe it either (,,). (E3).*

*I think so, because we never know, sometimes we know the person, sometimes we live inside the house with the person and sometimes we don’t know the health situation, doesn’t it (...). (E7).*

There were women who highlighted stable relationships as a group at risk by the existing naturalization of extramarital relationships, whose men and women do not have a relationship built on moral precepts of commitment, respect and fidelity.

*Most men and women also relate to other people, although together. (E1).*

The low perception of vulnerability among the majority of women was perceived, a factor that makes the stable relationship a critical scenario in the context of vulnerability to STIs, as there is generally no adoption of protective behaviors. For deponents, stable relationships promote security to women, “protecting” them from being afflicted by STIs, crediting in monogamy the guarantee for partner loyalty and the prevention of these infections:

*In my opinion, it doesn’t, because it’s just with that person, it doesn’t have sex with other people, I think so, right, in my opinion. (E3).*

*She only has a risk, if someone else doesn’t play, if the man doesn’t like to date on the outside, then she does. Now if he’s really just with her, I don’t think he has any (...). (E4).*

### **Disregarding vulnerabilities to STIs: I know, but I don’t care!**

When entering the subjective field of women, a strangeness was revealed in the face of the problem of vulnerabilities to STIs, since some consider the extra-marital relationship natural, be it of the partner or the woman herself. It is also pointed out that although they have already been affected by some type of these infections and are aware that they may reoccur, they behave carelessly, disregarding a safe sex life:

*He doesn’t know I have relationships on the outside. (...) when I go after one, that I go out in the middle of the world behind, he already knows that he’s after those things, right? (E4).*

*I didn’t mind, because if I had, I wouldn’t have gone back to him again. (E6).*

*(...) because I know it can cause him to transmit to me, but I don’t warn myself. (E8).*

They still had those who seemed impartial to the situation discussed, because they showed that they do not care about contracting an STI again, they are aware that the partner has a sexual disease, even so they had an unprotected relationship, including those who abstained from the sexual act with the partner,

not because he is with an STI, but because of the impossibility related to discomfort of the latter:

*I sincerely don't care (...). (E7).*

*(...) It gave him genital herpes (...). But between agents there is no use of condoms. When he was with the wounded one I didn't have sex with him, there is no way to have (...). (E2).*

Trust in their partner is an element that helps these women not consider their vulnerability to STIs. The conviction of partner loyalty increases the likelihood of recurrences of these infections in their lives, since they totally disregard the adoption of safe sexual practices. Among the participating women, the word trust has another meaning than necessarily believing in fidelity, but the belief in partner prevention in case of extramarital relationships:

*He is highly faithful, I am sure (...) and especially because he is afraid that he is already going through it (...). (E2).*

*(...) Of course I trust him a lot, I trust him too much (...). I think if he had had anything he would have told me. He always tells me everything. (E5).*

*(...) I think it's because I trust him too much, if I've taken it from him long ago, it's been kept (...). (E7).*

In addition to the situations mentioned, the statements reveal that the disregard for vulnerability is also related to attitudes of the partner that are generally not perceived as vulnerable to STIs, so they are irreducible when it comes to sexual relationship with protection:

*(...) I related to him without knowing he was ill. (E3).*

*I know no, I know no. He said he took it when he was a boy and it was work to get well (...). (E4).*

*No. I don't know. (...). (E8).*

## DISCUSSION

From the information obtained, we sought to look at the vulnerabilities involved, based on the assumption of understanding vulnerability as the possibility of exposure to illness resulting not only from a set of individual aspects, but also from collective and contextual factors that cause individuals greater susceptibility to the availability of resources to protect themselves<sup>9,11-15</sup>

The elements identified favor unsafe sexual practice without psychoactive maturation and responsibility, leaving them vulnerable. In another study, similar results were found in identifying that women perceive the importance of protective sexual relationship and vulnerability related to this cause, but for various reasons they do not use it, most often because they do not want to.<sup>16</sup>

This differs from the results found in one study, in which many women, despite recognizing that condom use is one of the main measures to prevent STI/HIV and perceiving themselves as practitioners of risk behavior, do not admit that they can even contract these infections.<sup>17</sup>

The self-perception of vulnerability outlined by women refers to the following question: "Why not adopt safe sexual practice, if there is an awareness of the possibilities of recontamination? These and other questions do not require answers and reflections on these that can facilitate the opening of a space for an approach in health that brings professionals closer to women, so that it is possible to understand the arrangements imbricated to the problem and then to program resolute strategies, magnetized by the vulnerabilities experienced.

Understanding must be awakened to broader issues in the "integral" sense that can rethink and recognize the processes that erupt into vulnerability, not only in its individual character, but also in the social that is one of its elements as continuous processes of forces that draw the paths along which the social individual is recognized on the social scene. The essential elements of vulnerability in health are diverse and multiple and are not understood as dimensions, since each one has its characteristics and concepts, but interconnected, that is, they only exist in the presence of the other, at the same time that several times their characteristics may be confused.<sup>9</sup>

It is believed that in order to understand vulnerability, it is necessary to critically and reflectively unfold the challenges and tensions involved in people's reality and not only perceive it as a mere intellectual exercise, in order to make the perspective of proactive, preventive and protective public health policies effective.

The low perception of vulnerability for an STI is usually related to the feeling of protection, especially when women are married or have a fixed and stable partner, as well as when they no longer have the possibility of becoming pregnant.<sup>15</sup> Therefore, individuals who do not feel vulnerable to an illness do not usually accept the recommended preventive measures.

The perception of vulnerability is linked to trust in the partner, the situation in which the partner finds himself, and the use of condoms in sexual relationship. Most women still do not perceive themselves as vulnerable to STIs/ AIDS or are aware of the importance and do not protect themselves.<sup>18</sup>

This perception among most women was justified by the belief that they were engaged in stable affective-sexual relationships in which they assumed mutual sexual exclusivity. They maintained that this preventive care was dispensable in their relationships, since they had only one partner and they believed that this had no other partner. Their conceptions of vulnerability were largely linked to the multiplicity of partnerships, which could occur when there was no commitment to exclusivity or when this commitment was not maintained.<sup>10</sup>

Corroborating these findings, it was identified in a study that the representations of vulnerability for women are related to certain limitations and particularities, present in the "other", appearing that they themselves would be excluded from such

situations and possibilities. Another important factor is the judgment that vulnerable people have a certain profile, since in their conception it would be women with multiple partners who do not protect themselves using the condom.<sup>19</sup>

At tunneling looks to this panorama, one apprehends a web watered by situations of vulnerabilities to which women are involved, considering that they are not conscious and sensitized with concreteness about the vulnerability to which they are exposed in sexual relationships, causing them to assume a carefree behavior or of non-perception in face of the risk and prevention of STI.

Sexual health is a fundamental part of any person's overall health assessment. Thus, knowing the sexual history and identifying vulnerabilities is fundamental to a person-centered approach, allowing one to know the person as a whole. This research should be structured to identify vulnerability factors related to sexual health, recognizing sexual practices and behaviors as well as opportunities for brief behavioral change interventions.<sup>20</sup>

In this context, it is important to expand actions encompassing health promotion programs that are increasingly effective and resolute with the challenge and moral and ethical obligation to make them accessible to all and, above all, to especially vulnerable segments such as women. It is necessary to think about sexual orientation strategies that dialogue with the realities of women's lives, paying attention to the relations of the subject and social elements, which intend to situations of precariousness and empowerment, and together assume several nuances that potentialize or weaken the processes of vulnerability in health.<sup>16</sup>

Women who live in married or stable unions generally have low perceptions of vulnerability because they believe in these affective bonds as a protective factor and therefore do not adopt safe sexual behavior, placing them in situations of vulnerability to STIs.<sup>21,22</sup> Therefore, this feeling of protection limits women to question themselves about their vulnerability and, if affected by these infections, favors the lack of early diagnosis, prevents treatment from being initiated, contributing to the complications arising from the grievance and perpetuating the transmission.<sup>10</sup>

It is believed to be fundamental to value, promote and encourage self-knowledge that implies knowing oneself, values, feelings, the way of seeing and living life and relationships with others so that it is possible to build a healthy affective involvement that contributes to personal growth, overcoming difficulties and strengthening self-esteem.<sup>23</sup>

Because so many other women have the same perceptions, it is considered that sexual health promotion activities should be focused on the couple, based on effective and viable strategies that emphasize the different vulnerabilities, warning about the risks of infection and promoting changes in the attitudes of both, such as respect and protection for the person who loves or relates.

The results revealed important elements of the characteristics, behaviors and contexts that lead women to disregard vulnerabilities, a situation that limits their initiative to preventing STIs. Such information is indicative of a disquieting scenario, while women do not incorporate in their lives, protective attitudes in a regular

and consistent way, showing vulnerability in terms of their sexual behavior and other social determinants. Other studies have shown the same evidence that women are aware of risk but do not adopt preventive measures.<sup>18,24</sup>

A similar result was found in a study in which female vulnerability is also associated with extra-marital events, mainly by men, and women know about these infidelity events and accept them because they consider them to be a male need and do not charge for condom use, thus contributing to the acquisition of an STI.<sup>25</sup>

Research shows that one of the motivations for women not to protect themselves concerns trust in their partner, since the coexistence and intimacy built up in the relationship seem to rule out the risk of contagion to STI. The expression trust is interpreted by women as the preventive attitude of the husband in his possible extramarital relationships. Therefore, women end up disregarding their vulnerability by putting security in their relationships and often exposing themselves to risks if their partners are not faithful.<sup>26,27</sup>

Research carried out with women in other states of the Northeast showed that condom adoption depends on male agreement, which is a hindrance to prevention, since they do not like barrier methods because they believe they interfere with sexual pleasure.<sup>28</sup> In this context, it is believed that the inclusion of men in preventive strategies constitutes a point of positive change in confronting these diseases, since their behavior directly affects their companion.<sup>28</sup>

Among African-American women, consistent condom use was predicted by the following variables: greater awareness of the relevance of condom negotiation, less fear of negotiating condom use, and talking with sexual partners about prevention.<sup>29</sup>

Women are part of one of the most vulnerable groups of STIs, having as main factor the cultural and social role to which they are subjected over the years, of exclusion from decision making both in their public and personal lives. Compared to men, they have less autonomy in their sex life and, consequently, less power to make decisions about sex with protection, increasingly impacting STIs in situations of vulnerability.<sup>30</sup>

Such information deserves reflection on what has been discussed about vulnerability so that people, especially women, perceive situations that may place them as vulnerable, pondering on their experiences and practices. It is also emphasized that the less vulnerable people feel, the less they take care to avoid certain harm.<sup>19</sup> From this perspective, it is essential to make women who have no notion of risk and no power to change their partner's behavior understand that risk also belongs to them.<sup>31</sup>

It is understood that in processes of vulnerability in health, the power relationship between the subject and the social is an open field of responses, reactions, results and possible inventions that can result in precarious conditions and empowerment. The conditions of precariousness involve situations in different ways that represent a sphere of social inequities and thus end up reinforcing the situations of Vulnerability in Health. Otherwise, there is the possibility of transforming these processes through

the experience of empowerment, since the subject can obtain means to face and minimize situations of Vulnerability in Health.<sup>16</sup>

The idea embedded in this perspective is that of deepening democracy from the individual and social point of view in which people are protagonists of their lives and projects. In the process of empowerment, women recognize that they can develop a sense of self capable of defending themselves, conquering, advancing and overcoming not only adversities but also common human obstacles. It is the act of taking possession of these internal resources that make them active, autonomous and emancipated subjects of the process of their existences, whether in the exercise of an egalitarian conjugality, the prevention or treatment of an illness, the denunciation of maltreatment, the administration of their sexuality.<sup>32</sup> However, it is not enough for this to remain on the individual level alone, since empowerment is relational and depends on the interactions with the environment in which women are circumscribed.<sup>32</sup>

## CONCLUSIONS

The research allowed to verify the low perception of women in relation to the vulnerabilities to the STIs, a situation that leads them to feel protected and limits their consideration of vulnerability to carry out concrete actions of prevention, potentiating the condition of vulnerability. They believe that the possibility of acquiring ISTs is linked to behaviors considered deviant, being probable only in the life of those who do not live a stable relationship, perpetuating ideas about such diseases that should have already been deconstructed.<sup>19</sup>

Thus, the main challenge is to translate the solutions to overcome the different contexts of women's vulnerability to STIs, from the elaboration of effective policies and concrete actions that ensure access to the promotion and prevention programs, available in the health system, with the guarantee of holistic and integral assistance for women's health.

It is necessary to reorient PHC services so that professionals and managers realize that political, social, cultural, and economic issues permeate the situations of vulnerability to which women are exposed and thus enable them to be protagonists of their health, which will strengthen public policies inherent to their realities and vulnerabilities.

Finally, it is worth highlighting as limitations of this study the fact that it did not include aspects related to the programmatic situation of vulnerability, a factor that would further substantiate the findings found, in order to contribute to the existing gaps in PHC, since it is believed that for health services to be able to offer what the community needs, continuous assessments of the work processes and identification of strategies that guarantee the principles and guidelines of the Single Health System (SUS) are necessary.

However, this study does not exhaust the understanding of women's vulnerability to STIs, given the complexity of the subject, and it is therefore proposed that research be applied to address the misconceptions found regarding women's perceptions of their vulnerability to STIs. In addition, it is deemed necessary

to develop other studies that can investigate more concepts and sub-concepts and the relationships established by women involving the processes of vulnerability in health.

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Study design. Data acquisition, data analysis and interpretation of results. Writing and critical review of the manuscript. Approval of the final version of the article. Responsibility for all aspects of the content and integrity of the published article. Samy Loraynn Oliveira Moura.

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